7.2.15 AUTHORIZATION FOR PSYCHIATRIC INPATIENT HOSPITAL AND PSYCHIATRIC HEALTH FACILITY SERVICES

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Revision History: Not Applicable

References: BHIN 22-017, [1] Cal. Code Regs., tit. 9, § 1810.440(b); 42 C.F.R. § 438.210 (a)(4), (b)(1),(2), [2] See DHS-BHD MHP Contract, Ex. A, Att. 6 A1, Sec. 1.B., [3] 42 C.F.R., § 438.210(e), [4] 42 C.F.R, § 438.330(a)(1), [5] 42 C.F.R, § 438.330(b)(3), [6] 42 C.F.R, § 438.608(a)(1), [7] DHS-BHD MHP Contract, Ex. B, Sec. 5.B; 42 C.F.R, § 433.51; Cal. Code Regs., tit. 9, §1840.112, [8] See State Plan, section 3, Supplement 3 to Attachment 3.1-A, page 2c; section 3, Supplement 2 to Attachment 3.1-B, page 5, [9] 42 C.F.R., § 438.210 (a)(4)(ii), [10] 42 C.F.R., § 438.210(a)(3)(ii), [11] 42 C.F.R., § 438.210(b)(1), DHS-BHD MHP Contract, Ex. A, Att.12, [12] 42 C.F.R, § 438.210(b)(2)(i-ii), [13] 42 C.F.R., § 438.10(g)(2)(iv), [14] 42 C.F.R. § 438.210(b)(2)(ii), [15] Welf. & Inst. Code, § 14197.1; Health & Saf. Code, §§ 1367.01(i), 1371.4(a); Managed Care boilerplate contract Exh. A, Att. 9, provision 7 C [16] 42 CFR § 456.170, [17] 42 CFR § 456.180; 42 CFR § 441.155, [18] Managed Care Two-Plan CCI Boilerplate exh. A, Att. 5., [19] Managed Care Two-Plan CCI Boilerplate exh. A, Att. 5, [20] Welf. & Inst. Code 14197.1; Health & Saf. Code, §1367.01(h)(2), [21] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3), [22] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3), [23] 42 C.F.R. § 438.210(b)(3); Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(e), [24] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(4), [25] 42 C.F.R. § 438.404(c), 42 C.F.R. § 431.213(c), [26] See generally 42 C.F.R., §§ 438.210(c), 438.404; MHSUDS IN 18-010E, [27] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3), [28] 42 C.F.R. § 438.402(c)(1)(ii), [29] 42 C.F.R. § 438.402(c)(1)(ii), [30] Cal. Code Regs., tit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400, [31] Cal. Code Regs., tit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400, [32] Cal. Code Regs., tit. 9, § 1820.230(d)(2)(B)(1); Welf. & Inst. Code, §§ 14184.402, 14184.102 and14184.400, [33] Cal. Code Regs., tit 9, § 1820.230(d)(2)(B)(2); Welf. & Inst. Code, §§ 14184.402 and 14184.102 and 14184.400, Title 42 of the CFR, part 438.910, Title 9 1850.320

Policy Owner: Behavioral Health Quality Assurance and Performance Improvement (QAPI), Quality Assurance Manager

Director Signature: **Signature on File**

I. Policy Statement

This policy outlines the Sonoma County Department of Health Services - Behavioral Health Division (DHS-BHD), Mental Health Plan (MHP), approach for conducting concurrent reviews of psychiatric inpatient hospital and psychiatric health facility services. DHS-BHD MHP maintains Utilization Management (UM) mechanisms to ensure that delivered services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures, are medically necessary, appropriate, timely, cost-effective, and culturally competent. Consistent applications of review criteria standards for initial and continuing service authorizations are met through concurrent reviews. DHS-BHD's UM is also employed to detect underutilization and overutilization, and to detect and prevent fraud, waste, and abuse.

II. Scope

This policy applies to all DHS-BHD "Covered Persons" including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as covered persons. Covered Persons do not include Community Based Organization (CBO) staff.

III. Definitions

Not Applicable

IV. Policy

Pursuant to existing state and federal requirements, DHS-BHD MHP operates a UM program that ensures members have appropriate access to Specialty Mental Health Services (SMHS).[1] The UM program evaluates medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures.[2] Compensation to individuals or entities that conduct UM activities are not structured to provide incentives for the individuals or entities to deny, limit, or discontinue medically necessary services to a member.[3] DHS-BHD MHP also implements an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to members.[4] This program includes mechanisms to detect both underutilization and overutilization.[5]

Additionally, DHS-BHD MHP's UM maintains procedures that are designed to detect and prevent fraud, waste, and abuse.[6] DHS-BHD MHPs ensure that claims for all covered SMHS meet federal and state requirements.[7] DHS-BHD MHPs provide, or

arrange for the provision of SMHS to Medi-Cal members who meet medical necessity and access criteria for SMHS, and approve, and authorize these services according to state requirements.[8] DHS-BHD MHPs place appropriate limits on a service 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 members with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports.[9] Further, DHS-BHD MHPs will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.[10]

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.

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, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make a mental health condition more tolerable, or are considered to ameliorate the mental health condition, are thus covered as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

V. Procedures

A. Requirements Applicable to Authorization of Inpatient SMHS

1. DHS-BHD MHPs have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.[12] DHS-BHD MHPs may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the DHS-BHD MHP's contract for SMHS. In accordance with Title 9, § 1820.220, DHS-BHD MHP has designated a Point of Authorization (POA), where psychiatric inpatient hospitals submit written requests for MHP payment authorizations for Medi-Cal psychiatric inpatient hospital services provided to Sonoma County Medi-Cal members. The contact information for the DHS-BHD MHP POA is:

   Acentra Health
   1600 Tysons Blvd.
   McLean, VA 22102
   Phone: (866) 449-2737
   FAX: (833) 551-2637

a. The POA conducts authorization and review functions on behalf of DHS-BHD MHP.

2. Authorization Procedures and UM Criteria are:

   a. Based on medical necessity and consistent with current evidence-based clinical practice guidelines, principles, and processes.

   b. Developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals, acting within their respective scopes of practice.

   c. Evaluated and updated as necessary, and at least annually, and are disclosed to the DHS-BHD MHP's members and network providers.

3. DHS-BHD MHPs and/or POA shall comply with the following communication requirements:

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

   b. Disclose to DHCS; the DHS-BHD MHP providers, members and the public, upon request, the utilization review policies and procedures that the DHS-BHD MHP, or POA, uses to authorize, modify, or deny SMHS. The DHS-BHD MHP may make the criteria or guidelines available through electronic communication by posting them online.

   c. Ensure the member handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS,[13] and,

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

4. Concurrent Review for Psychiatric Inpatient Hospital Services

   a. This concurrent review authorization process applies to all psychiatric inpatient level-of-care services in general acute care hospitals with psychiatric units, psychiatric hospitals, and Psychiatric Health Facilities (PHF) certified by DHCS as Medi-Cal providers of inpatient hospital services. For ease of reference, general acute care hospitals, psychiatric hospitals, and PHF are collectively referred to as "hospital" or "PHF" below. This authorization process applies to all inpatient admissions, whether voluntary or involuntary. To the extent there is a conflict, this

section supersedes California Code of Regulations, title 9, sections 1820.215, 1820.220, 1820.225 and 1820.230.

a. POA, hospitals, and PHF 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, or electronic transmission. The POA will consult with the member's treating provider as appropriate.[14] While reviewing an authorization request, the POA may communicate with the treating provider, and the treating provider may adjust the authorization request prior to the POA rendering a formal decision regarding the authorization request.

B. Admission and Authorization

1. Notification of member admission and request for treatment authorization.

2. The POA maintains online portal access to receive admission notifications and initial authorization requests 24-hours a day, and 7 days a week.[15] Within 24 hours of admission of a Medi-Cal member for psychiatric inpatient hospital services, the hospital or PHF must provide to the POA the member's admission orders,[16] initial plan of care,[17] a request to authorize the member's treatment, and a completed face sheet.

   a. The face sheet must include the following information (if available):

      i. Hospital name and address

      ii. Member name and DOB

      iii. Insurance coverage

      iv. Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System (MEDS)

      v. Current address/place of residence

      vi. Date and time of admission

      vii. Working (provisional) diagnosis

      viii. Name and contact information of admitting, qualified, and licensed practitioner

      ix. Utilization review staff contact information

   b. If, upon admission, a member 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

member'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.[18]

3. Review of Initial Authorization Request

    a. POA will decide whether to grant, modify or, deny the hospital's 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 above. POA must 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.[19]

C. Continued Stay Authorization

1. Continued Stay Authorization Request

    a. When medically necessary for the member, 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 POA. POA reviews and authorizes continued stay requests in increments of up to three (3) calendar days per request. Providers must submit documentation supporting medical necessity for the continued stay, in accordance with established guidelines. Additional authorization requests must be submitted as needed for ongoing care.

2. Exchange of information between hospital or PHF and POA

    a. The treating provider at the hospital or PHF may request information and records from the POA needed to determine the appropriate length of stay for the member. POA 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 POA and hospitals exchanging relevant client and clinical information as needed, to complete concurrent review procedures and for discharge planning and aftercare support.

    b. Clinical information to be exchanged includes:

        i. Current need for treatment, including involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.

        ii. 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.

iii. Precipitating events, if further identified or clarified by the treating hospital, after POA admission notice.

iv. Known treatment history as it relates to this episode of care, including daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.

v. Hospital information on prior episode history that is relevant to current stay.

vi. DHS-BHD MHP information of relevant and clinically appropriate client history.

vii. Medications, including medication administration records for this episode, changes in medication, response to current medication, or further recommendations.

viii. Substance use information, including any changes, inclusive of new indicators since initial intake assessment. Examples may include Substance Use Disorder (SUD) history, recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post-discharge.

ix. Known medical history, including 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.

x. Treatment plan, including any updates and changes to the initial treatment plan and evidence of progress or symptom management.

xi. Discharge and aftercare plan, including recommended follow-up care, social and community supports, and a recommended timeline for those activities.

xii. Number of continuing stay days requested.

3. Review of Continued Stay Authorization Request

   a. POA 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.[20]

   b. DHS-BHD 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 (below) have been met:

      i. The existing treatment authorization expires, and the hospital discharges the member (or the member'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 POA and the member's treating provider [21]; Or,

      ii. POA denies a hospital's continued stay authorization request, and the hospital discharges the member (or the member'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 POA and the member's treating provider.[22]

D. Adverse Decision, Clinical Consultation, Plan of Care, and Appeals

1. While the POA for a Licensed Practitioner of the Healing Arts (LPHA) reviews authorization requests and issues approvals within their scope of practice, all POA decisions to modify or deny a treatment request, will be made by a physician or psychologist who has appropriate expertise in addressing the member's behavioral health needs.[23] A psychologist may modify or deny a request for authorization for treatment for a member only if a psychologist admitted the member to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent with the psychologist's scope of practice.

2. 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 POA'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.[24]

3. If the POA modifies or denies an authorization request, POA will notify the member in writing of the adverse benefit determination via a Notice of Adverse Benefit Determination (NOABD) before the hospital discontinues

inpatient psychiatric hospital services.[25] The notice to the member will meet the requirements pertaining to NOABDs.[26]

4. If the POA denies a hospital's authorization request, the POA must work with the treating provider to develop a plan of care. Services and payment for services will not be discontinued until the member's treating provider(s) has been notified of POA's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical and behavioral health needs of the member.[27] If POA and treating hospital provider do not agree on a plan of care, the provider may, on behalf of the member, and with the member's written consent,[28] appeal the denial to POA (first-level appeal), as provided for in the NOABD. The hospital may provide the NOABD to the member after receiving notice from POA.

5. POA's denial of an authorization request and a consultation between the treating provider and POA may result in one of the following outcomes:

    a. POA and the hospital treating provider agree that the member shall continue inpatient treatment at the acute level of care, and the denial is reversed.

    b. POA and the hospital treating provider agree to discharge the member from the acute level of care, and a plan of care is established prior to the member transitioning services to another level of care.

    c. POA and the hospital treating provider agree to discharge orders, and a plan of care is established; however, if an appropriate outpatient or step-down facility bed is not available, the member remains in the hospital on administrative day level of care.

    d. POA and treating hospital provider do not agree on a plan of care, and the member or the treating provider, on behalf of the member, appeals the decision to POA.[29]

6. DHS-BHD MHP will review, process, and monitor inpatient second-level mental health Treatment Authorization Request (TAR) provider appeals from DHCS within 21 calendar days upon receipt of the notification from DHCS to provide documentation supporting the decision to deny or modify authorization for payment. Within 14 calendar days from the receipt of the provider's revised MHP payment authorization request, DHS-BHD MHP will approve the MHP payment authorization or work with POA to submit documentation to the Medi-Cal fiscal intermediary.

E. Authorizing Administrative Days

1. A hospital may claim for administrative day services when a member no longer meets medical necessity 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.[30] In order to conduct concurrent review and authorization for administrative day service claims, the POA will 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 member is placed on administrative day status.

2. Once five contacts to non-acute residential treatment facilities have been made and documented, any remaining days within the seven-consecutive-day period from the day the member is placed on administrative day status may be authorized. 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.[31]

3. POA may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the member.[32] The lack of appropriate non-acute treatment facilities, and the contacts made at appropriate facilities, shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.[33]

4. Examples of appropriate placement status options include, but may not be limited to, the following:

    a. The member's information packet is under review;

    b. An interview with the member has been scheduled for specified date [date];

    c. No bed available at the non-acute treatment facility;

    d. The member has been put on a waitlist;

    e. The member has been accepted, and will be discharged to a facility on specific date [date of discharge];

    f. The member has been rejected from a facility due to [reason]; and/or,

    g. A conservator deems the facility to be inappropriate for placement.

F. Treatment Authorization Request (TAR) Processing

1. After discharge, a TAR shall be submitted to POA by the treating facility within 14 calendar days of the date of discharge. POA will process and submit the TAR to the DHCS Fiscal Intermediary within 14 calendar days of receipt. In instances where the TAR is not processed by the DHCS Fiscal Intermediary (for example, "Short Doyle" or "county pay" scenarios), POA will aim to process and submit the TAR to DHS-BHD MHP within 14 calendar days of receipt.

G. Retrospective Authorization Requirements

1. Retrospective TARs may be submitted to POA for payment authorization beyond the timelines specified by regulations under the following limited circumstances, subject to verification by POA:

    a. Retroactive Medi-Cal eligibility determinations;

    b. Inaccuracies in the Medi-Cal Eligibility Data System;

    c. Authorization of services for members with other health care coverage pending evidence of billing, including dual-eligible members;

    d. Member's failure to identify payer.

2. TARs that meet retrospective criteria must be submitted by the provider to the POA within 60 calendar days of one of the following:

    a. The date Medi-Cal eligibility is discovered;

    b. The date a Remittance Advice (RA) showing partial payment or a Notice of Exhaustion of Benefits (EOB), is received from a third party.

3. Providers must bill any other insurance carrier, including Medicare, before submitting a retrospective TAR.

4. For retrospective reviews, providers must submit a completed TAR form, along with all relevant hospital records required to determine whether to approve, modify, or deny the request, following the same guidelines as standard concurrent reviews.

5. The POA will communicate the authorization decision to the provider within 30 calendar days of receiving all necessary information, in accordance with state requirements. Any adverse decisions will also be communicated to the individual who received the services, or their designee, within the same timeframe.

6. Authorization for inpatient psychiatric services will be based on clinical evaluation of the medical necessity of care, guided by the statutory and

regulatory definitions of "medical necessity" and clinical judgment applied to the documentation provided by inpatient facilities.

H. Utilization Review

1. Functions related to utilization review and auditing of documentation standards are distinct from UM and authorization functions. DHS-BHD MHPs may conduct utilization reviews and/or auditing activities in accordance with state and federal requirements. DHS-BHD MHPs retain the right to monitor compliance with any contractual agreements between an DHS-BHD MHP and network providers, and may disallow claims and/or recoup funds, as appropriate, in accordance with the DHS-BHD MHP's obligations to DHCS. For example, the DHS-BHD MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the member, or in other instances where there is evidence of fraud, waste, or abuse.

VI. Forms

None

VII. Attachments

Attachment #1:

https://calmhsa.acentra.com/wp-content/uploads/sites/18/2025/03/CalMHSA-Psychiatric-Inpatient-Concurrent-Review-Manual-January-2025.pdf