


BHS Policies and Procedures	
 <p>City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES</p>	<p>1380 Howard Street, 5th Floor San Francisco, CA 94103 (415) 255-3400 FAX (415) 255-3567</p>
<p>Policy and Procedure Title: Authorization of Outpatient Specialty Mental Health Services (SMHS)</p>	
<p>Issued By: DocuSigned by: <i>imo momoh</i> 360E6E598F1D468...</p> <p>Imo Momoh, MPA Managed Care Director of Behavioral Health Services</p> <p>Date: April 26, 2023</p>	<p>Manual Number: 3.03-22</p> <p>Reference: Behavioral Health Information Notice (BHIN) 22-016</p>

(Substantive Revision: Replaces Policy 3.03-22 dated February 22, 2023)

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 client’s needs and lived experiences.

Purpose: To communicate to San Francisco Mental Health Plans (SFMHPs) federal requirements related to the authorization of adult specialty mental health services (SMHS), except for psychiatric inpatient hospital and psychiatric health facility services, including policy changes the Department of Health Care Services (DHCS) has made to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

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. 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 MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to beneficiaries. 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 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.

Scope:

The following procedures are applicable to all Behavioral Health Services (BHS) civil service and contracted providers of Adult Crisis Residential Treatment Services and Adult Residential Treatment Services.

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.

Requirements Applicable to Authorization of all SMHS

It is the policy of BHS that SMHS providers, administrators, and staff shall establish and implement written policies and procedures to address the authorization of SMHS in accordance with this BHIN 22-016. Authorization procedures and utilization management criteria shall:

- Be based on SMHS access criteria, including access criteria for beneficiaries under age 21 pursuant to the EPSDT mandate;
- Be consistent with current evidence-based clinical practice guidelines, principles, and processes; Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP’s beneficiaries and network providers.
- Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;
- Be evaluated, and updated if necessary, at least annually; and,
- Be disclosed to the MHP’s beneficiaries and network providers.

BHS civil service and contracted providers shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the beneficiary’s behavioral health needs. No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a beneficiary or a provider, may deny, or modify a request for authorization of SMHS for a beneficiary for reasons related to medical necessity. 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 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 offer the treating provider the opportunity to consult with the professional who made the authorization decision. If a MHP modifies or

denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations. MHPs shall notify the requesting provider in writing and give the beneficiary written notice of any decision by the MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations. MHPs shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.

It is the policy of BHS to comply with the following 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;
- Maintain telephone access 24-hours a day, 7-days a week for providers to request expedited authorization of an outpatient service requiring prior authorization;
- Prior authorization or MHP referral is required for the following services:
 - Intensive Home-Based Services
 - Day Treatment Intensive
 - Day Rehabilitation
 - Therapeutic Behavioral Services
 - Therapeutic Foster Care
- No prior authorization shall be required for mental health assessment services, nor for outpatient services other than those services listed above. See “Prior Authorization or MHP Referral for Outpatient SMHS” below.
- 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 timeframes for the type of authorization.

All of the SFBHS 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 of Crisis Residential Treatment Services and Adult Residential Treatment Services

BHS civil service and contracted providers must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). SF MHP may not require prior authorization. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization. The MHP must then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary’s stay and based on beneficiary’s continued need for services.

In the absence of an MHP referral, MHPs shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. MHPs may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.

Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating provider within 24 hours of the decision and care shall not be discontinued until the beneficiary's treating provider has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where the MHP determines that care should be terminated (no longer authorized) or reduced, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

Prior Authorization or MHP Referral for Outpatient SMHS

BHS civil service and contracted providers shall follow prior authorization and/or MHP referral requirements for outpatient SMHS as specified below:

MHPs shall not require prior authorization for the following services/service activities:

- Crisis Intervention
- Crisis Stabilization;
- Mental Health Services, including initial assessment;
- Targeted Case Management;
- Intensive Care Coordination;
- Peer Support Services; and,
- Medication Support Services.

Prior authorization or MHP referral is required for the following outpatient services:

- Intensive Home-Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

For purposes of prior authorization, referral by the MHP to a contracted provider is considered to serve the same function as approving a request for authorization submitted by a provider or beneficiary.

DHCS considered the following factors in determining which services will be subject to MHP referral or prior authorization requirements:

- Service type;
- Appropriate service usage, cost, and effectiveness of service and service alternatives;
- Contraindications to service and service alternatives;
- Potential fraud, waste, and abuse;
- Patient and medical safety; and,
- Other clinically relevant factors.

MHPs may require providers to request payment authorization for the continuation of services at intervals specified by the MHP (e.g., every six months). MHPs shall determine these intervals based on the criteria and guidelines detailed in this BHIN.

Outpatient Authorization Timeframe and Documentation Requirements

MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. For cases in which a provider indicates, or the MHP determines, that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receipt of the request for service. The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

1. The beneficiary, or the provider, requests an extension; or,
2. The MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.

The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized. MHPs must document their determinations of whether a service requires MHP referral or prior authorization and maintain that documentation in accordance with Title 42 of the CFR, part 438.3(h).

If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where the MHP terminates, reduces, or suspends a previously authorized service, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services. The beneficiary's notice shall meet the requirements to notify beneficiaries of an adverse benefit determination.

Retrospective Authorization Requirements

It is the policy of BHS that SMHS providers, administrators, and staff must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). BHS civil service and contracted providers may conduct retrospective authorization of 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 payer.

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

UTILIZATION REVIEW

Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. Nothing in BHIN 22-016 prohibits the MHPs from conducting utilization review and/or auditing activities in accordance with state and federal requirements. SF MHP 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:

Director of Quality Management

Attachment(s):

Adult Residential Utilization Management Review Process

Attachment 1: Adult Residential Utilization Management Review Process

Distribution:

BHS Policies and Procedures are distributed by the BHS Quality Management Office of Regulatory Affairs

Administrative Manual

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Adult Residential Utilization Management Review Process

Rev 1/2023



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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Utilization Review Plan

Goals

The goals of the 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 to 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.

Definition of Terms

Adult Residential Treatment Services (ARTS): Adult residential treatment services are rehabilitative services provided in a non-institutional residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in a residential treatment program. Adult residential treatment services are provided in social rehabilitation facilities licensed by CDSS under the provisions of CCR, Title 22 and certified under the provisions of CCR, Title 9 and Mental Health Rehabilitation Centers licensed by Department of Health Care Services under the provision of [CCR Title 9](#).

Crisis Residential Treatment Services (CRTS): Crisis residential treatment services are therapeutic or rehabilitative services provided in a non-institutional residential setting. CRTS provide structured programs as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. CRTS are provided in social rehabilitation facilities licensed by the California Department of Social Services (CDSS) under the provision of CCR Title 22, and certified under the provisions of CCR Title 9 and Mental Health Rehabilitation Centers licensed by Department of Health Care Services under the provision of CCR Title 9.

Referent – Individual or agency making the request for service that meets Specialty Mental Health Services (SMHS) criteria. Referent should meet the definition of a mental health provider and currently providing services to the beneficiary to make an assessment or support a plan of care (Examples include: hospital social worker, intensive case manager, and conservator).

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 appropriate mental health provider based on level of care (The Plan of Care is still required when requests are made on weekends and/or holidays).

Point of Notification – SMHS has one point of notification for MH residential treatment authorization:
BHS Central UM

887 Potrero Ave S1010 San
Francisco, CA 94110
BHSCentralUM@sfdph.org 625-
206-7594

Prior Authorization Request Form – also referred to as a **Service Authorization Request (SAR)** form. The form can vary for the level of care being requested and by where it is requested from. Request form can be a written request or an electronic request, such as EPIC E-Consult. Appendix A provides examples of requests.

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

Utilization Management (UM) 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 need for care, evaluation and medical review, plans of care and utilization review plan. Each provider shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care and to identify problems with quality of care. Composition of the committee shall meet the requirements of Title 42, CFR, chapter IV, subchapter C, Part 456, Subpart D.

Scope

Per BHIN 22-016, San Francisco Mental Health Plan (SFMHP), also known as Mental Health Plan (MHP), follows the review requirements for all (over 18) Acute Diversion Treatment Services and Adult Residential Treatment Services for all contracted providers. The following steps outline the protocol for the prior authorization, concurrent, and retrospective review processes for residential treatment. The responsible party (referent, provider, or BHS Central UM) is designated for each step.

Adult Acute Diversion Units – Prior Authorization Protocol

Prior Approval Process

1. A crisis stabilization unit may assess a client and divert a client into an Acute Diversion Unit (ADU) directly without prior authorization. The ADU is responsible for notifying the Behavioral Health Utilization Management (BHS UM) within 72 hours of admission.
2. An inpatient hospital may assess a client and divert a client into an Acute Diversion Unit (ADU) within 7 days of admission or medical clearance, but must have a prior authorization for admission. The referent must complete the ADU Prior Authorization Request Form (PARF) and submit additional documentation with a rationale for the referral.
3. Referents should submit referrals by 1) fax to 628-206-7596, 2) encrypted email to BHSCentralUM@sfdph.org, or 3) E-Consult to Transitions Bed Placement.
4. BHS UM will review and decide within one (1) business day of receiving the request for ADU services.
5. If BHS UM requests additional documents for a review, the receipt of the referral date will change to when the additional documents are received if the additional documents are not received by the next business day.
 - a. If a referent does not respond or reply to the request within 2 business days. BHS UM will issue an incomplete referral response verbally and/or in writing.
 - b. If additional time is needed for a review, BHS UM will notify the referent in writing and issue a Notice of Action (NOA).
6. Once a BHS UM reviewer has enough information to complete a first-level or initial review, BHS UM will initiate a review process, make eligibility, and then make a medical necessity decision. At the first-level or initial review, decisions are based on DHCS guidelines, UM evaluation tool, level of care assessment, and SF eligibility requirements
 - a. There 3 outcomes that result from a first-level/initial review:
 - i. The referral can initiate approval for services, OR
 - ii. Request of additional time to make a determination, OR
 - iii. Initiate a “not able to approve” and referred to a second-level reviewer for denial or modification.
7. Once a decision is made, a decision letter will be faxed, e-mailed, or sent via EHR to the referent. Approval Letters include:
 - Decision ID
 - Level of Care Approved
 - Valid Treatment Authorization Period
 - Unit of Service (per day) once admitted
 - Type of Authorization (Initial/Continued Stay)
 - Priority Status (Routine/Expedited)

BHS Central UM will file the original referral paperwork, evaluation tool, or other documents and keep records for three (3) years.

8. If approved, the referent will receive an authorization letter and follow the instructions on the approval letter. The referent will contact the intake coordinator at the Community Based Organization (CBO) providing the service and follow the CBO's admission protocols.

Concurrent/Continued Stay Authorization

1. Once a beneficiary is admitted to a facility a continued authorization review process begins.
2. BHS Central UM Authorizers conduct concurrent Utilization Reviews. BHS Central UM will conduct Utilization Review with a Program Director (or Designee) at least weekly to ensure clients are in the most appropriate, least restrictive setting and continually meeting medical necessity. The UR of the treatment episodes may include:
 - a. Documentation review, including valid authorization or notification of admission, medication adjustments, and discharge planning
 - b. Interviews (with staff, providers, and clients)
 - c. Completion of decision support tool or level of care assessments BHS Central UM Authorizers will keep UR records of these reviews.
3. During the review, if a client no longer meets medical necessity during their stay, the BHS Central UM first-level reviewer can initiate a "not able to continue to approve" recommendation and refer the request to a second-level reviewer for denial or modification.
4. After the completion of 14 calendar days or units of service provided on the initial authorization, CBOs/providers may request for additional stay units if a client continues to meet medical necessity. BHS Central UM can grant extensions to the program for continued stays up to seven (7) calendar days at a time and a letter will be provided. The letter will include:
 - Decision ID
 - Level of Care Approved
 - Valid Treatment Authorization
 - Unit of Service (by day) when admitted
 - Type of Authorization (Initial/Continued Stay)
 - Priority Status (Routine/Expedited)

Discharge

A beneficiary will be discharged once deemed no longer meeting medical necessity at the level of care, able to be treated at a less restrictive environment, and/or when units of service have expired. The facility will notify BHS Central UM of expected discharges or changes to discharges which may require continued authorization. If a client remains at the facility without authorization, it will be considered an unauthorized stay. Those days will be non-billable and BHS Central UM will notify the billing department.

Adult Residential Treatment - Prior Authorization Protocol

1. A referent will determine whether a beneficiary is ready for a residential treatment level of care through their own internal procedure. The referent must complete a Prior Authorization Request Form (PARF) with a level of care request, and submit any additional documentation with rationale for the referral.
2. Referents should submit referrals by: 1) fax to 628-206-7596, 2) encrypted email to BHSCentralUM@sfdph.org, or 3) E-Consult to Transitions Bed Placement.
3. BHS Central UM will review and make a decision within five (5) business days for MH residential services. If an expedited review is desired, the referent will need to make a clear request for an expedited review. Expedited reviews must meet the definition of urgency; for example, an authorization request for continued community or clinic-based services for a member who is well stabilized and at low or no risk cannot be designated as expedited (urgent) just because the practitioner/provider did not submit the request in a timely manner.
4. The receipt of the referral date may change if BHS Central UM requests additional documents are not received by the next business day.
 - a. If a referent does not respond or reply to the request within two (2) business days, BHS Central UM will issue an incomplete referral response verbally and/or in writing.
 - b. If additional time is needed for a review, BHS UM will notify the referent in writing
5. Once a BHS Central UM reviewer has enough information to complete a first-level or initial review, BHS Central UM will initiate a review process, make eligibility, and then make a medical necessity decision. At the first-level or initial review, decisions are based on DHCS guidelines, a UM evaluation tool, a level of care assessment, and SF eligibility requirements.
 - a. There 4 outcomes that can result from a first-level/initial review:
 - i. The referral can initiate approval for services, OR
 - ii. Request additional time to make a determination, OR
 - iii. Denial due to eligibility decisions (such as coverage or residency). OR
 - iv. Initiate a “not able to approve” for medical necessity decisions and

referral to a second-level reviewer for denial or modification (see adverse decision).

6. If a decision is granted, a decision letter will be faxed, e-mailed, or sent via EHR to the referent. Approval Letters include:
 - Decision ID
 - Level of Care Approved
 - Valid Treatment Authorization Period
 - Unit of Service (per day) once admitted
 - Type of Authorization (Initial/Continued Stay)
 - Priority Status (Routine/Expedited)

BHS Central UM will file the original referral paperwork, evaluation tool, or other documents and keep records for three (3) years.

7. If approved, the referent will receive an authorization letter and follow the instruction on the approval letter. The referent will contact the intake coordinator at the Community Based Organization (CBO) providing the service and follow the CBO's admission protocol.

Concurrent/Continued Stay Authorization

1. Once a beneficiary is admitted to a facility, a concurrent/continued authorization review process begins.
2. BHS Central UM Authorizers conduct continued stay/concurrent Utilization Reviews. BHS Central UM will conduct Utilization Review with a Program Director (or designee) bi-weekly/monthly based on the level of care to ensure clients are in the most appropriate and least restrictive setting and continue to meet medical necessity. The UR of the treatment episodes may include:
 - a. Documentation review, including valid authorization or notification of admission, medication adjustments, and discharge planning.
 - b. Interviews (with staff, providers, and clients)
 - c. Completion of decision support tools or level of care assessments
 - d. BHS Central UM Authorizers will keep UR records of these reviews.
3. During the review, if a client no longer meets medical necessity during their stay. The BHS Central UM first-level reviewer can initiate a "not able to continue to approve" and referral to a second-level reviewer for denial or modification.
4. After the completion of units of service provided on the initial authorization, CBOs/Providers may request for additional units if a client continues to meet medical necessity. BHS Central UM can grant extensions to the program for continued stays up to 14 calendar days or 30 calendar days (based on level of care) at a time and a letter will be provided. The letter will

include:

- Decision ID
- Level of Care Approved
- Valid Treatment Authorization Period
- Unit of Service in day when admitted
- Type of Authorization (Initial/Continued Stay)
- Priority Status (Routine/Expedited)

Discharge

A beneficiary will be discharged once it is determined they no longer meet medical necessity at the level of care, they are able to be treated in a less restrictive environment, and/or when units of service have expired. The facility will notify BHS Central UM of expected discharges or changes to discharges which may require continued authorization. If a client remains at the facility without authorization, it will be considered an unauthorized stay. Those days will be non-billable, and BHS Central UM will notify the program and billing department per the unauthorized stay process.

Retrospective Reviews

A retrospective review request should be sent to BHS Central UM. Retrospective authorizations are requests that follow a member's discharge from residential service or after the member has received care without approval. 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

Adverse Decisions

1. A BHS Central UM reviewer can request a second-level/peer-to-peer review during initial, concurrent, or continued stays. All second-level/peer-to-peer reviewers are licensed mental health providers or have appropriate licensure for the service type. At second-level or peer review, decisions are based on DHCS guidelines, UM evaluation tools, level of care assessment, and SF eligibility requirements. There are four (4) outcomes that result from a second-level/peer-to-peer review:

- i. The second-level/peer-to-peer review can approve the request and authorize the service, OR
 - ii. The second-level/peer-to-peer can modify the requested service, OR
 - iii. Request for additional documentation and additional time (delay) to make a determination, OR
 - iv. The second-level/peer-to-peer can deny the request.
2. If the delay, denial, or modification occurred during the stay, BHS Central UM may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the beneficiary. The provider and BHS Central UM will determine an agreed-upon date to discontinue services and issue an NOA.
 3. BHS Central UM will notify the provider in writing and/or by phone of decisions that result in a delay, modification, or denial of an authorization request. The delay, denial, or modification will be issued with 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.
 4. BHS Central UM will follow the NOA process as outlined by BHS policy 3.11-04 or the most recent policy. A copy of the NOA will also be sent to Quality Management and a letter will be faxed/mailed/e-mailed to the referent and beneficiary.

An NOA is issued for all delays/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.

For all modifications/denials that meet NOA criteria, an NOA will be filled out and mailed to the client and provider for all denials within five (5) business days. NOAs are kept with Quality Management.

Appeals

A referent or beneficiary may appeal a denied, terminated, or reduced service request in writing. The written appeal shall be submitted to BHS Central UM within ninety (90) calendar days of the date of receipt of the adverse determination/non-approval of payment.

BHS Central UM will date stamp the appeal, organize the appeal, and forward it to the appropriate reviewer based on the level of care. All appeals resulting in an adverse decision from SFMHP against a provider will be reviewed by an appropriately licensed reviewer other than the individual who determined the initial denial.

The SFMHP will respond in writing within sixty (60) calendar days from the receipt of the appeal to inform the provider of the decision and outcome. There are two (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 California DHCS, when applicable.
2. If SFMHP grants the request by reversing the original decision, it will approve the revised request.

The SFMHP will record the appeal and the result of the appeal by notifying Quality Management.

Decision Support Tool

BHS Central 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 BHS Central UM Clinical Reviewers are trained on medical necessity criteria, and decision support tools, and are supervised to ensure consistent and uniform application. The 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.

Appendix A

ADU Request



Department of Public Health

Behavioral Health Services - Central UM
887 Potrero Ave, San Francisco, CA 94110
Please send completed request via
Email: BHSCentralUM@sfdph.org or
Fax: 628-206-7597

ADU Authorization Request

Client Name SSN

DOB BIS Number

Hospital Date of Admission

Clinical indications for request:

Person currently hospitalized whose inpatient stay may be shortened by admission to the program AND

- Depression with suicidal ideation or recent suicide attempt
Psychological disorganization preventing self-maintenance in the community
Person continues to need external structure to regain impulse control
Person in situational crisis who continues to need a supportive environment for a short period of time

Submitted by Date

Phone Fax


Placement Authorized Expires

Placement Not Authorized Reason

Authorizing Clinician Date

Updated: 07/2022

One Page PARF Request

	Department of Public Health London N. Breed Mayor of San Francisco	Behavioral Health Services - Central UM 887 Potrero Ave, San Francisco, CA 94110 Email: BHSCentralUM@sfdph.org FAX: (628) 206-7597	
Placement Authorization Request Form			
Client Name (AKA if known) _____	SSN _____	DOB _____	BIS Number (if available) _____
Client's current locations _____		Provider RU# (if known) _____	
Is Client a SF resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Where was client last 30 days? _____	
Entitlements: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> SSI		Other Income Source: _____	
Conservator Status: <input type="checkbox"/> T-Con <input type="checkbox"/> Permanent LPS <input type="checkbox"/> Probate		Conservator Name: _____	
Client can effectively manage ADLs without restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No		If incontinent, can client effectively manage self-care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SPR CLIENT: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending PLEASE NOTE, IF SPR CLIENT, APPROVAL IS REQUIRED			
SPR Clinician _____		Telephone # _____	
HAS ICM: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		ICM Clinician _____	
		Telephone # _____	
Level of Care Requested: _____		DSM V Diagnosis Code(s) _____	
Clinical Indications for Level of Care Request _____			

Recommended Treatment Goals _____			

Submitted By: _____ Date: _____			
Telephone #: _____		Fax #: _____	
PLACEMENT RECOMMENDATIONS <input type="checkbox"/> PLACEMENT AUTHORIZED <input type="checkbox"/> Med Supported Detox			
<input type="checkbox"/> AOD DDx Res <input type="checkbox"/> MH DDx Res <input type="checkbox"/> Transitional Res <input type="checkbox"/> LSAT <input type="checkbox"/> Clay/Loso <input type="checkbox"/> AOD Satellite <input type="checkbox"/> RCF/E			
<input type="checkbox"/> AOD Social Model Detox <input type="checkbox"/> AOD Social Model Res <input type="checkbox"/> Co-Op <input type="checkbox"/> Support Service Hotel <input type="checkbox"/> Hotel <input type="checkbox"/> DAH			
SPECIFY _____			

<input type="checkbox"/> NOT AUTHORIZED REASON: _____			

Authorizing Clinician _____		Date _____	
Updated: 07/2022			

Two Page Referral (Community Referrals) – page 1



**Department of Public Health
Transitions – Placement**
887 Potrero Ave
San Francisco, CA 94110

Jail Questions, please call: 628-206-4356
All Other Questions, please call: 628-206-4405
Fax completed form to: 628-206-4902

PRINT / TYPE

Is client a San Francisco resident? Y N _____ If no, has county of origin been notified? Y N _____
If no, why was client not referred back to county of origin? _____

Client Complete Name _____	AKA _____	Legal Charges Pending <input type="checkbox"/> Y <input type="checkbox"/> N
Address _____	BIS Number _____	Probation <input type="checkbox"/> Y <input type="checkbox"/> N
DOB _____	Ethnicity _____	T-Con <input type="checkbox"/> Y <input type="checkbox"/> N
	Age _____	P-Con <input type="checkbox"/> Y <input type="checkbox"/> N
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Primary Language / Secondary Language _____	English Comprehension <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good	English-speaking ability <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good

Referral to: Residential TX Support Service Housing ADU
 Dual Disorder Co-Ops Specify _____

Referent _____ Date client will be ready for placement _____

Referent Program	Date admitted	Referent phone number	Referent Fax number
Rationale for placement request. Please List client's preference		Precipitant for current crisis:	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FINANCIAL INFORMATION

Social Security Number _____ Amount of income _____
 Source of income SSI Other: _____ Has client applied for SSI? Y N Pending
 If not, why has client not applied for SSI? _____

Payee _____ Payee Agency/Relationship _____ Payee Phone/Pager _____
 Does client have Medi-Cal? Y N Pending
 Medicare A B Pending
 If no, referred to county Medi-Cal is established? Y N
 Other Health Coverage Y N
 Is Medi-Cal San Francisco County? Y N
 Specify _____

CONTACTS

Y N _____ Is Client Conserved? _____
 Conservator Name _____ Conservator Phone # _____ Conservator Fax # _____ Is Client coordinated? Y N _____

Coordinator Program	Coordinator Name	Phone Number / FAX Number	If not Coordinated, referred to which ISC	Date referred
_____	_____	_____	_____	_____
Case manager Name	Phone Number / FAX Number	Prescribing Psychiatrist	Phone # / Pager	
_____	_____	_____	_____	
M.D.	Phone Number / Pager	Provider Client knows best	Phone # / Pager	
_____	_____	_____	_____	

