SECTION 5, CHAPTER 1, POLICY 017

AUTHORIZATION AND UTILIZATION REVIEW OF

OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES

POLICY NUMBER:	5-1-017
SYSTEM OF CARE:	MENTAL HEALTH
FINALIZED DATE:	01.31.2022
EFFECTIVE:	01.01.2022
SUPERSEDES # :	Supersedes Policy #'s: N/A

A. PURPOSE: To establish and provide notification of uniform authorization and utilization review processes for Outpatient Specialty Mental Health services (SMHS) consistent with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to ensure Yolo County Health and Human Services Agency (HHSA) Behavioral Health (BH) and Network Providers are following federal and state requirements.

B. FORMS REQUIRED/ATTACHMENTS: N/A

C. DEFINITIONS:

1. **Specialty Mental Health Services (SMHS):** Defined by Title 9 C.C.R. 1810.247

2. **Mental Health Plan (MHP):** Yolo County HHSA BH. This does not include Network Providers.

3. **Network Providers**: Any provider, group of providers, or entity that has a network provider agreement with the MHP and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract with the MHP (42 C.F.R. § 438.2)

4. Access criteria:

a. For beneficiaries 21 years of age or older, Yolo County HHSA BH mental health plan shall provide covered specialty mental health services for beneficiaries who meet **both of the following** criteria, (1) and (2) below:

(1) The beneficiary has **one or both** of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

b. A suspected mental disorder that has not yet been diagnosed.

b. For enrolled beneficiaries under 21 years of age, Yolo County HHSA BH mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following** criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the Department of Health Care Services, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

(2) The beneficiary meets **both of the following** requirements in a. and b., below:

a. The beneficiary has **at least one** of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b. The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

5. **Involvement in child welfare**: The beneficiary has an open child welfare services case, or the beneficiary is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

6. **Homelessness**: The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the

meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

7. **Juvenile justice involvement:** The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

8. **Medical Necessity criteria**: Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

   For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

   Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

A. POLICY: The MHP will ensure that all Yolo County Medi-Cal beneficiaries have appropriate access to outpatient SMHS through a Utilization Management (UM) program. The UM program shall evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior authorization

procedures, or retrospectively, which evaluates medical necessity, appropriateness, and efficiency of services provided. The MHP shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.

1. **<u>Requirements Applicable to Authorization of all Outpatient SMHS:</u>**
    a. Authorization procedures and utilization management criteria shall adhere to the following principles:
        i. Be based on SMHS medical necessity and access criteria, and consistent with current clinical practice guidelines, principles, and processes;

        ii. Be developed with involvement from Network Providers, including, but not limited to, hospitals, organizational providers, and Licensed Mental Health Professionals acting within their scope of practice;

        iii. Be evaluated, and updated if necessary, at least annually; and,

        iv. Be disclosed to MHP beneficiaries and Network Providers.

    b. The MHP shall comply with the following general requirements:
        i. Ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

        ii. May place appropriate limits on a service based on medical necessity, or for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports.

        iii. Not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary.

        iv. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.

v. No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a beneficiary or a provider, may deny, or modify a request for authorization of SMHS for a beneficiary for reasons related to medical necessity.

vi. Ensure that compensation to individuals that conduct UM activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a beneficiary.

vii. The MHP shall notify the requesting provider in writing and give the beneficiary written notice of any decision by the MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations

viii. Ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate.

c. The MHP shall comply with the following communication requirements:

i. Notify Department of Health Care Services (DHCS) and Network Providers, in writing, of all services that require prior authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;

ii. Maintain telephone access 24-hours a day, 7-days a week for providers request expedited authorization of an outpatient service requiring prior authorization;

iii. A physician shall be available for consultation and for resolving disputed requests for authorizations;

iv. Disclose to DHCS, Network Providers, beneficiaries, and members of the public, the utilization review policies and procedures that the MHP or its Network Providers use to authorize, modify, or deny SMHS. These policies and procedures shall be available electronically and in hard-copy upon request;

v. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,

vi. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

d. All the MHP and Network Provider's authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

2. <u>Utilization Review:</u>

a. Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. The MHP retains the right to monitor compliance with any Network Providers and may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS. For example, the MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the beneficiary.

3. <u>Ongoing Monitoring Requirements:</u>

a. The MHP shall demonstrate ongoing compliance with the Parity Rule and MHSUDs Information Notice 19-026 and/or any requirements that have been adopted by DHCS via issuance of MHSUDs IN's. The MHP shall maintain policies and procedures and provide additional evidence of compliance with requirements upon request by DHCS and during compliance reviews and/or External Quality Review Organization reviews. If DHCS determines the MHP to be out of compliance with requirements, the MHP will be required to submit a Plan of Correction, as well as evidence of correction, to the DHCS.

B. PROCEDURE:

1. Determination of Access Criteria Eligibility and Medical Necessity:

a. Outpatient Services

i. Staff at Yolo County HHSA Access points will provide a screening to determine the correct referral destination (Managed Care Plan or MHP) for outpatient services. These staff will document their determination and refer to the appropriate provider based on said determination.

ii. Providers receiving referrals from the access points are required to provide medically necessary services with referred individuals and complete the appropriate assessment within a reasonable time and in accordance with generally accepted standards of care

1. All staff conducting assessments shall meet the qualifications for Licensed Practitioner of the Healing Arts (LPHA)

b. This criteria for a beneficiary to access outpatient SMHS set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:
    i. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
    ii. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
    iii. The beneficiary has a co-occurring substance use disorder.

c. Per Welfare and Institutions Code section 14184.402(f)(1)(A), a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code.
    i. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes)

2. Prior Authorization:

a. Prior authorization by the MHP is required for the following services:
    i. Intensive Home-Based Services
    ii. Day Treatment Intensive
    iii. Day Rehabilitation
    iv. Therapeutic Behavioral Services
    v. Therapeutic Foster Care

b. For purposes of prior authorization, referral by the MHP is considered to serve the same function as approving a request for authorization.

c. The MHP may require Network Providers to request payment authorization for the continuation of services at intervals specified by the MHP.

d. For continuation of services, Network Providers shall request payment authorization prior to the end of the specified current authorization period, in order for the MHP to make a timely decision, that ensures that there is no break in medically necessary services to the beneficiary. The following services shall require a payment authorization at intervals specified:
    i. Every three (3) months for Day Treatment Intensive
    ii. Every six (6) months for Day Rehabilitation

e. The MHP shall not require prior authorization for the following services/service activities:
    i. Crisis Intervention
    ii. Crisis Stabilization

iii. Mental Health Services
- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral

iv. Targeted Case Management
v. Intensive Care Coordination
vi. Medication Support Services.

f. The MHP may delegate responsibility for conducting Assessments to a Network Provider(s). In these instances, if a referral is made to a service identified as not requiring a prior authorization the MHP is not permitted to require prior authorization.

3. Outpatient Authorization Timeframe and Documentation Requirements:

a. The MHP shall review and make decisions regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the receipt of the information reasonably necessary and requested to make the determination.

b. For cases in which the MHP or a provider determine that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

c. The MHP may extend the timeframe for making an authorization decision for up to fourteen (14) additional calendar days if the following conditions are met:
   i. The beneficiary, or the provider, requests an extension; or
   ii. The MHP justifies and documents a need for additional information and how the extension is in the beneficiary's best interest. Documentation shall be available to the DHCS upon request.

4. Authorization Resolution:

a. If the MHP <u>approves</u> referral or prior authorization, they shall:
   iii. Specify the amount, scope, and duration of treatment that has been authorized.
   iv. Document their determinations and maintain documentation in accordance with Title 42 of the CFR, part 438.3(h).

b. If the MHP denies or modifies the request for authorization, they shall:
    i. Notify the beneficiary, in writing, of the adverse benefit determination and complete a NOABD prior to discontinuing services.

c. If the MHP terminates, reduces, or suspends previously authorized services, they shall:

    i. Notify the beneficiary, in writing, of the adverse benefit determination and complete a NOABD prior to discontinuing services.

5. Retrospective Authorization Requirements:

a. The MHP may conduct retrospective authorization of SMHS only under the following limited circumstances:
    i. Retroactive Medi-Cal eligibility determinations;
    ii. Inaccuracies in the Medi-Cal Eligibility Data System;
    iii. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
    iv. Beneficiary's failure to identify payer.

b. In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the beneficiary, or to the beneficiary's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and shall be communicated to the provider in a manner that is consistent with state requirements.

C. REFERENCES:

1. MHP Contract, Attachment A
2. DHCS Information Notice 19-026: Authorization of Specialty Mental Health Services
3. DHCS Information Notice 21-073: Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements
4. DHCS Information Notice 22-019: Documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services
5. 42 CFR § 438.210

Approved by:

Karleen Jakowski, LMFT Digitally signed by Karleen Jakowski, LMFT Date: 2023.01.31 10:44:13 -08'00'

Karleen Jakowski, LMFT, Mental Health Director
Yolo County Health and Human Services Agency

01/31/2023
Date