LIVE WELL SAN DIEGO

PROGRAM MANAGER MEETING

Outpatient 2 | Behavioral Health Services
March 14, 2024 | Zoom
9:30 AM – 11:30 AM
Meeting Summary

ITEM	SUMMARY/ ACTION ITEMS
1. Welcome – Michael Miller	

2. QA Updates – Elaine Mills	• Update to Student Intern Credentials and Claiming for Services
	• Changes to taxonomy code for MHRS credential
	• Medicare Coverage Updates
	• EHR updates
	• Next QIP date/time
	• System of Care Town Halls (Virtual)
	  ○ March 19, 2024 | 1:00pm - 2:00pm
	  ○ April 30, 2024 | 1:00pm - 2:00pm

3. Pathways to Well-Being (PWB)/Continuum of Care Reform (CCR)– Shaun Goff, Cynthia Roman	• Provision of services at County of San Diego and City of San Diego Local Assistance Centers (LAC) • Contact Shaun.Goff@sdcounty.ca.gov

4. North County Lifeline/BridgeWays– Leslie LaMay	• Program overview
	• Outpatient clinical services
	• Field support services
	• Referrals
	  ○ Monday – Friday 8:30am - 5:00pm
	  ○ Phone (760) 509-3413, Fax: (760) 724-1907
	• Contact Leslie LaMay llamay@nclifeline.org (760) 509-3444

5. San Diego Center for Children IOP & PHP – Christina Grice	• Intensive Outpatient Program (IOP) overview • Partial Hospital Program (PHP) overview • IOP and PHP Values • Contact admissions@centerforchildren.org; (833) 800-9105; cgrice@centerforchildren.org

6. Soluna Mental Health App – Allison Lawrence and Kade Smith	• DHCS-funded mental health app for youth aged 13-25 in California
	• Behavioral Health Virtual Services – CYBHI
	• App Features
	• Universal Support and Referral Network
	• Safety First: Mitigating Risks & Respecting Privacy
	• App Benefits
	• Contacts:
	  ○ Allison Lawrence alawrence@kooth.com
	  ○ Kade Smith kasmith@kooth.com
	• SolunaApp.com

6. Care Coordination - Eileen Quinn-O'Malley	• Warm Handoff Overview • Warm Handoff Purpose and Process

7. Networking with colleagues	• 10 minute break out groups

8. Announcements	• BHS Information Notice - Prior Authorization Request Form Alignment with CalAIM Update
	• Job Training Programs in San Diego, CA | Access2Jobs
	• Critical Issues in Child and Adolescent Mental Health Conference 2024 CICAMH Home - CICAMH
	  ○ April 26, 2024 Theme: Breaking Barriers-Innovative Approaches to Youth & Family Mental Wellbeing
	• Announcing Our 2024 TransYouth Care Symposium (mailchi.mp)
	  ○ April 26th & 27th and May 5th & 6th
	• Children & Youth Mental Health & Well Being Celebration
	  ○ May 11, 2024 2:00 pm - 6:00 pm Grossmont Center Main Courtyard
	• 44th Annual California Mental Health Advocates for Children and Youth 2024 Conference – CMHACY
	  ○ May 15-17, 2024
	• CalAIM Health Plan Provider Matrix https://211sandiego211.sharepoint.com/

Next Meeting: May 9, 2024 | 9:30 AM – 11:30 AM	

Program Manager Meeting

Children, Youth and Families | Behavioral Health Services
March 14, 2024| Zoom | 9:30 – 11:30 a.m.

Agenda

- **Welcome** – Michael Miller, LMFT
- **QA Updates** – Elaine Mills 10 minutes
  - Update to Student Intern Credentials and Claiming for Services
  - Changes to taxonomy code for MHRS credential
  - Medicare Coverage Updates
  - EHR updates
  - Next QIP date/time
  - System of Care Town Halls (Virtual)
    - March 19, 2024 | 1:00pm - 2:00pm
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- **Pathways to Well-Being (PWB)/Continuum of Care Reform (CCR) -** Shaun Goff, Cynthia Roman 10 minutes
  Page 2
  - Provision of services at County of San Diego and City of San Diego Local Assistance Centers (LAC)
- **North County Lifeline/BridgeWays** – Leslie LaMay | Pages 3-17 15 minutes
- **San Diego Center for Children/IOP & PHP**- Christina Grice | Pages 18-25 20 minutes
- **Soluna Mental Health App** – Allison Lawrence and Kade Smith | Pages 26-36 15 minutes
  - DHCS-funded mental health app for youth aged 13-25 in California
- **Care Coordination** – Eileen Quinn-O'Malley | Page 37 10 minutes
- **Networking with Colleagues** 10 minutes
- **Announcements** 10 minutes
  - BHS Information Notice - Prior Authorization Request Form Alignment with CalAIM Update | Pages 38-68
  - Job Training Programs in San Diego, CA | Access2Jobs
  - Critical Issues in Child and Adolescent Mental Health Conference 2024 CICAMH Home - CICAMH | Page 69
    - April 26, 2024 | Theme: Breaking Barriers-Innovative Approaches to Youth & Family Mental Wellbeing
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Pathways to Well-Being and Continuum of Care Reform

Pathways to Well-Being and Continuum of Care Reform Teams Serve the Community at the County of San Diego and City of San Diego Local Assistance Centers

- In response to the January 2024 storms and flooding, the County of San Diego opened a Local Assistance Center (LAC) in Spring Valley, January 2024. In addition, the County of San Diego HHSA provided Local Assistance Support services for a similar site hosted by the City of San Diego in February 2024.
- LACs are typically staffed and supported by local, state, and federal agencies, as well as non-profit and voluntary organizations, as appropriate. The LAC provides a single facility at which individuals, families, and businesses can access available recovery programs and services. The primary mission of San Diego County LACs is to assist San Diego County communities by providing a centralized location for services and resource referrals for unmet needs, assistance, and guidance following a disaster or significant emergency.
- The Pathways to Well-Being and Continuum of Care Reform Teams are tasked with representing Behavioral Health Services at LACs.
- If you ever have questions regarding an LAC, please contact Shaun Goff, Behavioral Health Program Manager for the Pathways to Well-Being team. Shaun.goff@sdcounty.ca.gov

New Local Assistance Center opens for residents impacted by storm

FEBRUARY 5, 2024 BY SDCNEWS

The Mountain View Community Center will serve as a temporary shelter for storm-impacted residents due to flooding in the Southeastern community. Photo: City of San Diego

Disaster Services Links

Alert San Diego- County of San Diego Storm Recovery Assistance Information
Recovery (alertsandiego.org)

FEMA Disaster Assistance
Home | disasterassistance.gov

2-1-1 San Diego
Home - 211 San Diego

Lifeline Community Services

Bridgeways

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Lifeline Community Service Mission

Lifeline's mission is to build self-reliance among youth, adults, and families through high-quality, community based services

The Bridgeways Program is funded by the County of San Diego

Lifeline Community Services

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Program Overview

- Bridgeways is an outpatient mental health program serving youth up to age 21 who are currently involved with the juvenile justice system or are at-risk for justice involvement.

- Services are offered across San Diego County in locations that best meet the needs of clients and families.

Included Services

Program consists of two distinct elements depending on client need.

Client's will typically be enrolled in one or the other:

1. **Outpatient Clinical Mental Health (OP)**
   - Staff Composition: Mental Health Clinicians, Peer Support Specialist, Psychiatrist, Registered Nurse

2. **Field Support Services (FSS)**
   - Staff Composition: Certified SUD Counselor aka Juvenile Recovery Specialist

Lifeline Community Services

County-Wide & Community-Based

- Clinic locations ***for both OP and FSS services*** include all of Lifeline's offices (Monday – Thursday 8:30-7:00pm, Friday 8:30-5:00pm):
  - 3890 Murphy Canyon Rd, San Diego
  - 200 Michigan Ave, Vista
  - 707 Oceanside Blvd., Oceanside
  - 334 Via Vera Cruz, San Marcos

- Additionally, **both OP and FSS** can be provided at the client's residence, in community locations, or through telehealth

Lifeline Community Services

Outpatient Clinical Services

Outpatient Treatment services include:

- Individual/family/group psychotherapy,
- Psychiatry services
  - Psychiatric medication evaluations, prescriptions, and medication management
- Case management/Rehabilitative services
- Psychoeducation groups
- Caregiver engagement

Lifeline Community Services

Outpatient Clinical Services

Psychoeducation/Psychotherapy Groups:

- Communication Skills
- Positive Relationships
- Substance Use
- Coping Skills
- Decision Making

Lifeline Community Services

Outpatient Clinical Services

Bridgeways aims to provide Clinical Behavioral Health Services for a minimum of 80 youth each year who are at risk of or are currently involved in the Juvenile Justice System

Clients may be Medi-Cal beneficiaries or uninsured, and meet medical necessity

Lifeline Community Services

Field Support Services

FSS provides supportive services for youth on probation

Services include, but are not limited to:

- Screenings
  - Screening Tools include: Commercial Sexual Exploitation Identification Tool (CSE-IT) & Substance Abuse Subtle Screening Inventory (SASSI).
- Development of relapse prevention plans
- Psychoeducational groups
- Case management
- Caregivers are engaged and encouraged to attend parent support groups.

Lifeline Community Services

Field Support Services

FSS Group Topics/Activities:

- Street Safety
- Anger Management
- Social Skills
- Expressive Arts
- Life Skills (resume building, healthy eating, self care), etc.

Lifeline Community Services

Field Support Services

Bridgeways aims to provide Field Support Services to 80 youth and their families annually.

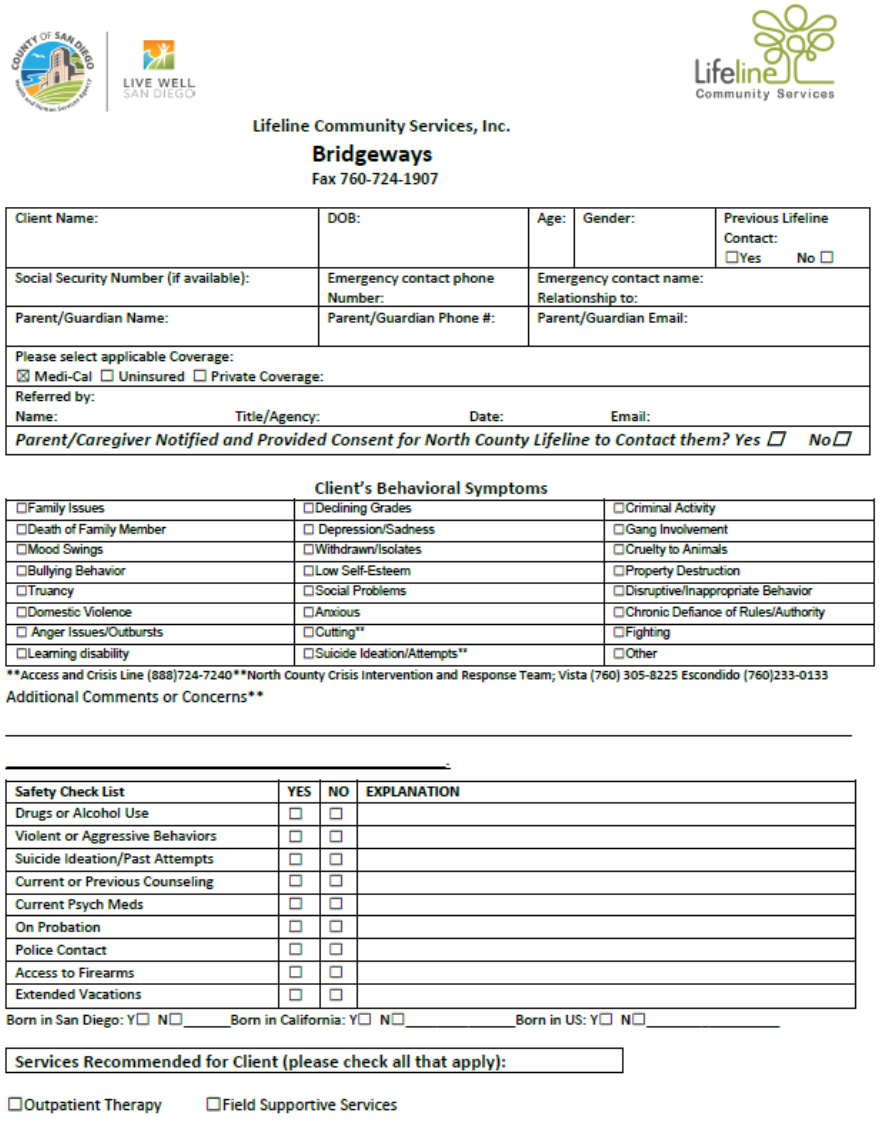
Referrals come from various partners including:

- Probation Officers,
- Juvenile Behavioral Health Court,
- School Personnel
- Child and Family Well Being
- Community Providers

Lifeline
Community Services

Referring Youth to Bridgeways

One shared referral form for both OP & FSS services.
Clients will typically be enrolled in one service or the other based on client need.



Lifeline Community Services, Inc.

Bridgeways

Fax 760-724-1907

Client Name:	DOB:	Age:	Gender:	Previous Lifeline Contact: ☐Yes No ☐
Social Security Number (if available):	Emergency contact phone Number:	Emergency contact name: Relationship to:		
Parent/Guardian Name:	Parent/Guardian Phone #:	Parent/Guardian Email:		
Please select applicable Coverage: ☒ Medi-Cal ☐ Uninsured ☐ Private Coverage:				
Referred by: Name: Title/Agency: Date: Email:				
Parent/Caregiver Notified and Provided Consent for North County Lifeline to Contact them? Yes ☐ No ☐				

Client's Behavioral Symptoms

☐Family Issues	☐Declining Grades	☐Criminal Activity
☐Death of Family Member	☐ Depression/Sadness	☐Gang Involvement
☐Mood Swings	☐Withdrawn/Isolates	☐Cruelty to Animals
☐Bullying Behavior	☐Low Self-Esteem	☐Property Destruction
☐Truancy	☐Social Problems	☐Disruptive/Inappropriate Behavior
☐Domestic Violence	☐Anxious	☐Chronic Defiance of Rules/Authority
☐ Anger Issues/Outbursts	☐Cutting**	☐Fighting
☐Learning disability	☐Suicide Ideation/Attempts**	☐Other

Access and Crisis Line (888)724-7240 North County Crisis Intervention and Response Team; Vista (760) 305-8225 Escondido (760)233-0133

Additional Comments or Concerns**

_____

_____.

Safety Check List	YES	NO	EXPLANATION
Drugs or Alcohol Use	☐	☐	
Violent or Aggressive Behaviors	☐	☐	
Suicide Ideation/Past Attempts	☐	☐	
Current or Previous Counseling	☐	☐	
Current Psych Meds	☐	☐	
On Probation	☐	☐	
Police Contact	☐	☐	
Access to Firearms	☐	☐	
Extended Vacations	☐	☐	

Born in San Diego: Y☐ N☐_____Born in California: Y☐ N☐_____Born in US: Y☐ N☐_____

Services Recommended for Client (please check all that apply):

☐Outpatient Therapy ☐Field Supportive Services

Referring Youth to Bridgeways

By phone: (760) 509-3413

Intake Line Hours:

Monday – Friday 8:30am - 5:00pm

By Fax: (760) 724-1907

Questions about a referral?

Contact Leslie LaMay, Program Manager

llamay@nclifeline.org - (760) 509-3444

Lifeline
Community Services

Questions?

Lifeline
Community Services

Thank you!

Lifeline
Community Services

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San Diego
Center for Children

IOP
PHP

Christina Grice, PhD
Program Manager

Intensive Outpatient Program (IOP)

Who

Adolescents who need more than once/week therapy and are at risk of hospitalization

Common treatment targets

- Depression
- Suicide ideation and/or self-injury
- Mental health impacts of oppressed identities
- Anxiety
- Bipolar/other mood disorders
- Chronic stress or trauma
- Interpersonal conflict or isolation

IOP

SDCC COMPONENTS

- 8 week, group-based, mental health program
- Mondays, Wednesdays, and Thursdays 4-7pm
- Youth are enrolled and attending school
- Dialectical Behavior Therapy (DBT) skills training
- Art-based interventions, process groups, experiential activities
- Weekly family support (3 caregiver groups and 1 multi-family skills group/month) 6-7pm Wednesdays
- Brief individual therapy focused on risk assessment and stabilization
- Care coordination, family therapy, Intensive Home Based Services, and discharge planning
- Psychiatry

Partial Hospital Program (PHP)

Who

Adolescents needing additional stabilization after hospitalization or to prevent hospitalization

A step up in level of care from IOP. Designed to be in between 24 hour care and IOP level of care.

Common treatment targets

- Depression
- Suicide ideation and/or self injury
- Mental health impacts of oppressed identities
- Anxiety
- Bipolar/other mood disorders
- Chronic stress or trauma
- Interpersonal conflict or isolation

PHP

SDCC COMPONENTS

- 3 week, group-based, mental health program
- Monday - Friday 9am-3pm
- DBT, CBT, Seeking Safety
- Art-based interventions, independent living skills groups
- Weekly multifamily group Wednesday 2-3pm
- Individual therapy and care coordination
- Family therapy and discharge planning
- Psychiatry

IOP AND PHP VALUES

Healing Community

Youth learn from and provide support to one another in a therapeutic setting

Therapists and Providers

Providers are trained to be authentic, relationship-based, and effective at teaching skills

Identity Exploration

Structured environment where youth 's identities / changing identities are affirmed

Care Coordination

Team members are trained to help connect youth and families to affirming community supports

Strengths -Based

Affirming youths strengths and assisting them to reclaim their life worth living

Discharge Circle Example

Strengths/accomplishments, suggestion for growth, positive vision for the future
Share messages of support

DBT Skill Modules	Concerns Addressed
EMOTION REGULATION	Steady negative emotional states (e.g. depression), intense mood changes with little control, emotional vulnerability
DISTRESS TOLERANCE	Impulsive behaviors (e.g. suicidal and non-suicidal self-injurious behavior, risky online behavior, disordered eating)
INTERPERSONAL EFFECTIVENESS	Unstable/conflictual relationships, difficulties getting wants and needs met
MINDFULNESS	Lacking self-awareness of emotions, thoughts, actions; difficulty reducing one's suffering while also difficulty accessing enjoyment

Questions?

cgrice@centerforchildren.org

For intake inquiries

Email: admissions@centerforchildren.org

Phone: (833) 800-9105

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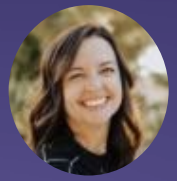
Soluna Connection Call

Children, Youth & Families Program Managers Meeting 3.14.2024



Allison Lawrence
Customer Success Manager
alawrence@kooth.com

Kade Smith
Customer Success Manager
kasmith@kooth.com

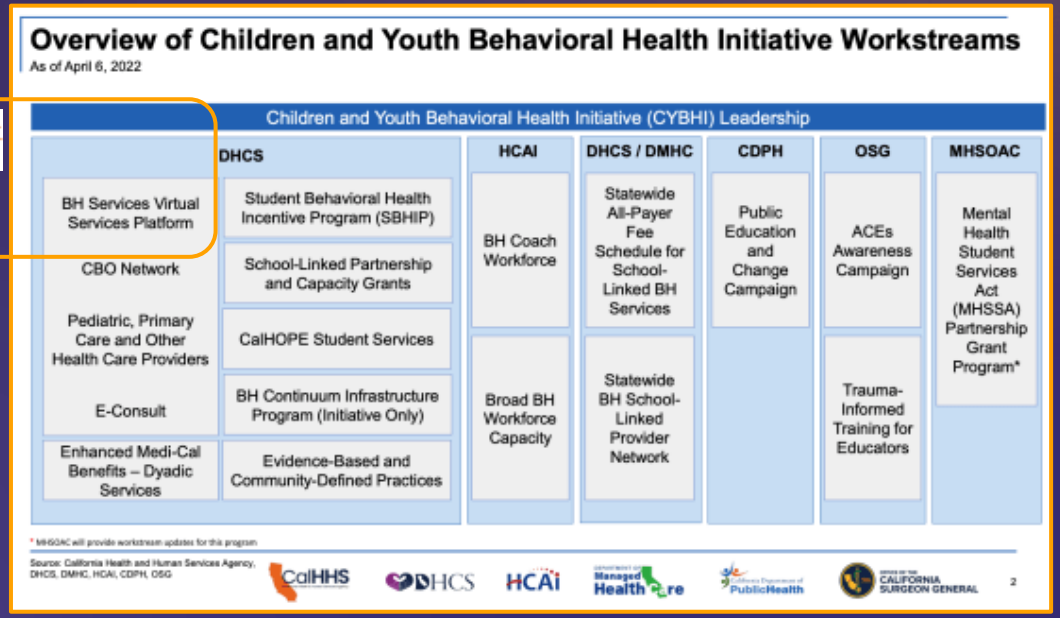
SolunaApp.com

Kooth in California: Integrated Care

- Selected from over **450** vendors
- **Funded** by DHCS
- Behavioral Health Virtual Services - CYBHI
  BrightLife Kids (Brightline): 0 - 12
  Soluna (Kooth): 13 - 25
- 1 of 15 workstreams

brightline

kooth



Transforming Youth Behavioral Health Over 20 Years

Kooth UK

Founded over 20 years ago

Over 1 million hours of professional support

11 million youth aged 10-25 access to mental wellness resources

User Research Drives Our Product

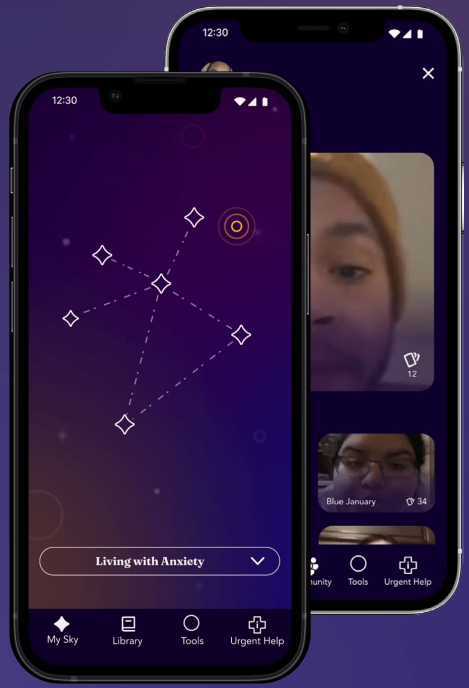
Research teams dedicated to engaging with our users

Everything from app design to supports offered

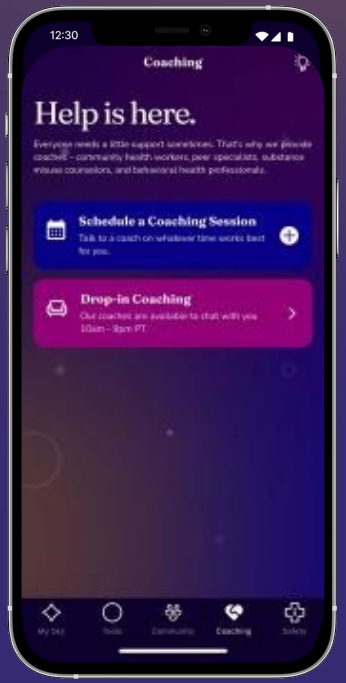
App Features

Tier 1:
Self-Guided Resources

Tier 2:
Community Support



Tier 3:
Professional Support



Soluna is offered in English, Spanish and 17 other languages

Universal Support & Referral Network

Sub-Clinical Model

Emphasis on:
Prevention & Early Intervention

Intention:
To empower users with tools they need to navigate challenges

Diagnosis & Clinical Intervention

Higher Acuity Needs:
-Searchable Repository
-Care Navigation
-Crisis Resources
-Closed loop care

soluna

Universal Support for 13-25 year Olds

Working Together to Provide Comprehensive Care

Soluna integrates with services, acting as a central hub to triage and treat users **(sub-clinical)** as well as improving access to the State's behavioral health ecosystem.

Soluna
A CalHOPE Program,
Powered by Kooth

Safety First: Mitigating Risks & Respecting Privacy

In-App Support

Pre-Moderation allows **risk identification** and triggers practitioner intervention

Monitoring Risk

Anonymous model fosters **secure environment** for users to be themselves AND for **empathetic engagement** with practitioners

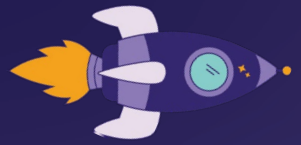
Crisis Resources

Full adherence to federal and state reporting and regulatory guidelines

Focus: Autonomy & Empowerment of the User

Soluna's Benefits

- Available 24/7
- No Cost
- Safe and Confidential
- Professional Help and Peer Support



Guided support from our team makes it easy to be a part of the solution

Discovery

Planning

Awareness

Enablement

Ongoing Engagement

What's Next?

- Reach out to us!
  - **Allison Lawrence,** alawrence@kooth.com
  - **Kade Smith,** kasmith@kooth.com
- Strategy, resources, events

soluna

Thank You!

Kade Smith
Customer Success Manager
kasmith@kooth.com
Phone # 570.218.9365

Allison Lawrence
Customer Success Manager
alawrence@kooth.com
Phone # 570.218.5810

Warm Handoff

"Helping to the door and walking through together"

Definition

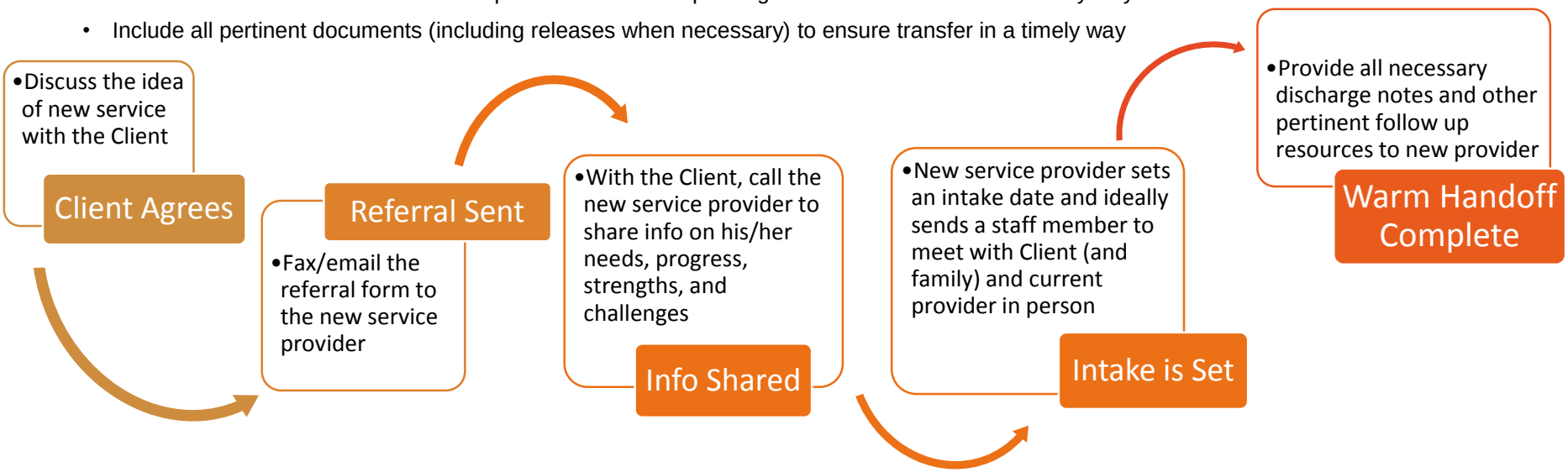
A Warm Handoff is the carefully coordinated transfer or linkage of a client, to another provider, entity, agency, or organization who will be continuing, adding, or enhancing services.

Purpose

An ideal warm handoff from another agency would involve: 1) clear communication, 2) a joint session with past and current provider, 3) a final session from the past provider, and 4) information from the past provider about what works well or doesn't work well when working with the youth. This collaborative process is extremely successful for clients because it allows the entire team to come together, discuss specific tasks, and figure out who will be responsible for completing the tasks moving forward.

This Warm Hand-Off Will:

- Occur prior to the case closing to the current program (case closure dependent on Program protocol)
- Sometime occur with concurrent services
- Be conducted by the provider who has worked with the client
- Include the family, client or youth in the process whenever possible
- Include feedback to the new service provider regarding the success of the Warm Hand Off in a timely manner
- Include a direct conversation between providers to ensure passing of critical information in a timely way
- Include all pertinent documents (including releases when necessary) to ensure transfer in a timely way



* Allowed to share information about a client in order to coordinate care

To:	**BHS Children's Mental Health Providers**
From:	**Behavioral Health Services**
Date:	**February 6, 2024**
Title	**Prior Authorization Request Form Alignment with CalAIM Update**

Overview
California Advancing and Innovating Medi-Cal (CalAIM) aims to modernize the State's Medicaid program. CalAIM initiatives intend to improve the beneficiaries' experience in receiving effective services that streamline and standardize Medi-Cal behavioral health clinical documentation requirements.

The release of the Behavioral Health Information Notice (BHIN) 23-068, which supersedes BHIN 22-019, provides further clarification and updates to clinical documentation standards. This includes documenting assessments, progress notes, treatment goals, and outcomes. Prior authorization forms have been revised to reflect updated requirements for care/treatment plans, and include the following changes:

Intensive Home-Based Services (IHBS)
The IHBS prior authorization form has been updated to remove the requirement for a standalone treatment plan and continues to require Intensive Care Coordination (ICC) to receive IHBS.

Therapeutic Foster Care (TFC)
The TFC prior authorization form has been updated to remove the requirement for a standalone treatment plan and continues to require ICC to receive TFC.

Intensive Outpatient Program (IOP)
Partial Hospitalization Program (PHP)
IOP and PHP are new levels of care initiated in 2024. IOP and PHP leverage day treatment services and require a prior authorization.

Short Term Residential Therapeutic Program (STRTP)
Day Services Request (DSR) form continues to be utilized (04.01.22).

Therapeutic Behavioral Services (TBS)
TBS prior authorization form continues to be utilized (04.01.22).

Ancillary Specialty Mental Health Services (SMHS) Request Form
Ancillary SMHS Request form continues to be utilized when outpatient services are concurrently provided with Day Treatment services (01.02.20).

Attachments:
- IHBS Prior Authorization Request Form and Explanation Sheet (02.01.24)
- TFC Prior Authorization Request Form and Explanation Sheet (02.01.24)
- IOP & PHP Prior Authorization Day Services Request (DSR) Form and Explanation Sheets (01.01.24)
- STRTP Day Services Request (DSR) Form and Explanation Sheet (04.01.22)
- TBS Prior Authorization Request and Referral Form and Explanation Sheet (04.01.22)
- Ancillary SMHS Request Form and Explanation Sheet (01.01.20)

For More Information:
- Contact your Contracting Officer's Representative (COR)

2020

County of San Diego Mental Health Plan

Ancillary Specialty Mental Health Services (SMHS) Request

COMPLETED BY: Day Services Provider and Ancillary Specialty Mental Health Services Provider (SMHP) when client is receiving both Day Services and ancillary SMHS

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

COMPLETION REQUIREMENTS:

- Within 5 business days of a SMHP beginning treatment, a stand-alone "Ancillary SMHS Request" form shall be submitted to Optum to request ancillary SMHS from a separate program/provider in addition to Day Services
  1. The Day Services Provider completes the identified Day Services section (Client Information and Day Program Information) and sends by fax or secure email to the Organizational or Fee For Service (FFS) Provider
  2. In collaboration with the Day Services Provider, the SMHP completes the identified Organizational/FFS Provider sections (Provider Information and Authorization Request for Ancillary SMHS in Addition to Day Services), signs and sends to the Day Services provider by fax or secure email
  3. The Day Services provider reviews the "Ancillary SMHS Request" form, signs, and faxes to Optum
  4. For continuing authorization steps 1-3 are completed on the timeline of the Prior Authorization UM cycle of the Day Services Provider

DOCUMENTATION STANDARDS:

The following elements of the Ancillary SMHS Request form shall be addressed:

1. **Client Information (completed by Day Services Provider)**
   - Include Name, Client ID and Date of Birth
2. **Day Program Information (completed by Day Services Provider)**
   - Include Legal Entity, Day Program Name, Phone number and Day Services Program Unit and Subunit number, Day Services Authorization Start Date and Day Services Authorization End Date
3. **Organizational Specialty Mental Health Services Program Information (Completed by Organizational Providers only, Fee For Service Providers leave blank)**
   - Include Legal Entity, SMHS Program Name, Phone number and SMHS Program Unit and Subunit number
4. **Fee For Service (FFS) Specialty Mental Health Service Provider Information (Completed by FFS Providers only; Organizational Providers leave blank)**
   - Include Provider Name, Provider ID Number, Phone Number, and Fax Number
5. **Authorization Request for Ancillary SMHS in Addition to Day Services (completed by Organizational or Fee For Service Provider)**
   - Select the total amount of ancillary SMHS requested in addition to Day Services

1. Provide the amount SMHS sessions requested per week
2. Provide the Start Date of the requested authorization period
3. Provide the End Date of the requested Authorization period – shall match the end date for the Day Services Authorization as outlined on the form in Day Program Information section
4. Provide the Start Date of the Ancillary Provider Assignment

6. Ancillary Service Necessity Criteria (completed by Organizational or Fee For Service Provider)

❖ Check all that apply and explain (choose at least one for Medical Necessity)

- Requested service(s) is not available through the Day Program. Describe why the service is not available
- Continuity or transition issues make these services necessary for a time limited interval. Describe the need for services to be available for continuity or transition
- These concurrent services are essential to coordination of care. Describe why concurrent services are essential

7. Signature(s)

- Must include the printed/typed name, credentials, signature and date of the Ancillary SMHP
- Must include the printed/typed name, credentials, signature and date of the Day Services Provider

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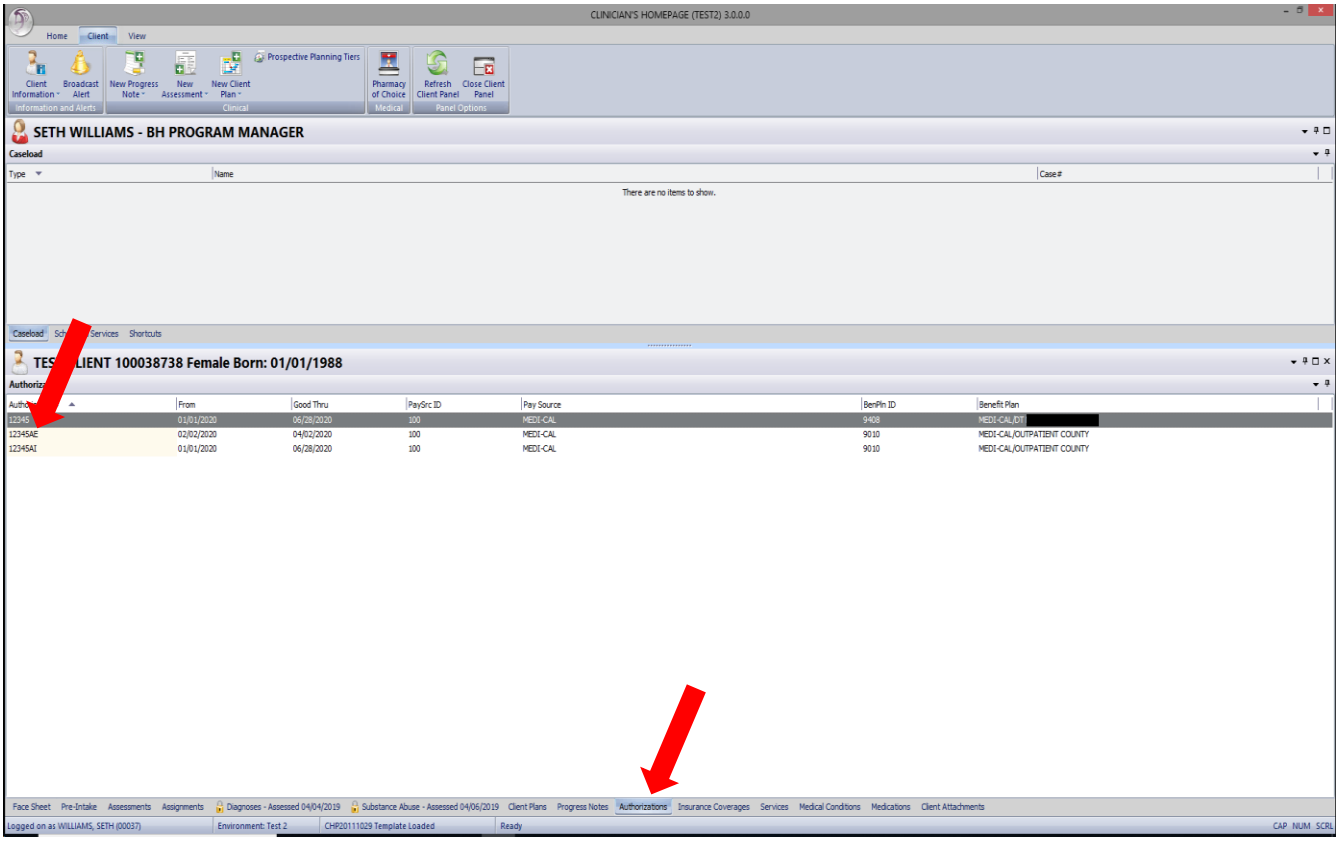
OPTUM AUTHORIZATION

- Upon receipt from the Day Services provider, Optum reviews and retains the "Ancillary SMHS Request" form

- When the ancillary services are authorized, the start date and end date shall be viewable to the Day Services provider and the SMHP in the CCBH Authorizations Tab on the Clinicians Home Page within 5 days of Optum receipt. Ancillary authorization will be indicated by an "AE" next to the authorization number in the "Authorization #" column (see image below)

- When the Ancillary Services Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and the requesting Day Service provider, who shall inform the Ancillary SMHP of denial within 3 business days

(Image on next page)



Note: The updated "Ancillary SMHS Request" form shall be utilized beginning 1/1/2020

References: DMH LETTER NO.: 02-01 Dated 4/16/2002: Clarification Regarding Medi-Cal Reimbursement for Day Treatment for Children and Youth in Group Home Programs

DMH INFORMATION NOTICE NO.: 02-06 Dated 10/1/02: Changes in Medi-Cal Requirements for Day Treatment Intensive and Day Rehabilitation

County of San Diego Mental Health Plan

Ancillary Specialty Mental Health Services (SMHS) Request

Submitted by the Day Services Provider to Optum in Coordination with the Ancillary Specialty Mental Health Provider (SMHP)

Please Check: ☐ **Initial Request (within 5 business days of Ancillary Start date)**
☐ **Continuing Request (completed on Day Services UM cycle)**

FAX TO: (866) 220-4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then Option 4

COMPLETED BY DAY SERVICES PROVIDER

CLIENT INFORMATION

Client Name: _____ **Client ID**: _____ **Client Date of Birth:** _____

DAY PROGRAM INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Day Program Subunit#**: _____

Day Services Authorization Start date: _____ ***Day Services Authorization End Date:** _____

COMPLETED BY ANCILLARY ORGANIZATIONAL PROVIDERS (IF FEE FOR SERVICE PROVIDER LEAVE BLANK)

ORGANIZATIONAL SPECIALTY MENTAL HEALTH SERVICES PROVIDER (SMHP) INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Program Subunit#**: _____

TO BE COMPLETED BY ANCILLARY FEE FOR SERVICE PROVIDERS (IF ORGANIZATIONAL PROVIDER LEAVE BLANK)

FEE FOR SERVICE (FFS) SMHP INFORMATION

PROVIDER LAST NAME: _____ **PROVIDER FIRST NAME**: _____ **PHONE:** _____ **FAX**: _____

COMPLETED BY ANCILLARY ORGANIZATIONAL OR FFS PROVIDER

AUTHORIZATION REQUEST FOR ANCILLARY SMHS IN ADDITION TO DAY SERVICES

SELECT THE AMOUNT OF ANCILLARY SMHS REQUESTED (Inclusive of all Individual, Collateral, ICC, IHBS, Group, Rehab, Case Management or other covered SMHS provided by the Ancillary SMHP):

Sessions Requested Per Week _____

Ancillary Authorization Start Date: _____

Ancillary Authorization End Date: _____
Matches the Day Services Authorization End Date Listed Above

Ancillary Provider Assignment Start Date: _____

MEDICAL NECESSITY CRITERIA FOR ANCILLARY SMHS

Ancillary Service Necessity Criteria - check all that apply and explain (choose at least one):

☐ Requested service(s) is not available through the day program. Describe why service is not available: _____

☐ Continuity or transition issues make these services necessary for a time limited interval. Describe the need: _____

☐ These concurrent services are essential to coordination of care. Describe why services are essential: _____

Ancillary Organizational/FFS SMHP (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Day Service Provider (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

FOR OPTUM USE ONLY

Optum reviews and retains. Optum Authorization Determination is documented on the Prior Authorization Day Services Request (DSR) form and is viewable to the Day Service Provider and SMHP within 5 business days of Optum receipt in the CCBH Clinicians Home Page Authorizations Tab.

2024

County of San Diego Mental Health Plan
Intensive Home-Based Services (IHBS)
Prior Authorization Request

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

Note: Child/Youth must be receiving Intensive Care Coordination (ICC) in order to be eligible for IHBS

COMPLETION REQUIREMENTS:

1. IHBS Prior Authorization Request form is completed and submitted to Optum via FAX (866) 220-4495 or through the IHBS Prior Authorization Web-Based for all clients that will be receiving IHBS prior to initial provision of IHBS
2. Continuing request is completed by IHBS provider and resubmitted within 12 months before previous authorization expires
3. Prior authorization must be obtained before IHBS are initiated

DOCUMENTATION STANDARDS:

The following elements of the IHBS Prior Authorization Request form must be addressed

1. Client Information
   - Must include name, DOB and Client ID
2. Program Information
   - Must include Legal Entity, Program Name, Phone, Fax, Unit #, Subunit # and Program Manager Name
3. Medical Necessity (All items required for authorization of IHBS)
   - Must indicate client is under the age of 21 (service only available to youth under age 21)
   - Must indicate that Client is eligible for and receiving ICC Services (Not eligible for IHBS unless receiving ICC)
   - Must indicate medical necessity criteria **BHIN 21-073** is documented in the Behavioral Health Assessment (BHA) or Progress/CFT Note. Include date of BHA or Progress/CFT Note and DSM/ICD Mental Health diagnosis
   - Amount requested: Must select only one
     - Up to 15 hours per week
     - 16-25 hours per week
       - If 16-25 hours of IHBS per week is selected, provider must attach written Contracting Officer Representative (COR) support and documented rationale for not referring to TBS
   - Duration requested: IHBS will be requested for up to 12 months
4. Authorization Determination:
   - Optum will make a determination to approve the request when the 5 IHBS criteria are met and provides authorization determination within 5 business days of receipt
   - Optum will send the approved authorization to requesting provider which will include start and end date for IHBS (scope, amount and duration) to be filed in hybrid chart
     OR
   - Optum will deny, modify, reduce, terminate or suspend IHBS request and an NOABD will be sent to Medi-Cal beneficiary and requesting provider

FAX TO: **Optum Public Sector San Diego**
Fax: (866) 220 – 4495
Phone: (800) 798-2254, Option 3, then Option 4
IHBS Prior Authorization Request web based electronic form: IHBS Prior Authorization Request- Web Based

County of San Diego Mental Health Plan
Intensive Home-Based Services (IHBS) Prior Authorization Request

☐ Prior Authorization Request
(Prior to provision of IHBS)

☐ Continuing Request
(After initial authorization of up to 12 months)

Client Information

Client Name: _____	Date of Birth: _____	Client ID: _____

Program Information

Legal Entity: _____		Program Name: _____
Phone: _____		Fax: _____
Unit #: _____	Subunit #: _____	Program Manager Name: _____

SCOPE OF SERVICE

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided in alignment with the care plan for the client, and as referenced in the Integrated Core Practice Model (ICPM), informed by the Child and Family Team (CFT). IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet access criteria.

IHBS Criteria: (All 6 items are required for authorization of IHBS)

1. ☐ **Client is under the age of 21**
2. ☐ **Intensive Home-Based Services (IHBS) has been identified as a beneficial component for the clinical care of the youth**
3. ☐ **Intensive Care Coordination (ICC): Client is eligible for and receiving ICC services.**
   (Not eligible for IHBS unless receiving ICC)
4. ☐ **Client meets medical necessity criteria for Specialty Mental Health Services BHIN 21-073 as documented in (select all that apply)**
   - ☐ **Behavioral Health Assessment (BHA) dated: _____**
   - ☐ **DSM/ICD Mental Health diagnosis: _____**
   - ☐ **Progress/CFT Note dated: _____**
   - ☐ **Other: _____**
5. **Amount Requested:** (Select one)
   - ☐ **Up to 15 hours of IHBS intervention per week;**
   - ☐ **16-25 hours of IHBS intervention per week; must provide rationale for not referring to TBS and attach written COR support: _____**
6. **Duration Requested:** (Select one)
   - ☐ **Up to 12 months of IHBS intervention**

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed Identified document(s) in section 4**
☐ **IHBS scope, amount and duration authorized as requested: START DATE: _____ END DATE: _____**
☐ **IHBS request is ☐ denied; ☐ modified; ☐ reduced; ☐ terminated; or ☐ suspended**
Reason: _____
NOABD was issued to the Medi-Cal beneficiary and provider on the following date: _____

Optum Clinician Signature/Date/Licensure:

Within five business days of Optum receipt, authorization will be forwarded to the requesting provider

2024

County of San Diego Mental Health Plan

IOP & PHP Prior Authorization Day Services Request (DSR)

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

CO-SIGNATURE:

- Prior Authorization Day Service Requests must be completed by or co-signed by a Licensed Mental Health Professional
- Co-signature from Licensed Mental Health Professional indicates they have reviewed and agree with the findings of the request

COMPLETION REQUIREMENTS:

1. Prior Authorization Day Services Request form is completed by the Day Services provider and submitted to Optum via FAX (866) 220-4495 for all clients prior to the initial provision of Day Services
2. Continuing Prior Authorization Day Services Requests are completed by the Day Services provider and submitted prior to expiration of the initial authorization period (within 12 weeks for Intensive Outpatient Program [IOP] and 4 weeks for Partial Hospitalization Program [PHP])
3. Continuing Prior Authorization Day Services Requests shall be submitted at least 5 business days prior to the expiration of Day Services Authorization, and can be submitted up to 10 business days prior to the expiration
4. Prior authorization shall be obtained before Day Services are initiated. For hybrid programs, Outpatient Services may be provided prior to the authorization of Day Services

DOCUMENTATION STANDARDS:

The following elements of the Prior Authorization Day Services Request form shall be addressed:

1. Client Information

- Include Name, Client ID and Date of Birth

2. Day Program Information

- Include Legal Entity, Program Name, Phone number, Fax number, Unit number, and Day Services Program Subunit number

3. Scope, Amount and Duration of Day Services Request

- Identify the scope and duration of Day Services to be provided (IOP – Day Intensive Half [DIH] for 8-12 weeks, PHP – Day Intensive Full [DIF] –2-4 weeks)
- Include the amount of services requested (select Up to 3 Days Per Week, Up to 5 Days Per Week or Up to 6 Days Per Week) which shall not exceed the Day Program schedule that has been approved by BHS QM

4. **Medical Necessity Criteria for Day Services**

- **Diagnosis -** Provide the ICD 10 mental health diagnoses that are the focus of mental health treatment
- **Medical Necessity Criteria (BHIN 21-073)**
    1. Select and explain the client's condition that places them at high risk for a mental health disorder due to experiencing trauma

       OR
    2. The client meets one of the following:
        - Significant impairment or probability of significant deterioration in an important area of life function

- Reasonable probability of not progressing developmentally as appropriate
- 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

3. The client's condition is due to one of the following:
   - A diagnosed mental health disorder
   - A suspected mental health disorder not yet diagnosed
   - A significant trauma putting the client at risk for a future mental health diagnosis

5. Ancillary Services Request (Internal)

- IOP must complete the Ancillary Request section in order to provide Day Services and Outpatient Specialty Mental Health Services (SMHS) during the course of treatment
- IOP shall only provide Outpatient SMHS outside of scheduled Day Service hours, or during scheduled Day Service hours if the youth is unable to attend the Day Program that day

  The following Outpatient SMHS are <u>never</u> allowed to be claimed on the same day that Day Services have been claimed:

  - Collateral
  - Case Management

  Additionally, the following SMHS are <u>never</u> allowed to be claimed as Outpatient Services at any time while a client is enrolled in Day Services, as they are bundled with Day Services

  - Assessment
  - Client Plan

- Provide the Day Program Outpatient Subunit number
- Select the amount of Outpatient SMHS requested per day (up to 8 hours)
- Select and describe <u>at least one</u> reason Outpatient SMHS are medically necessary in addition to Day Services

  1. Reason why; requested service(s) is not available during day program hours
  2. Reason why; continuity or transition issues make these services necessary for a limited time
  3. Reason why; these concurrent services are essential for coordination of care

- Note; if the client is receiving ancillary SMHS from **another program or provider**, the Day Services Provider shall coordinate with the separate Outpatient Provider to **complete a stand-alone Ancillary SMHS Request Form**

7. Signature(s)

- Must include the printed/typed name, credentials, signature and date of the Program Clinician completing the request
- Must include the printed/typed name, credentials, signature and date of a Licensed Mental Health Professional if the Program Clinician completing the request is not a Licensed Mental Health Professional

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OPTUM AUTHORIZATION SECTION

- ❖ The following sections are completed by Optum upon receipt from the Day Services provider
- ❖ Optum will review and retain the Prior Authorization Day Services Request (DSR) form
- ❖ Within 5 business days of Optum receiving the DSR, authorization(s) will be viewable in the CCBH Clinician Home Page Authorizations Tab

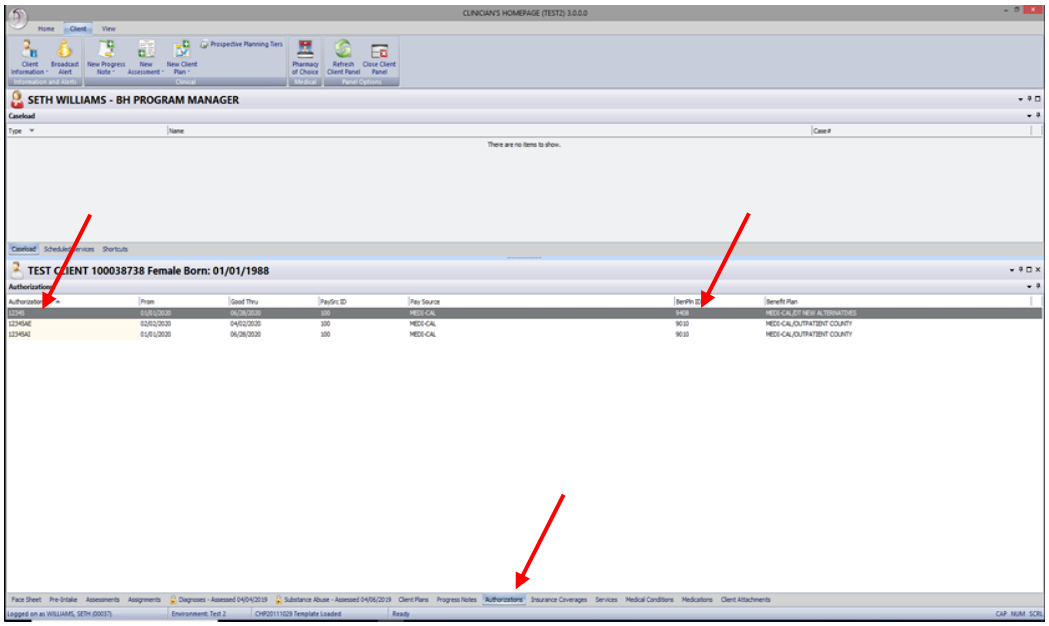
County of San Diego Mental Health Plan
IOP & PHP Prior Authorization Day Services Request (DSR)

- **Day Services Prior Authorization Determination**
  - When the scope, amount and duration of services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Day Services authorizations will be indicated as "Medi-Cal/DT" with the legal entity name in the "Benefit Plan" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting provider

- **Ancillary Services Determination (Internal)**
  - When the Internal Ancillary Outpatient Services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Internal Ancillary Services will be indicated by an "AI" next to the authorization number in the "Authorization #" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting Day Service provider

- **Ancillary Services Determination (External)**
  - When an ancillary Specialty Mental Health Provider (SMHP) begins treatment, a stand-alone "Ancillary SMHS Request" form must be submitted to Optum by the Day Service provider to request ancillary SMHS from a separate program/provider in addition to Day Services
  - When external ancillary services are authorized, the start date and end date shall be viewable to the requesting provider and the ancillary SMHP in the CCBH Clinician Home Page Authorizations Tab. External ancillary services will be indicated by an "AE" next to the authorization number in the "Authorization #" column (see image below)
  - When the External Ancillary Services Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and the requesting Day Service Provider, who shall communicate with the ancillary SMHP within 3 business days
  - See "Ancillary SMHS Request" form and explanation form for additional information

CCBH Clinician Home Page Authorizations Tab:



Note: The Prior Authorization Day Services Request (DSR) form replaces the Intensive Services Request (ISR) form effective 1/1/2020

References:

Behavioral Health Information Notice (BHIN) No: 21-073 Dated 12/12/2021 : Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req

DHCS MHSUDS INFORMATION NOTICE NO.: 19-026 Dated 5/31/19: Authorization of Specialty Mental Health Services

DMH INFORMATION NOTICE NO.: 02-06 Dated 10/1/02: Changes in Medi-Cal Requirements for Day Treatment Intensive and Day Rehabilitation

County of San Diego Mental Health Plan

IOP & PHP Prior Authorization - Day Services Request (DSR)

Submit at least 5 business days prior to projected start date

Initial Request (prior to services): ☐IOP (DIH) or ☐PHP (DIF)

Continuing Request: ☐IOP (beyond initial 3 months) or ☐PHP (beyond initial 1 month)

IOP & PHP - DSR
FAX TO: (866) 220-4495
Optum Public Sector San Diego
Phone: (800) 798-2254
Option 3, then Option 4

Out of County Client – Must Include

☐AB1299 – Attach Notice of Presumptive Transfer, OR

☐AAP/KinGAP – Attach SAR & written COR approval to serve youth under County contract due intent to discharge youth to San Diego residence

☐Written COR exception

CLIENT INFORMATION

Client Name: _____ **Client ID**: _____ **Client Date of Birth:** _____

DAY PROGRAM INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Subunit#**: _____

SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST

Day Intensive Half (DIH) at least 3 hours | Day Intensive Full (DIF) more than 4 hours

SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):

☐Intensive Outpatient Program (IOP – DIH up to ~~for 8~~ 12 weeks) ☐Partial Hospitalization Program (PHP – DIF up to ~~for 2~~ 4 weeks)

AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)

☐Up to 3 Days Per Week ☐Up to 5 Days Per Week ☐Up to 7 Days Per Week

MEDICAL NECESSITY CRITERIA FOR DAY SERVICES

DIAGNOSIS: Provide the ICD 10 mental health diagnoses that are the focus of mental health treatment

Diagnosis 1: **Diagnosis 2:** **Diagnosis 3:**

Medical Necessity Criteria (BHIN 21-073)

Client has a condition placing them at high risk for a mental health disorder due to experience of trauma (*choose at least one*):

☐ Scoring in the high-risk range under a trauma screening tool | Score: _____
☐ Involvement in the child welfare system
☐ Juvenile justice involvement
☐ Experiencing homelessness
Additional information as needed: _____

OR

Client has at least one of the following:

☐ A significant impairment or reasonable probability of significant deterioration in an important area of life functioning
Explain: _____
☐ A reasonable probability of not progressing developmentally as appropriate | Explain: _____
☐ 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 | Explain: _____

AND

The client's condition is due to one of the following:

☐ A diagnosed mental health disorder, according to the criteria of current editions of the DSM and the ICD-10 classifications
☐ A suspected mental health disorder that has not yet been diagnosed | Suspected DSM/ICD Mental Health Diagnosis: _____
☐ Significant trauma placing the beneficiary at risk of a future mental health condition | Explain: _____

ANCILLARY SERVICES REQUEST (INTERNAL)

IOP must request ancillary authorization (through this form) if client is going to receive Day Services and Outpatient Services from the same provider/program

Outpatient Subunit#: _____

1. **SELECT THE AMOUNT OF OUTPATIENT SMHS REQUESTED PER DAY** (Inclusive of all Individual, Collateral, ICC, IHBS and Group SMHS provided by Day Service provider in addition to Day Program Services):
   ☐ Up to 8 hours per day ☐ Other: _____
2. **MEDICAL NECESSITY FOR OUTPATIENT SMHS** (must select at least one):
   ☐ Requested service(s) is not available during day program hours. Describe why service is not available: _____
   ☐ Continuity or transition issues make these services necessary for a limited time. Describe the need: _____
   ☐ These concurrent services are essential for coordination of care. Describe why services are essential: _____

When a client is concurrently receiving SMHS from another provider, the IOP/PHP must request, obtain, and submit to Optum a stand-alone (external) Ancillary Specialty Mental Health Services (SMHS) Request Form

Program Clinician (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Licensed Clinician (Print): _____ **Credentials:** _____

Co-Signature: _____ **Date:** _____

- Co-Signature required if Program Clinician is not a Licensed Mental Health Professional

FOR OPTUM USE ONLY

Optum completes and retains. Within 5 business days of Optum receipt, authorization determination status will be viewable to the requesting provider in the CCBH Clinicians Home Page Authorizations Tab.

DAY SERVICES PRIOR AUTHORIZATION DETERMINATION

☐ **Day Services scope, amount and duration authorized with START DATE**: _____ **END DATE**: _____

Day Services request is ☐ **denied** ☐ **modified** ☐ **reduced** ☐ **terminated or** ☐ **suspended as follows**: _____

NOABD was issued to the beneficiary and provider on the following date: _____

ANCILLARY SERVICES DETERMINATION (INTERNAL)

☐ **Internal Ancillary OP SMHS authorized: START DATE**: _____ **END DATE**: _____

Internal Ancillary OP SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

ANCILLARY SERVICES DETERMINATION (EXTERNAL)

(External authorization requests are submitted to Optum when indicated through a separate Ancillary SMHS Request Form)

☐ **External Ancillary SMHS authorized: START DATE**: _____ **END DATE**: _____

External Ancillary SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

Optum clinician Signature/Date/Licensure: _____

2022

County of San Diego Mental Health Plan
Prior Authorization Day Services Request (DSR)

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

CO-SIGNATURE:

- Prior Authorization Day Service Requests must be completed by or co-signed by a Licensed Mental Health Professional
- Co-signature from Licensed Mental Health Professional indicates they have reviewed and agree with the findings of the request

COMPLETION REQUIREMENTS:

1. Prior Authorization Day Services Request form is completed by the Day Services provider and submitted to Optum via FAX (866) 220-4495 for all clients prior to the initial provision of Day Services
2. Continuing Prior Authorization Day Services Requests are completed by the Day Services provider and submitted prior to expiration of the initial authorization period (within 90 days for STRTP and 180 days for San Pasqual Academy)
3. Continuing Prior Authorization Day Services Requests shall be submitted at least 5 business days prior to the expiration of Day Services Authorization, and can be submitted up to 10 business days prior to the expiration
4. Prior authorization shall be obtained before Day Services are initiated. For hybrid programs, Outpatient Services may be provided prior to the authorization of Day Services

DOCUMENTATION STANDARDS:
The following elements of the Prior Authorization Day Services Request form shall be addressed:

1. Client Information

- Include Name, Client ID and Date of Birth
- Include the Placing or Referring agency
- For STRTPs-Select one of the options for the Qualified Individual Assessment
- For Out of County clients, the request shall include either:
  - (STRTP only) A copy of the Notice of Presumptive Transfer Form for foster youth placed through AB1299 Presumptive Transfer in a STRTP and a copy of QI Assessment reflecting STRTP level of care determination or
  - A copy of the SAR for youth placed through AAP/KinGAP. For youth in a STRTP the request shall include written COR approval, obtained by emailing the COR, to serve youth under the County contract due to planned discharge to a San Diego residence.

2. Day Program Information

- Include Legal Entity, Program Name, Phone number, Fax number, Unit number, and Day Services Program Subunit number

3. Scope, Amount and Duration of Day Services Request

- Identify the scope and duration of Day Services to be provided (STRTP – 90 days, or SPA – 180 days).
- Include the amount of services requested (select Up to 5 Days Per Week or Up to 6 Days Per Week) which shall not exceed the Day Program schedule that has been approved by BHS QM

4. Medical Necessity Criteria for Day Services

- **Diagnosis -** Provide the name of the DSM/ICD Mental Health diagnoses that are the focus of mental health treatment
- **Medical Necessity Criteria**
  1. Select and explain how client meets medical necessity. (Must meet either A or B and C):
     - A. Client has a condition placing them at risk for a mental health disorder due to trauma. At least one of the below.
       - Scoring in the high-risk range under a trauma screening tool
       - Involvement in the child welfare system
       - Juvenile Justice Involvement
       - Experiencing homelessness

       OR
     - B. Client has at least one of the following:
       - A significant impairment or reasonable probability of significant deterioration in an important area of life functioning
       - A reasonable probability of not progressing developmentally as appropriate
       - 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
     - C. The client's condition is due to one of the following:
       - A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD-10 classifications
       - A suspected mental health disorder that has not yet been diagnosis
       - Significant trauma placing the beneficiary at risk of a future mental health condition
- **Day Services Necessity Criteria**: Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01
  2. Describe client's needs for Day Services in order to move from a higher level of care to a lower level of care, or to prevent deterioration and admission to a higher level of care
  3. For **continuing service requests only** – Describe progress made towards treatment goals during the current authorization period, and/or explain how progress is expected to be made towards treatment goals during the next authorization cycle

5. Ancillary Services Request (Internal)

- STRTPs and SPA must complete the Ancillary Request section for the STRTP or SPA to provide Day Services and Outpatient Specialty Mental Health Services (SMHS) during the course of treatment
- If youth at SPA are receiving Day Services, in addition to Day Services SPA shall only provide the Outpatient SMHS of Intensive Care Coordination (ICC) for the purpose of a Child and Family Team (CFT) meeting outside of Day Service hours
- STRTP hybrid Day Service and Outpatient programs shall only provide <u>select</u> Outpatient SMHS outside of scheduled Day Service hours, or during scheduled Day Service hours if the youth is unable to attend the Day Program that day

  The following Outpatient SMHS are <u>never</u> allowed to be claimed on the same day that Day Services have been claimed:

  - Collateral
  - Case Management

  Additionally, the following SMHS are <u>never</u> allowed to be claimed as Outpatient Services at any

timewhile a client is enrolled in Day Services, as they are bundled with Day Services

  - Assessment
  - Client Plan

- For Outpatient SMHS that are provided on the same day as Day Services, the provider must document rationale for ancillary Outpatient SMHS, inclusive of:

  1. Reason why; requested service(s) is not available during day program hours
  2. Reason why; continuity or transition issues make these services necessary for a limited time
  3. Reason why; these concurrent services are essential for coordination of care

- Provide the Day Program Outpatient Subunit number

  1. Select the amount of Outpatient SMHS requested per day (up to 8 hours)
  2. Select and describe <u>at least one</u> reason Outpatient SMHS are medically necessary in addition to Day Services

- Note; if the client is receiving ancillary SMHS from **another program or provider**, the Day Services Provider shall coordinate with the separate Outpatient Provider to **complete a stand-alone Ancillary SMHS Request Form**

6. Clinical Review Report: Required by the Interim STRTP Regulations Version 2 section 14 titled "Clinical Reviews, Collaboration, and Transition Determination"

- Clinical Review Report section is completed for STRTPs requesting continued Day Services. SPA which is not an STRTP, shall therefore always leave this section blank. STRTPs shall also leavethis section blank on the initial Prior Authorization Day Services Request

  1. Describe the type and frequency of services provided during the <u>previous</u> 90-day authorization period for both Day Services and Outpatient Services
  2. Describe the impact of services toward the achievement of Client Plan Goals and include goals of transitioning to lower level of care
  3. The Clinical Review Recommendation shall be discussed in a CFT meeting or Treatment team meeting that includes the Head of Service or a Licensed Mental Health Clinician at minimum every 90 days
  4. Provide the date of the most recent CFT meeting or Treatment Team meeting where the Clinical Review Recommendation was discussed
  5. Provide a Clinical Review Recommendation for: Continued Treatment in the STRTP, Transition from the STRTP, or Other
     - If Transition is selected, describe the recommendation for transition
     - If Other is selected, describe the treatment recommendation

- The Clinical Review Report shall be reviewed for completion by Optum upon submittal
- The Clinical Review Report shall be reviewed by the BHS Continuum of Care Reform (CCR) team, who will follow up directly with the program when indicated
- Recommendation for transition or continued treatment must be supported in the client record and CFT documentation

7. Signature(s)

- Must include the printed/typed name, credentials, signature and date of the Program Clinician completing the request
- Must include the printed/typed name, credentials, signature and date of a Licensed Mental Health Professional if the Program Clinician completing the request is not a Licensed Mental Health Professional

OPTUM AUTHORIZATION SECTION

- ❖ The following sections are completed by Optum upon receipt from the Day Services provider
- ❖ Optum will review and retain the Prior Authorization Day Services Request (DSR) form
- ❖ Within 5 business days of Optum receiving the DSR, authorization(s) will be viewable in the CCBH Clinician Home Page Authorizations Tab

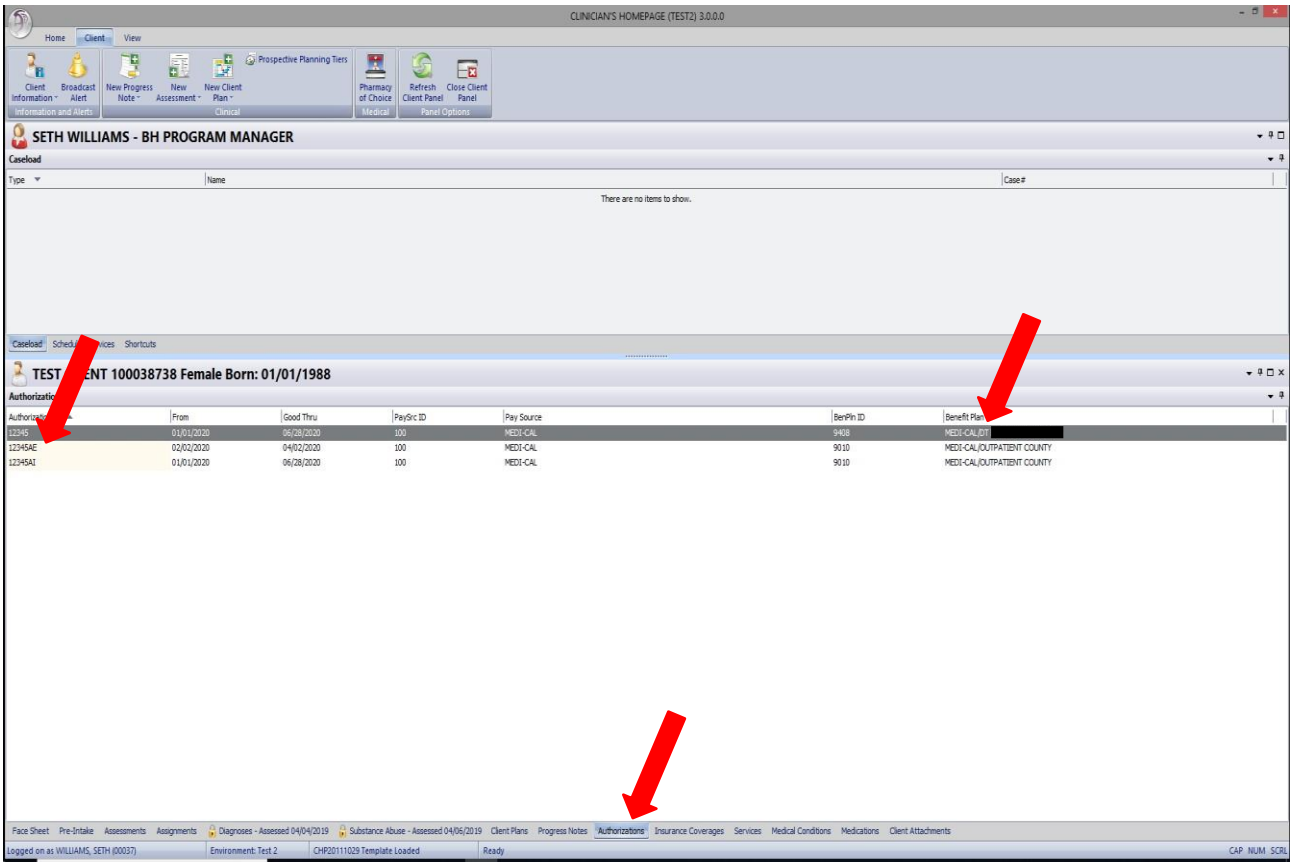
- **Day Services Prior Authorization Determination**
  - When the scope, amount and duration of services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Day Services authorizations will be indicated as "Medi-Cal/DT" with the legal entity name in the "Benefit Plan" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting provider

- **Ancillary Services Determination (Internal)**
  - When the Internal Ancillary Outpatient Services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Internal Ancillary Services will be indicated by an "AI" next to the authorization number in the "Authorization #" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting Day Service provider

- **Clinical Review Report Determination** (completed by STRTPs only)
  - For STRTP providers Optum shall review the Clinical Review Report for completion. If incomplete, Optum shall send notification to the requesting provider to resubmit with required data elements
  - Optum shall send the completed Clinical Review report to the BHS CCR team for review
  - The BHS CCR team shall follow up with the STRTP regarding the Clinical Review Report when indicated

- **Ancillary Services Determination (External)**
  - When an ancillary Specialty Mental Health Provider (SMHP) begins treatment, a stand-alone "Ancillary SMHS Request" form must be submitted to Optum by the Day Service provider to request ancillary SMHS from a separate program/provider in addition to Day Services
  - When external ancillary services are authorized, the start date and end date shall be viewable to the requesting provider and the ancillary SMHP in the CCBH Clinician Home Page Authorizations Tab. External ancillary services will be indicated by an "AE" next to the authorization number in the "Authorization #" column (see image below)
  - When the External Ancillary Services Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and the requesting Day Service Provider, who shall communicate with the ancillary SMHP within 3 business days
  - See "Ancillary SMHS Request" form and explanation form for additional information

CCBH Clinician Home Page Authorizations Tab:



Note: The Prior Authorization Day Services Request (DSR) form replaces the Intensive Services Request (ISR) form effective 1/1/2020

References: DHCS MHSUDS INFORMATION NOTICE NO.: 19-026 Dated 5/31/19: Authorization of Specialty Mental Health Services

DMH LETTER NO.: 02-01 Dated 4/16/2002: Clarification Regarding Medi-Cal Reimbursement for Day Treatment for Children and Youth in Group Home Programs

DMH INFORMATION NOTICE NO.: 02-06 Dated 10/1/02: Changes in Medi-Cal Requirements for Day Treatment Intensive and Day Rehabilitation

DHCS MHSUDS Information Notice No.: 17-016 Dated May 5, 2017; Statewide Criteria for Interim Mental Health Program Approval for STRTP and Enclosure 1 – Interim Mental Health Program Approval for STRTPs

County of San Diego Mental Health Plan

Prior Authorization Day Services Request (DSR)

Submit At Least 5 Business Days Prior To Projected Start Date

Please Check: ☐ **Initial Request (prior to services)**
☐ **Continuing Request (STRTP required every 90 Days, SPA every 180 Days)**

FAX TO: (866) 220-4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then Option 4

CLIENT INFORMATION

Client Name: _____

Client ID: _____

Client Date of Birth: _____

Placing/Referring Agency: ☐CWS ☐Probation ☐ Dual Placement ☐ Other: _____

Qualified Individual Assessment – only for STRTPs

☐QI Assessment has been completed and an STRTP Level of Care was recommended
☐Emergency Placement - QI Assessment shall be completed within 30 days of placement

Out of County Client - Through: ☐ CWS ☐ Probation

Out of County Client - Must Include Either:

☐ AB1299; for STRTP only, a copy of Notice of Presumptive Transfer (foster youth) and a copy of QI Assessment reflecting STRTP level of care determination (foster youth)

☐ AAP/KinGAP; for STRTP must include SAR copy and written COR approval to serve youth under County contract due to discharge to San Diego residence

DAY PROGRAM INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Day Program Subunit#**: _____

SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST

SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):

☐ STRTP Hybrid Day Rehab and Outpatient Services (Up to 90 days)

☐San Pasqual Academy (SPA) Day Rehab (Up to 180 Days)

AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)

☐ Up to 5 Days Per Week ☐ Up to 6 Days Per Week

MEDICAL NECESSITY CRITERIA FOR DAY SERVICES

DIAGNOSIS: Provide the DSM/ICD Mental Health diagnoses that are the focus of mental health treatment.

Diagnosis 1: **Diagnosis 2:** **Diagnosis 3:**

Medical Necessity Criteria (BHIN 21-073)

Client has a condition placing them at high risk for a mental health disorder due to experience of trauma (*choose at least one*):

☐ Scoring in the high-risk range under a trauma screening tool
Score: _____

☐ Involvement in the child welfare system

☐ Juvenile justice involvement

☐ Experiencing homelessness
Additional Information As Needed: _____

OR

Client has at least one of the following:

☐ A significant impairment or reasonable probability of significant deterioration in an important area of life functioning
Explain: _____

☐ A reasonable probability of not progressing developmentally as appropriate
Explain: _____

☐ 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.
Explain: _____

AND

The client's condition is due to <u>one</u> of the following:

☐ A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD-10 classifications

☐ A suspected mental health disorder that has not yet been diagnosed
Suspected DSM/ICD Mental Health Diagnosis: _____

☐ Significant trauma placing the beneficiary at risk of a future mental health condition
Explain: _____

Day Services Necessity Criteria: *(Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01)*

1. Client requires structured Day Services in order to move from higher level of care to lower level of care or to prevent deterioration and admission to a higher level of care. Describe: _____
2. **Continuing service requests only -** Current treatment goals have not been met. **Describe progress** toward treatment goals or how progress is expected to be made during the next authorization cycle: _____

ANCILLARY SERVICES REQUEST (INTERNAL)

STRTP and SPA must request ancillary authorization if client is going to receive Day Services and Outpatient Services from the same provider/program

STRTP/SPA must submit a stand-alone (external) <u>Ancillary Specialty Mental Health Services (SMHS) Request Form</u> for any client receiving Day Services and SMHS from another provider/program

Outpatient Subunit#: _____

1. **SELECT THE AMOUNT OF OUTPATIENT SMHS REQUESTED PER DAY (Inclusive of all Individual, Collateral, ICC, IHBS and Group SMHS provided by Day Service provider in addition to Day Program Services):**

   ☐ Up to 8 hours per day

2. **MEDICAL NECESSITY FOR OUTPATIENT SMHS (must select at least one):**

   ☐ Requested service(s) is not available during day program hours. Describe why service is not available: _____

   ☐ Continuity or transition issues make these services necessary for a limited time. Describe the need: _____

   ☐ These concurrent services are essential for coordination of care. Describe why services are essential: _____

CLINICAL REVIEW REPORT: Section 14 of Interim Mental Health Program Approval for STRTP

FOR STRTP CONTINUING (90 DAY) REQUESTS ONLY

1. **Describe the type and frequency of services that have been provided by the STRTP during the previous 90-day review period:**

   ☐ Day Services - Describe the type and frequency of Day Services provided by the STRTP during the past 90 days:
   _____

   ☐ Outpatient Services (OP) - Describe the type and frequency of OP services provided by the STRTP during the past 90 days:
   _____

2. **Describe the impact of these services towards the achievement of Client Plan Goals (include progress toward goals of transitioning to lower level of care):** _____

3. **Date of most recent mental health program staff meeting, which must include Head of Service or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed** (must occur at least every 90 days and prior to submittal of DSR): _____

4. **Date of most recent CFT meeting** (must occur at least every 90 days and prior to submittal of DSR): _____

   The CFT/mental health program staff agree that the STRTP continues to meet the specific therapeutic needs of the youth:
   ☐ **Yes** ☐ **No** ☐ **Other** _____

   The CFT Meeting Summary and Action Plan is available based on UM reviewer request: ☐ **Yes** ☐ **No**

5. **Clinical Review Recommendation**: ☐ Continued treatment in STRTP ☐ Transition from the STRTP, include transition recommendation _____ ☐ Other _____
   - ❖ **Recommendation for transition or continued treatment must be supported in client record and CFT documentation**

Program Clinician (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Licensed Clinician (Print): _____ **Credentials:** _____

Co-Signature: _____ **Date:** _____

- ❖ **Co-Signature required if Program Clinician is not a Licensed Mental Health Professional**

FOR OPTUM USE ONLY

Optum completes and retains. Within 5 business days of Optum receipt, authorization determination status will be viewable to the requesting provider in the CCBH Clinicians Home Page Authorizations Tab.

DAY SERVICES PRIOR AUTHORIZATION DETERMINATION

☐ **Day Services scope, amount and duration authorized: START DATE:_____END DATE: _____**

Day Service request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

ANCILLARY SERVICES DETERMINATION (INTERNAL)

☐ **Internal Ancillary OP SMHS authorized: START DATE:_____END DATE: _____**

Internal Ancillary OP SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

CLINICAL REVIEW REPORT DETERMINATION

☐ **Clinical Review Report is complete and addresses all four components; see Clinical Review Report section**

Follow up for the Clinical Review Report will occur through the County CCR team when indicated.

ANCILLARY SERVICES DETERMINATION (EXTERNAL)

(External authorization requests are submitted to Optum when indicated through a separate Ancillary SMHS Request Form)

☐ **External Ancillary SMHS authorized: START DATE:_____END DATE: _____**

External Ancillary SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

Optum clinician Signature/Date/Licensure:

County of San Diego Mental Health Plan

Therapeutic Behavioral Services (TBS)
Prior Authorization Request & Referral Form

2022

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

Note: TBS referral may be initiated by school staff, CWS, probation, etc., but requires that a Specialty Mental Health Provider (SMHP) is serving the youth and billing Medi-Cal; therefore, it is best when SMHP submits the authorization/referral.

COMPLETION REQUIREMENTS:

1. TBS Prior Authorization Request & Referral Form is completed and submitted to Optum for prior authorization for all clients being referred to TBS
2. Continuing request is completed by TBS provider and must be submitted to Optum at least 7 calendar days before previous authorization expires
3. Prior authorization must be obtained before TBS services are initiated
4. Once authorized by Optum, the form is sent by Optum to TBS provider as an authorized referral

DOCUMENTATION STANDARDS:

The following elements of the TBS Prior Authorization & Referral From must be addressed

1. Youth Information
   - Must include name, DOB, Medi-Cal or SSN, current address, parent/caregiver name and phone number
2. Referring Party/Therapist Information
   - Completed by SMHP including FFS/TERM Therapist who is claiming Medi-Cal services
3. Additional Referring Party Information; when applicable
   - Complete only if referring party is not the SMHP
4. Child Welfare Service or Probation Involvement *(select yes or no)*
   - If 'yes', identify name, phone number, FAX and email of Social Worker or Probation Officer
5. Other Party Involvement; when applicable
   - Identify additional supportive figures; i.e., CASA, Mentor, Big Brother/Sister, Attorney, etc.
6. Specific Request Regarding TBS Coach *(optional)*
   - Identify client's preference regarding language, culture, gender, etc.
7. TBS Class Criteria/Eligibility Per DMH Information Notice NO:08-38
   - Must be completed by the SMHP
     1) Confirm the youth is under 21 and a full scope Medi-Cal beneficiary
     2) Confirm the youth is receiving Specialty Mental Health Services from a Medi-Cal provider
     3) Confirm the conditions for eligibility: *(must check a minimum of one)*
        - Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option or has had at least one emergency psychiatric hospitalization within the past 24 months

- Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs Youth may need out of home placement
- Youth may need out of home placement, a higher level of residential or acute care
- Youth is transitioning to a lower level of care and needs TBS to support the transition
- Youth has previously received TBS while a member of the certified class
- Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

8. Determination Criteria
   - Must be completed by the SMHP
     1) Current diagnosis
     2) Check Yes or No if Medical Necessity (BHIN 21-073) is met.
     3) Document what TBS shall focus on.
     4) Indicate date of Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR) or Progress Note demonstrating the need so Optum may review in electronic health record
     5) Select the scope, duration and amount of TBS services being requested
   - SMHP enters date authorization request form was submitted to Optum

Please note that the Authorization Determination start date is the first day that TBS may be provided. The end date must be no longer than six months from the start date. A continuing authorization may be submitted for an additional duration of service and will be completed when indicated by the TBS provider.

9. Authorization Determination
   - Optum will make a determination to approve the request when Class Criteria and Medical Necessity are met
   - Optum will send the approved authorization/referral to referring provider and TBS provider which will include:
     - Start and end date for TBS services (scope, amount and duration)
     - Approval of any additional requested hours, when applicable

   or
   - Optum will deny, modify, reduce, terminate or suspend TBS request
     - An NOABD will be sent to beneficiary and referring provider

If Optum is unable to confirm SMHP, the referral will be sent to TBS provider to confirm active SMHP claiming Medi-Cal, which may impact the processing time lines for authorization review

FAX TO: (866) 220 – 4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then option 4

THERAPEUTIC BEHAVIORAL SERVICES (TBS)
PRIOR AUTHORIZATION REQUEST & REFERRAL FORM

☐ Initial Request (submitted by SMHP) ☐ Continuing Request (6 mos.) (Submitted by TBS provider)

* Indicates a required section for Initial Requests

Youth Information*:

*Name: _____	*DOB: _____	*Medi-Cal or SSN: _____
*Current Address: _____		
School: _____	School District: _____	
*Parent/Caregiver Name: _____	*Parent/Caregiver Phone: _____	

Referring Party/Therapist Information*: ***Please Note: Client must be receiving services from a Specialty Mental Health Provider (SMHP) billing Medi-Cal.***

*SMHP Name: _____	*SMHP Credential: _____
*SMHP Program Name: _____	*Address: _____
*Phone: _____	*Fax: _____

Additional Referring Party Information: (*If same as SMHP, please leave blank)*

Name: _____	Agency: _____	Relationship: _____
Address: _____		
Phone: _____	Fax: _____	E-Mail: _____

CWS/Probation Involved: ☐ Yes ☐ No CWS Contact Name: _____ Probation Contact Name: _____

Phone: _____	Fax: _____	E-Mail: _____

Other Party Involvement: *(i.e. CASA, Mentor, Attorney, Big Brother/Sister, etc.)*

Name/Relationship: _____	Contact Phone: _____
Name/Relationship: _____	Contact Phone: _____

Specific requests with regard to TBS Coach's language, culture, gender, etc.: _____

TBS Class Criteria / Eligibility Per DMH Information Notice NO: 08-38 (Completed by SMHP)* – *All questions below require completion.*

1. Is Youth a full-scope Medi-Cal beneficiary under age 21? ☐ **Yes** ☐ **No** **AND**
2. Is Youth receiving specialty mental health services from a Medi-Cal funded therapist/case manager? ☐ **Yes** ☐ **No**
3. Which of the following conditions have been met by the Youth? *(*Check all that apply, must check a minimum of 1)*
   - ☐ Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** has had at least one emergency psychiatric hospitalization within the past 24 months
   - ☐ Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs
   - ☐ Youth may need out of home placement, a higher level of residential or acute care
   - ☐ Youth is transitioning to a lower level of care and needs TBS to support the transition
   - ☐ Youth has previously received TBS while a member of the certified class
   - ☐ Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

FAX TO: (866) 220 – 4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then option 4

Determination Criteria, (completed by the SMHP)*:

1. ***Diagnosis for focus of TBS**: _____
2. ***Medical Necessity (BHIN 21-073) is met** ☐ **Yes** ☐ **No**
3. ***TBS shall focus on (client challenges/behaviors):** _____
4. ***Date of most recent Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR), or Progress Note that demonstrates need** Click to enter a date.
5. *SMHP Clinician is requesting the following TBS services: ***(Must include amount, scope & duration)***
   - ☐ Up to 25 hours of TBS Intervention per week - **amount**
   - ☐ TBS **scope** inclusive of Assessment (SC48), Plan Development (SC46), Intervention (SC47) and Collateral (SC49)
   - ☐ Up to 6 months of TBS Intervention – **duration**
   - ☐ Other *(explain any changes to amount, scope or duration being requested. Please note each authorization cycle is 6 months- Re-authorization may be obtained for additional services)*: _____

SMHP submitted form to Optum on: Click to enter a date.
(Optum shall notify provider of determination within 5 business days of receipt)

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed BHA, OAR or Progress Note**
☐ **TBS scope, amount and duration authorized as requested: START DATE**: _____ **END DATE**: _____
☐ **Additional TBS hours authorized per week** (beyond 25 hours per week): _____
TBS Request is Reduced/Modified as follows: ☐scope _____ **☐amount** _____ **☐duration** _____
TBS request is ☐denied ☐modified ☐reduced ☐terminated or ☐suspended
NOABD was issued to the beneficiary and provider on the following date: _____
☐ Optum unable to confirm SMHP. Authorization is contingent on TBS provider confirming active SMHP claiming Medi-Cal.

Optum Clinician Signature/Date/Licensure:

Typically, within two business days of Optum clinician signature, authorization will be forwarded to TBS and referring provider
^Date pre-authorization received by TBS Provider: _____ (^*completed by New Alternatives)*

2024

County of San Diego Mental Health Plan

Therapeutic Foster Care (TFC)
Prior Authorization Request

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

Note: Child/Youth must be receiving Intensive Care Coordination (ICC) in order to be eligible for TFC

COMPLETION REQUIREMENTS:

1. TFC Prior Authorization Request form is completed and submitted to Optum via FAX (866) 220-4495 for all clients that will be receiving TFC prior to initial provision of TFC – through FFAST
2. Continuing request is completed by TFC provider and resubmitted within 12 months before previous authorization expires
3. Prior authorization must be obtained before TFC services are initiated, and a continuing request must be authorized prior to providing services once the initial request expires

DOCUMENTATION STANDARDS:

The following elements of the TFC Prior Authorization Request form must be addressed

1. Client Information
   - Must include name, DOB and Client ID
2. Foster Family Agency Stabilization and Treatment (FFAST) Program Information
   - Must include Legal Entity, Program Name, Phone, Fax, Unit #, Subunit # and Program Manager Name
3. TFC Criteria (Items #1-5 are required for authorization of TFC)
   - Must indicate client is under the age of 21 (service only available to youth under age 21)
   - Must indicate client is eligible for and receiving ICC services (Not eligible for TFC unless receiving ICC)
   - Must indicate client has a CFT in place to guide TFC service provision and include the date of the most recent CFT meeting (not eligible for TFC unless a CFT is in place)
   - Must indicate medical necessity criteria for TFC **BHIN 21-073** is documented in the Behavioral Health Assessment (BHA). Include date of BHA or Progress/CFT Note and DSM/ICD Mental Health diagnosis
   - Must indicate either of the following Clinical Indicators of Need for TFC services, as set forth by the Medi-Cal Manual 3rd Edition (or most current edition), in Chapter 2 "Target Population", or indicate if it is not applicable and the need for TFC is based on items #1-4
     - Indicate if the client is at risk of losing their placement and/or being removed from the home as a result of the caregiver's inability to meet the client's mental health needs; and either:
       - There is a recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the client's mental health needs, and the client is immediately at risk of residential, inpatient, or institutional care; or
       - Client is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the client, or support effective rehabilitation; or

- Not applicable, TFC need is based on meeting criteria #1-4 above

4. TFC Frequency and Duration Request
   - Amount requested: TFC intervention will be requested for up to 7 days per week
   - Duration requested: TFC will be requested for up to 12 months of intervention
5. Optum Authorization Determination
   - Optum will make a determination to approve the request when the 5 TFC criteria are met and will provide authorization determination within 5 business days of receipt
   - When the scope, amount and duration of TFC services are authorized, the start date and end date shall be viewable to the TFC provider in the CCBH Clinician Home Page Authorizations Tab
     OR
   - Optum will deny, modify, reduce, terminate or suspend the TFC request and an NOABD will be sent to the Medi-Cal beneficiary and requesting provider

FAX TO: **Optum Public Sector San Diego**
Fax: (866) 220 – 4495
Phone: (800) 798-2254, Option 3, then Option 4

County of San Diego Mental Health Plan
Therapeutic Foster Care (TFC) Prior Authorization Request - Through FFAST

☐ Prior Authorization Request (Prior to provision of TFC)

☐ Continuing Request (After initial authorization of up to 12 months)

Client Information

Client Name: _____	Date of Birth: _____	Client ID: _____

Foster Family Agency Stabilization and Treatment (FFAST) Information

Legal Entity: San Diego Center for Children		Program Name: FFAST
Phone: 858-633-4115		Fax: 858-737-6972
Unit #: 6980	Subunit #: 6986	Program Manager Name: Aisha Pope

SCOPE OF SERVICE:

Therapeutic Foster Care is a short-term, intensive, highly coordinated, trauma- informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs, documented with service code Therap Foster Care – TFC (94).TFC services are available to Katie A subclass members as well as beneficiaries under 21 who are eligible for the full scope of Medi-Cal services, meet medical necessity criteria and are receiving Intensive Care Coordination. A Child and Family Team must be identified in order to provide TFC. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment.

TFC Criteria: (Items 1-5 are required for authorization of TFC)

1. ☐ **Client is under the age of 21**
2. ☐ **Intensive Care Coordination (ICC): Client is eligible for and receiving ICC services.**
   (Not eligible for TFC unless receiving ICC)
3. ☐ **Client has a CFT in place to guide TFC service provision. Most recent CFT meeting date: _____**
   (Not eligible for TFC unless a CFT is in place)
4. ☐ **Client meets medical necessity criteria for Specialty Mental Health Services BHIN 21-073 as documented in: (select all that apply)**
   - ☐ **Behavioral Health Assessment (BHA) dated: _____**
   - ☐ **DSM/ICD Mental Health diagnosis: _____**
   - ☐ **Progress/CFT Note dated: _____**
   - ☐ **Other: _____**

5. ***The following are clinical indicators of need and are not requirements or conditions for TFC services - per Medi-Cal Manual Third Edition, Chapter 2 "Target Population":*** (Check at least 1)
   Client is at risk of losing their placement and/or being removed from their home as a result of the caregiver's inability to meet the client's mental health needs; and, either:
   - ☐ **There is a recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the client's mental health needs, and the client is immediately at risk of residential, inpatient, or institutional care; or**
   - ☐ **Client is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the client, or support effective rehabilitation; or**
   - ☐ **Not applicable, TFC need is based on meeting criteria #1-4 above.**

FAX TO: **Optum Public Sector San Diego**
Fax: (866) 220 – 4495
Phone: (800) 798-2254, Option 3, then Option 4

TFC FREQUENCY AND DURATION REQUEST:

1. **Amount Requested:**
   ☐ **Up to 7 days of TFC intervention per week**
2. **Duration Requested:**
   ☐ **Up to 12 months of TFC intervention**

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed BHA, Client Plan and/or Progress Notes**

☐ **TFC scope, amount and duration authorized as requested: START DATE: _____END DATE: _____**

☐ **TFC request is ☐ denied; ☐ modified; ☐ reduced; ☐ terminated; or ☐ suspended**

Reason: _____

NOABD was issued to the Medi-Cal beneficiary and provider on the following date: _____

Optum Clinician Signature/Date/Licensure:

Within five business days of Optum receipt, authorization will be forwarded to the requesting provider

BREAKING BARRIERS

INNOVATIVE APPROACHES TO YOUTH AND FAMILY MENTAL WELLBEING

APRIL 26

TRANSYOUTHCARE SYMPOSIUM 2024

Dr. Aydin Olson-Kennedy

Dr. Johanna Olson- Kennedy

Darlene Tando, LCSW

Early Bird pricing until February 28th!

TYCS offers a comprehensive 15-hour virtual training designed for professionals committed to delivering adept mental health and medical care for gender-diverse children, transgender youth, and young adults. Earn CEUs for mental health providers and nursing, ensuring a robust foundation in providing sensitive and competent virtual care.

APRIL 26 & 27
MAY 5 & 6

Transyouth Care
Educational Symposiums for Professionals

TINYURL.COM/TRANSYOUTHCARE

Children, Youth and Families

Mental Health & Well-Being Celebration!

Lighting the Path to Social Justice!

Meet many local organizations & resources!
Music, drum circles, & bubble dance parties!
Activities, artwork, and games for all ages!
Opportunity drawings for many prizes!

May 11, 2024
2:00 to 6:00PM

Grossmont Center
Main Courtyard
5500 Grossmont Center Drive
La Mesa, CA 91942

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Community Advocacy Program
NAMI SAN DIEGO & IMPERIAL COUNTIES


CMHACY
California Mental Health Advocates for Children and You
Mental Health is Everyone's Business:
Inclusive Conversations for Changing Times
May 15 - May 17