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: _____