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BHS Policies and Procedures	
City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES	1380 Howard Street, 5th Floor San Francisco, CA 94103 (415) 255-3400 FAX (415) 255-3567
Policy and Procedure Title: Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services	
Issued By: Imo Momoh, MPA BHS Director of Managed Care Date: February 22, 2023	DocuSigned by: imo momoh 360E6E598F1D468... Manual Number: 3.03-21 Reference: Behavioral Health Information Notice (BHIN) 22-017

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our clients' needs and lived experiences.

Purpose: Pursuant to existing state and federal requirements, MHPs are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to specialty mental health services (SMHS). The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization review procedures.[3] Compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for the individuals or entities to deny, limit, or discontinue medically necessary services to a beneficiary.[4] MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to beneficiaries.[5] This program must include mechanisms to detect both underutilization and overutilization. Additionally, MHPs must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.

MHPs are responsible for certifying that claims for all covered SMHS meet federal and state requirements. MHPs provide or arrange for the provision of SMHS to Medi-Cal beneficiaries that meet medical necessity and access criteria for SMHS, and approve, and authorize these services according to state requirements.

MHPs may place appropriate limits on a service for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports. Further, MHPs may not arbitrarily deny or reduce

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the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

Parity Final Rule
On March 30, 2016, CMS issued the Parity Rule to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries. It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule requires states to ensure that treatment limitations imposed for Medicaid MH and SUD services are no more restrictive than the predominant treatment limitations imposed for substantially all medical and surgical services within a benefit classification. In addition, the Parity Rule prohibits an MHP from applying a non-quantitative treatment limitation (a requirement that limits the scope or duration of a benefit) to a mental health benefit unless the limitation is comparable to, and applied no more stringently, than it is applied to corresponding medical benefits.

Welfare and Institutions Code (W&I) section 14197.1 requires DHCS to ensure that all covered mental health benefits and substance use disorder benefits, as those terms are defined in section 438.900 of Title 42 of the CFR, are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the CFR, as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by CMS.

Parity Assessment and Compliance Plan
The Parity Rule required DHCS to conduct an analysis of its delivery systems to determine if any applicable limitations exist. This included a review of quantitative treatment limitations, financial and information requirements, and non-quantitative treatment limitations (NQTL). An NQTL is a limit on the scope or duration of benefits, which is not expressed numerically, such as authorization requirements. An NQTL may not be applied to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.

DHCS submitted its Parity Compliance Plan to CMS to demonstrate compliance with the Parity Rule by the implementation deadline of October 2, 2017, and updated the plan in October 2019. The Parity Compliance Plan outlines the findings from DHCS' parity assessment. During its assessment of the State's authorization policies across delivery systems, DHCS identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs and Medi- Cal Managed Care Plans (MCPs). Pursuant to DHCS' Parity Compliance Plan and federal Parity Rule requirements, this BHIN addresses the inconsistencies for inpatient services by implementing policy changes related to authorization of inpatient psychiatric hospital services and psychiatric health facility services to align the policies with those governing the MCPs. Policy related to outpatient SMHS is provided in BHIN 21-016.

Scope:
This policy applies to all Authorization of Inpatient Specialty Mental Health Services providers within the San Francisco Behavioral Health Network.

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Policy:
Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT.

Requirements Applicable to Authorization of Inpatient SMHS
It is the policy of SFDPH that SMHS providers, administrators, and staff establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with this DHCS requirement BHIN 22-017. SFMHP or its providers shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. SFMHP or its providers shall manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the MHP's contract for specialty mental health services.

Authorization procedures and utilization management criteria shall:

- Be based on medical necessity and consistent with current evidence-based clinical practice guidelines, principles, and processes.
- Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice.
- Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's beneficiaries and network providers.

SFMHP and/or its providers shall comply with the following communication requirements:

- Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services.
- Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online.
- Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
- Provide written notification regarding authorization decisions in accordance with the established

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timeframes for the type of authorization.

SFMHP and/or its providers authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

Concurrent Review for Psychiatric Inpatient Hospital Services

This concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and psychiatric health facilities (PHFs) certified by DHCS as Medi-Cal providers of inpatient hospital services. For ease of reference, general acute care hospitals, psychiatric hospitals and PHFs are collectively referred to as "hospital or PHF" below.

This authorization process applies to all inpatient admissions, whether voluntary or involuntary. To the extent there is a conflict, this section supersedes California Code of Regulations, title 9, sections1820.215, 1820.220, 1820.225 and 1820.230.

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

Procedures

I. Admission and Authorization

a. Notification of beneficiary admission and request for treatment authorization.

   SFMHP and/or its providers shall maintain telephone access to received admission notification and initial authorization requests 24 hours a day and 7 days a week. Within 24 hours of admission of a Medi-Cal beneficiary for psychiatric inpatient hospital services, the hospital or PHF shall provide the responsible county MHP (or MHP of the beneficiary) the beneficiary's admission orders, initial plan of care, a request to authorize the beneficiary's treatment, and a completed face sheet. The face sheet shall include the following information (if available):

   i. Hospital name and address
   ii. Patient name and DOB
   iii. Insurance coverage
   iv. Medi-Cal number and county of responsibility identified in the Medi- Cal Eligibility Data System
   v. Current address/place of residence
   vi. Date and time of admission
   vii. Working (provisional) diagnosis
   viii. Date and time of admission
   ix. Name and contact information of admitting, qualified, and licensed practitioner.

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x. Utilization review staff contact information.

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

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

II. Continued Stay Authorization

a. Continued Stay Authorization Request
When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay-authorization request for a specified number of days to the responsible county MHP.

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

Clinical information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- Risk assessment to include any changes, inclusive of new indicators since initial intake assessment that reflects current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.
- Precipitating events if further identified or clarified by the treating hospital after the MHP admission notice.
- Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes,

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rounds sheet, lab results) of the treating hospital.

- Hospital information on prior episode history that is relevant to current stay.
- MHP information on relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
- Substance use information to include any changes, inclusive of new indicators since the initial intake assessment. Examples may include SUD history, any recent changes in SUD, the role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post-discharge.
- Known medical history to include co-occurring factors that may be related to the care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.
- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.
- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.
- Number of continuing stay days requested.

c. Review of Continued Stay Authorization Request

SFMHP and/or its providers shall issue a decision on a hospital or PHF's continued-stay authorization request within 24 hours of receipt of the request and all information reasonably necessary to make a determination.

SFMHP and/or its providers remain responsible to cover the cost of each day of an inpatient hospital stay, at the applicable rate for acute psychiatric inpatient hospital services, until the requirements in paragraph 1 or 2 have been met:

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

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

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

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

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

c. If SFMHP or its providers modifies or denies an authorization request, the SFMHP or its providers shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.
    a. If SFMHP or its providers denies a hospital's authorization request, the SFMHP or its providers must work with the treating provider to develop a plan of care. Services and payment for services shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary. If SFMHP or its providers and the treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.
    b. An SFMHP or its providers' denial of an authorization request and consultation between the treating provider and the MHP may result in one of the following outcomes:
        - SFMHP or its providers and the hospital treating provider agree that the beneficiary shall continue inpatient treatment at the acute level of care, and the denial is reversed.
        - SFMHP or its providers and the hospital treating provider agree to discharge the beneficiary from the acute level of care and a plan of care is established prior to the beneficiary transitioning services to another level of care.
        - SFMHP or its providers and the hospital treating provider agree to discharge orders and a plan of care is established; however, an appropriate outpatient or step-down facility bed is not available and the beneficiary remains in the hospital, on administrative day level of care.
        - SFMHP or its providers and treating hospital provider do not agree on a plan of care and the beneficiary, or the treating provider on behalf of the beneficiary appeals the decision to the MHP.

Authorizing Administrative Days

A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review and authorization for administrative day service claims, the SFMHP or its providers shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven consecutive-day period from the day the beneficiary is placed on

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administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

SFMHP and/or its providers may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, the date of the contact, and the signature of the person making the contact.

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

- The beneficiary's information packet is under review;
- An interview with the beneficiary has been scheduled for [date];
- No bed available at the non-acute treatment facility;
- The beneficiary has been put on a waitlist;
- The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
- The patient has been rejected from a facility due to [reason]; and/or,
- A conservator deems the facility to be inappropriate for placement.

RETROSPECTIVE AUTHORIZATION REQUIREMENTS

SFMHP and/or its providers must establish written policies and procedures regarding the retrospective authorization of SMHS. MHPs may conduct retrospective authorization of inpatient SMHS under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Beneficiary's failure to identify the payer.

UTILIZATION REVIEW

Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. Nothing in this BHIN prohibits the MHPs from conducting utilization reviews and/or auditing activities in accordance with state and federal requirements. MHPs retain the right to monitor compliance with any contractual agreements between an MHP and the MHP's network providers and may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS. For example, the MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the beneficiary, or in other instances where there is evidence of fraud, waste, or abuse.

Contact Person:

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Director of Quality Management

Attachment(s):

Adults, Adolescents, and Children Psychiatric In-patient Utilization Management Review Process

Distribution:

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Adults, Adolescents, and Children Psychiatric In-patient Utilization Management Review Process

Rev. 10/2023

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Contents

Utilization Review Plan

Goals

The goals of the San Francisco Mental Health Plan (SFMHP) Utilization Review Program include:

1. Promoting and maintaining high standards of mental health care.
2. Developing mechanisms for monitoring delivery of services.
3. Identifying over and under-utilization of inpatient and community residential resources.
4. Developing policies and procedures that provide uniform application of utilization review.
5. Developing the process of conducting and reporting utilization review findings.
6. Developing a mechanism to identify issues and solutions to problems relating to utilization review.
7. Implement Title 9, California Code of Regulations, Chapter 10. Psychiatric Inpatient Hospital Services.

Definition of Terms

Admission Notification – Two types of admissions are acknowledged: emergency admission and planned admission.

a. Emergency Admissions

Emergency admissions will be made based on medical necessity, the appropriateness of care, and the intensity of professional services needed by the consumer. In the event the consumer meets admission criteria, she/he may be admitted. Hospitals must notify the SFMHP Point of Notification of the admission within 24 business hours of the admission. Following notification, SFMHP will initiate the utilization review process.

b. Planned Admissions

Planned admissions always require prior authorization by SFMHP and are also coordinated with the SFMHP Point of Notification. Planned admission requests for SFMHP payment authorization shall be approved when written documentation provided indicates that the beneficiary meets the medical necessity criteria for reimbursement of psychiatric inpatient hospital services. The request shall be submitted to the Point of Notification and approved prior to admission.

Border Communities - Border communities are reviewed and authorized as if the hospital is located in California. They are set up for billing CA Medi-Cal and are paid through DXC using regular behavioral health/mental health Treatment Authorization Requests (TARs). These cities include: **Oregon (**Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, Merrill), **Nevada (**Carson City, Incline Village, Minden, Reno, Sparks, Las Vegas, Henderson, Zephyr Cove), and **Arizona** (Bullhead City, Kingman, Lake Havasu City, Parker, Yuma).

Inpatient Hospital Services - Services that are ordinarily furnished in a general acute hospital for the care and treatment of an acute episode of illness under the direction of a physician, and that are furnished in an institution that:

a. Is maintained primarily for the care and treatment of consumers with disorders other than psychiatric.
b. Is licensed or formally approved as a hospital by the California Department of Health Care Services (DHCS).
c. Meets the requirements for participating in Medicare and Medi-Cal.

Review - An evaluation and decision-making process by SFMHP staff to determine medical necessity, appropriateness of the level of care, and intensity of professional mental health services provided.

Plan of Care - A written plan of care that is essential for all consumers in all settings and which is approved and signed by the physician before admission or before authorization of payment (includes weekends and holidays). The plan of care will include:

a. A DSM-IV diagnosis
b. Symptoms, complaints, and complications indicating the need for admission
c. A description of the functional level of the beneficiary
d. Specific and quantifiable long and short-range goals/treatment objectives related to the beneficiary's mental health needs within specific time frames
e. Physician orders which are to include medications, treatments, etc.
f. Specific treatment interventions and services with the professional discipline responsible for each element, including medications, treatments, restorative and rehabilitative services, activities, social services, diet, etc.
g. Prognosis and the estimated duration of treatment
h. Specification of a drug regimen or no drug regimen
i. Plans for continuing care, including review and modification of the plan of care
j. Tentative discharge date and plan
k. Dated and legible physician signature
l. Documentation that the plan of care is reviewed at least every 90 days by the attending or staff physician

Point of Notification – Children and Adolescents (Younger than 18 of age) and Adults (over 18):

Designated Point of Notification – Adults, Adolescents, and Children

- Adult Inpatient Authorization

(628) 206-7471 or SFMentalHealthPlanUM@sfdph.org
(628) 206-7596 fax

Utilization Review (UR) Program - A system of guidelines with the objectives of:

a. Establishing medical necessity and the level of care for services provided to the Medi-Cal eligible consumer.

b. Ensuring that available resources, including facilities and services are used efficiently, effectively and in the best interest of the consumer.

Provider Utilization Control

All providers shall comply with Federal requirements for utilization control pursuant to Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D. These requirements include certification of the need for care, evaluation, medical review, plans of care, and a utilization review plan. Each provider shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to the level of care and to identify problems with the quality of care. The composition of the committee shall meet the requirements of Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D.

Scope

Per BHIN 22-017, the San Francisco Mental Health Plan (SFMHP), also known as Mental Health Plan (MHP), follows the concurrent review requirements for all adult (over 18) psychiatric inpatient hospital services (hospital) and psychiatric health facilities (PHF). The following steps outline the protocol for the concurrent and retrospective review processes for inpatient psychiatric hospitalizations with SF Medi-Cal. The responsible party (Hospital/PHF or MHP) is designated for each step.

The described review process is limited to psychiatric inpatient hospitals or psychiatric health facilities within the State of California and some out-of-state border communities. Other hospitals not listed within the State of California or border communities will be directed to the California Department of Health Care Services for authorization and payment.

Concurrent Authorization Protocol - Adults

Admission and Notification

1. When a beneficiary is admitted to a hospital for psychiatric evaluation and treatment in the State of California, the designated hospital staff is responsible for notifying the appropriate MHP to obtain authorization. The hospital must notify the MHP with the following within 24 business hours of admission. Written Notification of Admission must include the following:
    a. Admission Orders
    b. Initial Plan of Care
    c. Completed Face Sheet:
        i. Hospital Name and Address
        ii. Client Name and DOB
        iii. Insurance Coverage
        iv. Medi-Cal Number
        v. Name and contact information of admitting, qualified and licensed practitioner

vi. Utilization Review staff contact information

If notification is received after 24 business hours or after the hospital stay, the hospital must submit a written justification for the delay. SFMHP will follow the guidelines set by the DHCS to deem if the delay meets a psychiatric emergency (as defined in Health & Safety Code section 1317.1(k)) or qualifies for a retrospective review.

2. The SFMHP will confirm the client is a San Francisco Medi-Cal recipient and if dually covered, SFMHP will request verification if the client has exhausted Medicare or other insurance first.

3. The SFMHP will add the client to the admission/TAR log sheet and include the date of notification, method (phone, fax, Electronic Health Record (EHR), etc.), and responsible first-level reviewer (all acute care utilization reviewers will be performed by a licensed mental health professional).

4. The SFMHP will add the client to the respective hospital's spreadsheet. The SFMHP will fax the hospital the spreadsheet to confirm receipt of the admission notification and request the admitting physician, nursing, and social worker notes with the Medication Administration Record (MAR) if they have not been provided with the admission notification.

5. The SFMHP will notify/remind the hospital of the DHCS concurrent review requirements and request that the progress notes with the MAR be faxed every day or updated through EHR throughout the hospitalization.

6. The SFMHP will fill out the Utilization Review tracking form.

7. The SFMHP will initiate a first-level review at the requested level and either grant authorization or recommend a second-level review to modify or deny the hospital/PHF's stay. The decision is based on DHCS guidelines, UM evaluation tools, and the SFMHP Inpatient Psychiatric Utilization Review/Payment Authorization Plan for determining acuity.

8. If the SFMHP recommends a second-level review for modification or denial, a review will be completed by an M.D or D.O. and follow protocols accordingly.

9. Once the admission notes are received and reviewed, the SFMHP will fax the hospital/PHF the spreadsheet with the authorization and SFMHP will begin the concurrent review process.

Continued Stay Authorization

When medically necessary, the SFMHP and Hospital/PHF will conduct a concurrent review for continued stay authorization:

1. The hospital or PHF must submit daily records for the continued-stay-authorization request before the end of the initial authorization period.

2. The MHP may request and exchange information with the hospital/PHF as needed to determine the length of stay and to decide whether to grant, modify or deny the request. Information may include, but is not limited to, relevant treatment information, risk assessment, psychiatric and medical history, substance use information, and service planning information.

3. The MHP will provide basic resources for recommendations for discharge planning and aftercare, but discharge plans are the sole responsibility of the hospital or PHF.

Administrative Days

Administrative days may be authorized when a non-acute client has been referred to and is awaiting placement, at a treatment facility (ex: ADU, residential treatment facility, locked sub-acute treatment (LSAT) facility, or a state hospital). The hospital/PHF must document attempts to follow guidelines by the DHCS outlined in BHIN 22-017 or the most recent BHIN. Hospitals must document a minimum of five contacts per week with appropriate facilities, in an attempt to find placement.

The administrative authorization begins on the day the appropriate lower level of care referral is received by SFMHP.

Administrative days will not be authorized for non-acute clients referred to non-treatment facilities (ex: residential care facilities, psychiatric respite (Hummingbird), or homeless shelters).

Administrative days will not be authorized for non-acute clients awaiting discharge to the community that is delayed due to travel arrangements or family situations.

Administrative days will not be authorized for non-acute clients awaiting community conservatorship or for case management linkage.

Discharge

The hospital will notify the SFMHP within 24 business hours of discharge.

Once notified, the SFMHP will fax the hospital the spreadsheet or summary with a final authorization determination, request an administrative and acute TAR, and/or other documents as needed.

The hospital will submit an original TAR to SFMHP (fax or electronic TAR are not valid) within 14 calendar days of discharge. If a TAR is submitted after 14 calendar days of discharge, the TAR will be deemed untimely and denied for payment.

The SFMHP will date stamp the original TAR upon arrival/receipt.

The SFMHP will re-confirm that the client's Medi-Cal status has not changed upon receipt of the TAR. If the client's Medi-Cal status has changed, the SFMHP will provide instructions to the hospital.

The SFMHP will check the TAR for errors. If errors are found, the SFMHP will notify the hospital/PHF with a deferment letter and the hospital/PHF will need to submit the changes within 10 calendar days. If a TAR is not corrected or an additional TAR is not submitted within 10 days, the TAR will be deemed untimely and denied for payment.

Once the TAR is approved, the SFMHP will complete the county section of the TAR with the authorization.

The SFMHP will fax a copy of the completed TAR to the hospital's Utilization Review department or business office within 14 calendar days of receipt.

The SFMHP will record the TAR information on the TAR submission tracking spreadsheet.

The SFMHP will fax or mail the TAR to the Medi-Cal fiscal intermediary, DXC, for services rendered at Medi-Cal billable hospitals. Please note: TARs are not faxed or mailed for Short Doyle clients or hospitalization at Medi-Cal non-billable hospitals.

DXC fax number: 916-638-7606
PO Box 13029
Sacramento, CA 95813-4029

The SFMHP will record all inpatient services in Avatar.

The SFMHP will file the original TAR copy and will keep the TAR for seven years as per Community Behavioral Health Services (CBHS) policy.

Retrospective Reviews

Retrospective authorizations refer to a request for authorizations following the member's discharge from inpatient hospitalization or after the member has received care without notification for 24 business hours. There are restrictions that govern when retrospective authorizations can occur.

A provider may request a retrospective review under limited circumstances:

a. Retroactive Medi-Cal eligibility determination
b. Inaccuracies in Medi-Cal Eligibility Data System (MEDS)
c. Authorization of services for clients with other health care coverage with evidence of billing (including dual-eligible beneficiaries) and/or

d. Beneficiary's failure to identify a payor

The written request must contain the minimum information:

a. Retrospective request letter
b. Treatment Authorization Request (TAR)
c. Evidence of meeting retrospective review limits
d. Admission notes or relevant progress notes (physician, nursing, etc.)
e. Discharge Notes
f. Medication Administration Record (MAR)

Retrospective reviews should be sent to the point of notification.

Adverse Decisions

Modifications/Denials

Denials may be based on acuity or for administrative reasons. All modifications/denials based on medical necessity criteria are referred to a second-level reviewer with a CBHS UR psychiatrist (CCR, Title 9, 44 Ch.11, Section 1820.220). The current psychiatrist is Dr. David Kan.

A decision to modify or deny an authorization request will be provided to the treating provider in writing. The denial or modification letter must include a clear explanation of the reasons for the decision, a description of the criteria or guidelines used, the right to file an appeal, procedures to file an appeal with timeframes, and the provider making the decision.

Hospitals/PHF must comply with all timelines for notifying SFMHP of admissions and discharges, TAR submissions, and submissions of pertinent medical records needed to determine acuity. If timelines are not met, SFMHP may issue a denial or adverse decision.

A Notice of Adverse Benefit Decision (NOABD) is issued for all modifications/denials under the following circumstances:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit
- The reduction, suspension, and/or termination of previously authorized service(s)
- The denial, in whole or in part of a payment
- Failure to provide services in a timely manner
- Failure to act within the timeframes provided regarding the standard resolution of grievances and appeals
- Denial of member requests to dispute financial liability, including cost sharing and other members' financial liability

All modifications/denials that meet a Notice of Adverse Benefit Determination (NOABD) requirement are filled out and mailed to the client and provider for all denials within 14 calendar days. NOABD are kept for seven years with the TAR and tracked in the TAR log.

Appeals

A hospital/PHF may appeal a denied, terminated, or reduced service request for SFMHP payment authorization of psychiatric inpatient hospital services which is based upon Title 9, California Code of Regulations, Chapter 10. Psychiatric Inpatient Hospital Services to the SFMHP. The written appeal shall be submitted to the SFMHP within 90 calendar days of the date of receipt of the adverse/non-approval of payment.

Appeals must contain the minimum information:

a. Appeal letter
b. New Treatment Authorization Request (TAR)
c. Admission notes (physician, nursing, etc.)
d. Relevant progress notes
e. Discharge notes
f. Medication Administration Record (MAR)

Appeals should be sent to:

ATTN: Appeals
San Francisco Behavioral Health Center
887 Potrero Avenue, 2nd Floor, Suite S1010
San Francisco, CA 94110

The SFMHP will date stamp the appeal, organize the appeal, and forward it to the CBHS appeal psychiatrist. All determinations resulting in an adverse decision of SFMHP against a provider will be reviewed by a physician other that the individual who determined the initial denial. The current appeal psychiatrist is Dr. Ana Gonzalez.

The SFMHP will respond in writing within 60 calendar days from the receipt of the appeal to inform the provider of the decision and outcome. There are 2 outcomes that can occur from the appeal:

1. If no basis is found for altering the original decision, the provider will be notified that the decision was upheld and informed of its right to submit an appeal to the DHCS, when applicable.
2. If SFMHP grants the request by reversing the original decision, it will approve the revised payment authorization within 14 calendar days from the date of receipt.

Once the appeal response letter is received from the appeal psychiatrist, the SFMHP will complete the TAR with the appeal authorization decision.

The MHP will return (via fax, mail, or email) the appeal response letter, completed appeal TAR, and hospital appeal letter to the hospital within 60 calendar days of the receipt of the appeal packet. If SFMHP does not respond within 60 calendar days of the appeal, the provider retains the right to appeal directly to the DHCS.

The MHP will record the TAR information on the TAR submission tracking log and fax the TAR to the Medi-Cal fiscal intermediary, DXC

DXC fax number: 916-638-7606
PO Box 13029
Sacramento, CA 95813-4029

The MHP will record the appeal and the result on the appeal spreadsheet.

Appeals to the California Department of Mental Health

If the provider chooses to appeal to the DHCS as a level of appeal regarding an SFMHP denial payment authorization, the appeal shall be submitted in writing, along with supporting documentation, within 30 calendar days from the date of the SFMHP written decision of denial. Supporting documentation shall be included, but not limited to:

1. Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records, or memos.
2. Clinical records supporting the existence of medical necessity if at issue.
3. A summary of reasons why SFMHP should have approved the SFMHP payment authorization.
4. Contact person(s) name, address, and phone number.

The DHCS shall notify SFMHP and the provider of its receipt of a request for appeal within seven (7) calendar days, along with a request for specific documentation supporting the denial of the SFMHP payment authorization.

SFMHP shall submit the required documentation within 21 calendar days or the DHCS shall find in favor of the provider.

The DHCS shall have 60 calendar days from the receipt of the SFMHP documentation to notify, in writing, the provider and SFMHP of its decision and the basis for the decision.

1. The DHCS may allow both a provider representative and an SFMHP representative an opportunity to present an oral argument to the DHCS.
2. If the DHCS grants a provider's appeal, SFMHP has 14 calendar days from the receipt of the provider's revised request for payment to approve the SFMHP TAR or submit documentation to the Medi-Cal fiscal intermediary required to process the SFMHP payment authorization.

Consumer Appeals/Grievances

SFMHP will follow the guidelines described in BHS Policy/Procedure regarding Consumer Complaint Grievance Resolution Procedure #3.11 - 03.

Consumer Notification of Action

SFMHP shall send written notification of Post-Service Denial of Payment (NOA-C) to consumers when payment has been denied within 14 days of payment denial.

Decision Support Tool

UM Decision Support Tools were developed by BHS Clinical Leadership with input and participation from designated network providers and are based on the service definitions developed by regulatory entities. Practitioners/providers have access to the criteria and service definitions upon which decision support tools are based, but do not have access to the actual decision support tools at any time as they are considered propriety.

All UM Clinical Reviewers are trained on medical necessity criteria, decision support tools, and are supervised to ensure consistent and uniform application. BHS Central UM reviews the tools annually. Ongoing inter-rater reliability (IRR) reviews are conducted to ensure the standardized application of tools and criteria made by all BHS Central UM Clinical Reviewers. Clinical Reviewers receive intensive training in the application of decision support tools and must meet the threshold on post-training competency review to begin the independent review process.

Acute Care UM Review Contact

Phone

CA DHCS requires a County Mental Health Plan point of notification for the Inpatient Mental Health Services Program. The number for the San Francisco Mental Health Plan (SFMHP) is 628-206-7471.