COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 1, POLICY 015

AUTHORIZATION OF INPATIENT AND RESIDENTIAL SPECIALTY MENTAL HEALTH SERVICES

POLICY NUMBER:	5-1-015
SYSTEM OF CARE:	MENTAL HEALTH
FINALIZED DATE:	03.08.2024
EFFECTIVE:	04.15.2022
SUPERSEDES # :	N/A

A. PURPOSE: To establish and provide notification of uniform authorization procedures for Acute Psychiatric Inpatient Hospital, Psychiatric Health Facility (PHF), Crisis Residential Treatment Services (CRTS), and Adult Residential Treatment Services (ARTS) to ensure Yolo County Health and Human Services Agency (HHSA) Behavioral Health (BH) and Network Providers are following federal and state requirements.

B. RELATED DOCUMENTS: N/A

C. DEFINITIONS:

1. **Inpatient Specialty Mental Health Services (SMHS)**: Refers to Acute Psychiatric Inpatient Hospital, Psychiatric Health Facility Services, Crisis Residential Treatment Services, and Adult Residential Treatment Services Specialty Mental Health Services.
2. **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® (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.

3. **Mental Health Plan (MHP):** Yolo County HHSA BH. This does not include Network Providers.
4. **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)
5. **Specialty Mental Health Services:** Defined by Title 9 C.C.R. 1810.247

D. POLICY:

The MHP will ensure that authorization for reimbursement of psychiatric inpatient hospital, PHF, CRTS and ARTS services are conducted in accordance with concurrent review standards from the California Department of Health Care Services (DHCS) in Behavioral Health Information Notice (BHIN) 22-017 and BHIN 22-016 and are available 24 hours per day, 7 days per week.

The MHP will ensure that all Yolo County Medi-Cal beneficiaries have appropriate access to Inpatient 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 or concurrent authorization procedures.

1. **Requirements Applicable to Authorization of all Inpatient SMHS**
    a. The MHP will ensure consistent application of review criteria for authorization decisions, and will consult with the requesting provider when appropriate. The MHP may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the MHP Contract with DHCS for specialty mental health services.

b. Authorization procedures and utilization management criteria shall adhere to the following principles:

   i. Be based on SMHS medical necessity 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.

c. The MHP shall comply with the following general requirements:
   i. 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.
   ii. 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.
   iii. 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.
   iv. 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.
   v. 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.
   vi. 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

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

viii. The MHP shall cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older in accordance with MHSUDS IN No. 18-008, Welf. & Inst. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009) and Yolo County Policies.

d. 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 or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;

ii. 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;

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

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

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

2. Utilization Review

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, or in other instances where there is evidence of fraud, waste, or abuse.

3. Ongoing Monitoring Requirements

a. The MHP shall demonstrate ongoing compliance with the Parity Rule and BHIN 22-017 and/or any subsequent requirements that have been adopted by DHCS via issuance of BHIN'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 DHCS.

4. Realignment Funding

a. The MHP shall use 1991 Realignment funding, when appropriate, to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS IN No. 18-008; Welf. & Inst. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e).)

E. PROCEDURE:

Concurrent Review and Authorization for Acute Psychiatric Inpatient Hospital/Psychiatric Health Facility (PHF) Services

The concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and PHFs certified by DHCS as Medi-Cal providers of inpatient hospital services. General acute care hospitals, psychiatric hospitals and PHFs are collectively referred to as "hospital or PHF" in the procedures below. This authorization process applies to all inpatient admissions, whether voluntary or involuntary. To the extent there is a conflict, these requirements supersede California Code of Regulations, Title 9, Sections 1820.215, 1820.220, 1820.225 and 1820.230.

The MHP, hospitals and PHFs are required to exchange protected health information by any method compliant with the Health Insurance Portability and Accountability Act (HIPAA) and agreed upon by both parties to the exchange, which may include fax, telephone and electronic transmission. The MHP will consult with the beneficiary's treating provider as appropriate. While reviewing an authorization request, THE MHP may communicate with the treating provider and the treating provider may adjust the authorization request prior to the MHP rending a formal decision regarding the authorization request.

1. Admission and Authorization

a. Notification of beneficiary admission and request for treatment authorization

The MHP will maintain telephone access to receive admission notifications and initial authorization requests 24-hours a day and 7 days a week. Within 24 hours of admission of a Yolo County Medi-Cal beneficiary or a Yolo County resident who

is uninsured, indigent, and was not placed by the MHP, for psychiatric inpatient hospital services, the hospital or PHF is required contact the MHP's BH Quality Management Admission Notification Line to request to authorize the beneficiary's treatment, provide the MHP the beneficiary's admission orders, initial plan of care, a, a completed face sheet. The face sheet must include the following information (if available):

- Hospital name and address
- Patient name and date of birth
- Insurance coverage
- Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System (MEDS)
- Current address/place of residence
- Date and time of admission
- Working (provisional) diagnosis
- Date and time of admission
- Name and contact information of admitting, qualified and licensed practitioner
- Utilization review staff contact information

If, upon admission, a beneficiary is in a psychiatric emergency medical condition, as defined in Health & Safety Code section 1317.1(k), the time period for the hospital to request authorization shall begin when the beneficiary's condition is stabilized, as defined in Health & Safety Code section 1317.1(j). For emergency care, no prior authorization is required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

b. Review of initial authorization request

The MHP will decide whether to grant, modify or deny the hospital or PHF's initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in 1.a. above. The MHP will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services.

If a Medi-Cal beneficiary is placed by the MHP and has Medi-Cal from another county, concurrent review and authorization will not be conducted by the MHP. The hospital/PHF shall be responsible to coordinate authorization and payment with the county of responsibility.

2. Continued Stay Authorization

a. Continued Stay Authorization Request

When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF must submit a continued-stay- authorization request for a specified number of days to the MHP.

b. Exchange of information between hospital or PHF and the MHP

The treating provider at the hospital or PHF may request information and records from the MHP needed to determine the appropriate length of stay for the beneficiary. The MHP may request only information from the hospital and treating provider that is reasonably necessary to decide whether to grant, modify or deny the request. The exchange of information is intended to occur flexibly, with the MHP and hospitals exchanging relevant client and clinical information as needed to complete concurrent review procedures and for discharge planning and aftercare support.

Clinical information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- Risk assessment to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.
- Precipitating events if further identified or clarified by the treating hospital after the MHP admission notice.
- Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.
- Hospital information on prior episode history that is relevant to current stay.
- The MHP information of relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
- Substance use disorder (SUD) information to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.

- Known medical history to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.
- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.
- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.
- Number of continuing stay days requested.

c. Review of Continued Stay Authorization Request

The MHP will issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.

The MHP remains responsible to cover the cost of each day of an inpatient hospital stay, at the applicable rate for acute psychiatric inpatient hospital services, until the requirements in paragraph i or ii have been met:

- The existing treatment authorization expires and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider; or,
- The MHP denies a hospital's continued stay authorization request and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider.

3. Adverse Decision, Clinical Consultation, Plan of Care, and Appeal

a. While Licensed Mental Health Practitioners (LMHPs) / Licensed Practitioners of the Healing Arts (LPHAs) may review authorization requests and issue approvals within their scope of practice, all MHP decisions to modify or deny a treatment request must be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs. A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent within the psychologist's scope of practice.

b. A decision to modify an authorization request will be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and will include

a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision will also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.

c. If the MHP modifies or denies an authorization request, the MHP will notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.

d. If the MHP denies a hospital's authorization request, the MHP will work with the treating provider to develop a plan of care. Services and payment for services may not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary. If the MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

e. A MHP denial of an authorization request and a consultation between the treating provider and the MHP may result in one of the following outcomes:
    - The MHP and the hospital treating provider agree that the beneficiary shall continue inpatient treatment at the acute level of care, and the denial is reversed.
    - The MHP and the hospital treating provider agree to discharge the beneficiary from the acute level of care and a plan of care is established prior to the beneficiary transitioning services to another level of care.
    - The MHP and the hospital treating provider agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down facility bed is not available and the beneficiary remains in the hospital, on administrative day level of care.
    - The MHP and the treating hospital provider do not agree on a plan of care and the beneficiary, or the treating provider on behalf of the beneficiary, appeals the decision to the MHP.

Authorization of Administrative Days

1. A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services but has not yet been

accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status.

2. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
3. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.
4. The MHP may waive the requirements of five contacts per week requirement if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made to appropriate facilities shall be documented and include:
    a. Status of the placement
    b. Date of the contact
    c. Signature of the person making contact
5. Examples of appropriate placement status options include, but may not be limited to:
    a. The beneficiary's information packet is under review;
    b. An interview with the beneficiary has been scheduled for [date];
    c. No bed available at the non-acute treatment facility;
    d. The beneficiary has been put on a wait list;
    e. The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
    f. The beneficiary has been rejected from a facility due to [reason]; and/or,
    g. A conservator deems the facility to be inappropriate for placement.

Concurrent Review of Crisis Residential and Adult Residential Treatment Services

1. The MHP shall utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS) and may not require prior authorization.
2. If the MHP refers a beneficiary to a CRTS or ARTS facility, the referral may serve as the initial authorization when parameters of the authorization have been specified (e.g., number of days authorized)
3. The MHP shall then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.
4. In the absence of a referral from the MHP, the MHP shall conduct concurrent review of treatment authorizations following the first business day of admission to a facility through discharge.
5. The MHP may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.
6. Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating provider within 24 hours of the decision and care shall not be discontinued until the beneficiary's treating provider has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.
7. If the MHP denies or modifies the request for authorization, the MHP shall notify the beneficiary, in writing, of the adverse benefit determination. In cases where the MHP determines that care should be terminated (no longer authorized) or reduced, the MHP shall notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

Retrospective Authorization Requirements

1. The MHP may conduct retrospective authorization of SMHS (inpatient and outpatient), under the following limited circumstances:
    a. Retroactive Medi-Cal eligibility determinations;
    b. Inaccuracies in the Medi-Cal Eligibility Data System (MEDS);
    c. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
    d. Beneficiary's failure to identify a payer.
2. In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual'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.

F. REFERENCES:

1. DHCS Information Notice 22-016: Authorization of Outpatient Specialty Mental Health Services
2. DHCS Information Notice 22-017: Mental Health Medi-Cal Administrative Activities Claiming Policy Related to State-Funded Only Beneficiaries

Approved by:

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