3.20 Medical Necessity and Authorization of Specialty Mental Health Services

I. PURPOSE

- To operationally define medical necessity criteria
- To clarify how Specialty Mental Health Services (SMHS) are authorized
- To describe SLOBHD's utilization management (UM) and utilization review (UR) processes

II. SCOPE

Applies to authorization of outpatient SMHS for all SLOBHD staff and contracted providers

III. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will follow all applicable regulations and contract provisions when determining medical necessity for SMHS and when authorizing treatment. SLOBHD will place appropriate limits on services based on medical necessity and will provide or arrange/pay for services in an amount, duration, and scope reasonably needed to achieve their purpose. SLOBHD will authorize services for beneficiaries with ongoing or chronic conditions in a manner that reflects the beneficiary's ongoing need for services and supports.

IV. REFERENCES

- Code of Federal Regulations, Title 42, §438.210, §438.330, §438.608
- California Code of Regulations, Title 9, §1830.205, §1830.210
- California Code of Regulations, Title 22, §51340(e-f)
- Welfare & Institutions Code, §14197.1
- Contract with Department of Health Care Services (DHCS), Exhibits A, B
- MHSUDS Information Notice 17-040
- MHSUDS Information Notice 19-020
- MHSUDS Information Notice 19-026
- SLOBHD Policy & Procedure 3.30 *Notice of Adverse Benefit Determination*
- SLOBHD Policy & Procedure 3.21 *Authorization of Out-of-Plan Services for Youth*
- SLOBHD Policy & Procedure 3.22 *Concurrent Authorization of Psychiatric Inpatient Services*
- SLOBHD Policy & Procedure 3.23 *Availability, Timeliness, and Array of Services*
- SLOBHD Policy & Procedure 5.00 *Outpatient Mental Health Assessment*
- SLOBHD Documentation Guidelines
- SLOBHD Implementation Plan
- SLOBHD Assessment Practice Guidelines

V. DEFINITIONS

- Medical Necessity is a set of criteria established in California Code of Regulations, Title 9, §1830.205 that help determine whether a beneficiary qualifies to receive outpatient SMHS. Beneficiaries who do not meet medical necessity criteria, but who could benefit from non-Specialty Mental Health Services, will be referred to CenCal Health for services provided by the Managed Care Plan.

- Assessment Start Date is the date the client keeps a first assessment appointment. This marks the beginning of the Assessment Process.

- Assessment End Date is the date the clinician completes and signs the assessment form. This marks the end of the Assessment Process. The Assessment End date must be before the Treatment Start Date.

- Treatment service is a Case Management, Therapy, Rehab, Med Support, ICC, Plan Development service (any SMHS other than a 2nd Assessment or Crisis Intervention). A treatment service may be face-to-face, telephone, or telehealth and may be provided anywhere in the community.

- Treatment 1st Offered Date is the first offered treatment service after the assessment process and must be within 10 business days of the Assessment Start Date.

- Treatment Start Date is the date of the first kept treatment service

- Authorization follows a determination of medical necessity and is the process whereby SLOBHD staff and/or contract staff (when permitted by contract), in collaboration with the beneficiary, determine the specific SMHS that will be part of the beneficiary's Assessment Initial Treatment Plan (AITP) or Treatment Plan (TP) to produce the outcome necessary to treat the beneficiary's qualifying condition

- Authorization Start Date is the date the clinician has enough information to make an authorization decision. It is usually, but not always, the same as Assessment Start Date.

- Authorization End Date is the date a decision about medical necessity is made. It must be within 5 business days of the Authorization Start Date and is evidenced by signature of LMHP/RA and evidence of client participation and agreement with the AITP.

- Closed Out Date is the date either the Assessment Process or the Treatment process ended due any of the following Closure Reasons:
  - 01 = Beneficiary did not accept any offered assessment dates
  - 02 = Beneficiary accepted, but did not attend assessment appointment
  - 03 = Beneficiary attended assessment, but did not complete assessment process
  - 04 = Beneficiary completed assessment process, but declined offered treatment
  - 05 = Beneficiary accepted, but did not attend initial treatment appointment
  - 06 = Beneficiary did not meet medical necessity criteria.

- Licensed Mental Health Professional (LMHP) is a Physician; licensed, waivered, or registered

Psychologist; LMFT/LCSW/LPCC; Nurse Practitioner; or Registered Nurse.

- A Registered Associate (RA) is an individual who is registered with the Board of Behavioral Sciences and is working toward licensure as an LPCC, LMFT, or LCSW.

VI. PROCEDURE

A. Medical Necessity
Medical Necessity is determined following a comprehensive assessment of needs and strengths by an appropriately qualified staff member. See SLOBHD Policy & Procedure 5.00 *Outpatient Mental Health Assessment* for detail. The Assessment process begins with the first kept assessment service and ends when the assessment form is written and signed by a LMHP or Registered Associate working under the direction of an LMHP.

1. Diagnostic Criteria:

   a. The client must have an included mental health diagnosis
   b. See the most current list of included and excluded diagnoses, which are established in SLOBHD's contract with DHCS. The current included list contains DSM 5 F Codes and some additional diagnoses found in ICD 10, but not DSM 5.

      ❖ *A client with an included diagnosis may receive SMHS if an excluded diagnosis is also present; however, SMHS always focus on treating the symptoms and impairments that result from the included diagnosis*

2. Functional Impairment Criteria: (One of the following must be true as a result of the diagnosis)

   a. Client has a significant impairment in an important area of life functioning

   ❖ *The Child Assessment of Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) rating scales are imbedded in many assessments to improve consistency in rating degree of impairment.*

   ❖ *The CANS or ANSA ratings for life domains or functional impairment will be rated severe due to mental illness when there is a significant impairment in that area*

   b. Client has a probability of significant deterioration in an important area of life functioning

   ❖ *The assessment must clearly document the reason the clinician believes the client will likely deteriorate to a significant level of impairment if this criterion is used to document medical necessity. CANS or ANSA ratings may be moderate when accompanied by an explanation that supports the clinician's belief that deterioration is likely without SMHS.*

   ❖ *Beneficiaries with mild to moderate levels of functional impairment are eligible for non-specialty mental health services provided by CenCal Health. Please see the current referral procedure for details.*

c. For beneficiaries under age 21: There is a reasonable probability child will not progress developmentally as individually appropriate without SMHS

❖ *Documentation must specify how the beneficiary's development will be impaired without SMHS*

d. EPSDT Functional Impairment Criteria, for beneficiaries under age 21: EPSDT services are necessary to correct or ameliorate the mental illness

❖ *A beneficiary may qualify for SMHS under this provision without meeting Functional Impairment criteria a-c, provided the beneficiary has a mental illness that could be corrected with the types of SMHS, including those that are EPSDT entitlements, such as TBS, IHBS, ICC, or other intensive case management services that are not available through the Managed Care Plan. Documentation must include an explanation about how the EPSDT services will help and why other level of care interventions, such as non-Specialty Mental Health Services provided by CenCal Health, would not be enough.*

3. Intervention Criteria: (All three must be true)

a. The focus of the proposed mental health intervention(s) must be to address impairments arising from the included diagnosis

❖ *The interventions listed in a Treatment Plan must have a logical link to the symptoms and impairments that result from the included diagnosis. Services that target impairments from an excluded diagnosis do not support medical necessity for SMHS.*

b. There must be a reasonable expectation that the proposed interventions will significantly diminish the impairment, prevent significant deterioration in functioning, or allow a child to progress developmentally as appropriate.

❖ *When used as part of the reason for denying or terminating services, this criterion is sometimes summarized as "not likely to benefit from services". The specific reasons for this conclusion must be very clearly documented in the Assessment (and NOABD) and must be based on, at minimum, recent treatment (within the last 90 days) and a current assessment of the beneficiary's motivation/readiness for change. If an unsuccessful treatment episode occurred in the more distant past, another trial of treatment is indicated before determining that the client is "not likely to benefit" from treatment now because a person's motivation and readiness for treatment may change significantly over time. Documentation of participation in treatment within the last 90 days that did not maintain or improve a beneficiary's mental health condition is required if the "not likely to benefit" criterion is used as a service denial reason.*

c. The condition would NOT be responsive to physical healthcare-based treatment.

- *The final criterion means that physical health care-based treatment is not enough to help the beneficiary and, therefore, SMHS are necessary to improve or maintain the beneficiary's condition.*
- *Physical health care treatment includes medication and other services provided by a Primary Care Physician and includes the non-specialty mental health services provided by CenCal Health, such as office-based therapy, psychiatry, etc.*
- *If a beneficiary can benefit from physical healthcare-based treatment, the beneficiary will be referred for services provided by CenCal's authorized provider of non-specialty mental health services. Refer to the current referral procedure for details.*

B. Authorization

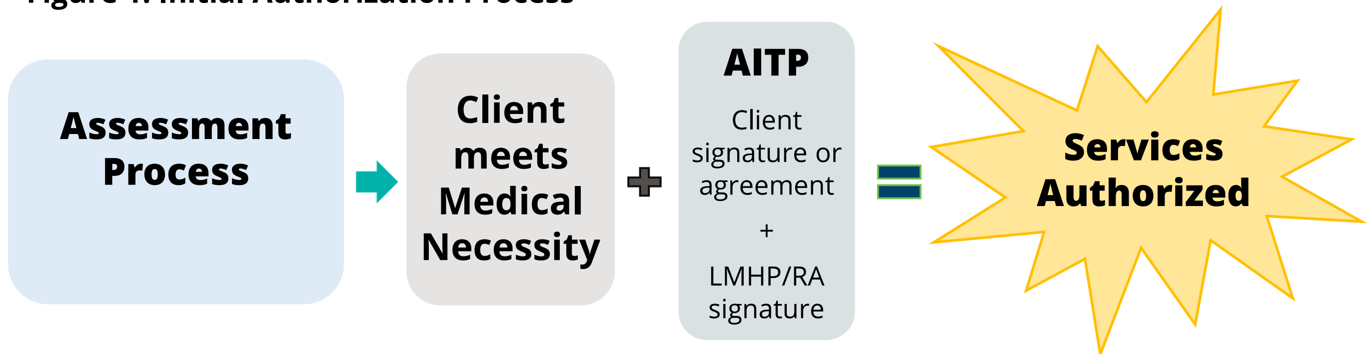
The services listed on an AITP or TP are authorized when the TP contains:

- Documentation of the client's or legally authorized representative's participation and agreement with the TP (this may be a written explanation or may be evidenced by electronic or hardcopy signature)

AND

- Signature of a Licensed Mental Health Professional (LMHP) or Registered Associate (RA)

Figure 1: Initial Authorization Process



1. Some services do not need to be on a TP in order to be provided and claimed, including Assessment, Plan Development, Crisis Intervention, and Crisis Stabilization. Due to limitations in EHR functionality, Assessment and Plan Development are added to all SLOBHD TPs to make Progress Noting easier, but the services do not require authorization and are claimable whether they are on the TP or not. Crisis services are not added to the TP, because they are unplanned.

2. Other services may be provided and claimed after they are included on a TP, but before the TP contains the signatures discussed above. These services include urgent Medication Support (the progress note must describe the urgency), Case Management/Intensive Care Coordination (limited to referral/linkage to help a

beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services).

3. Routine SMHS not mentioned in 1 or 2 above must only be provided and claimed after they are authorized on a TP that contains evidence of client participation and agreement AND the signature of an LMHP/RA. All the services on the TP are authorized for the duration of the TP, which is up to one year (unless the TP specifies a shorter duration). The authorization begin date is the later of the two elements – client signature/agreement or LMHP/RA signature.

4. Typically, a Program Supervisor or designee reviews, signs, and “Final Approves” TPs, but the LMHP’s/RA’s signature authorizes services

5. When the assessment results in a determination that the client DOES NOT meet medical necessity and will be referred to CenCal Health for non-SMHS, the assessment services and a Case Management service to make the referral can be documented in an Interim Services Log (ISL)

C. Prior Authorization

1. Some services require pre-authorization. These include:
   a. Day Treatment (Intensive and Rehabilitative)
   b. Therapeutic Behavioral Services (TBS)
   c. Intensive Home-Based Services (IHBS)
   d. Therapeutic Foster Care (TFC)

2. Prior Authorization means that, before these services may be provided or claimed, the beneficiary must first have an assessment to determine medical necessity for SMHS, followed by a separate authorization process to add these services to a TP or to a specialized TP.

   a. IHBS and TFC are added to the TP after a Child Family Team (CFT) determines that they are medically necessary. Note: When IHBS or TFC are authorized, the AITP no longer is detailed enough and an annual TP is required. See Documentation Guidelines for additional detail.
   b. TBS requires a separate TBS assessment and TBS TP.

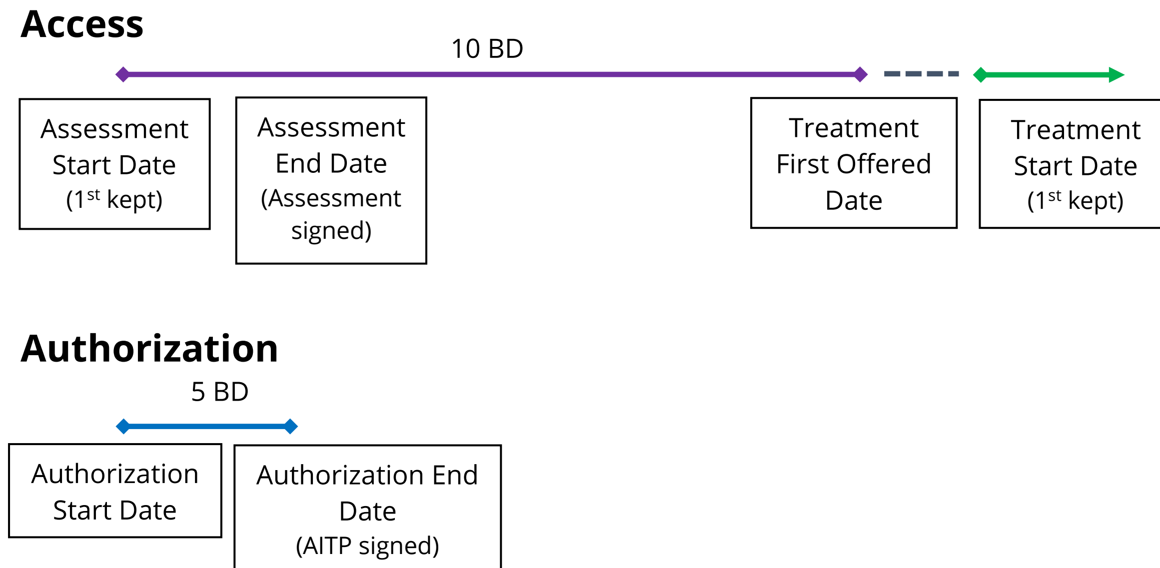
3. See TBS, Day Treatment, and Continuum of Care Reform policies for detail.

D. Timelines for Authorization

Note: Access timeliness and Authorization timeliness are related, but separate processes. See SLOBHD Policy & Procedure 3.23 *Availability, Timeliness, and Array of Services* for detail

about access timelines.

Figure 2: Overlap of Access and Authorization Timelines



1. Standard Authorization:
    a. The authorization process starts when the LMHP/RA completing the assessment has enough information to reasonably make a medical necessity determination. This will typically, but not always, be the date of the first assessment service.
    b. An authorization decision must be made as expeditiously as the beneficiary's mental health condition requires, not to exceed five (5) business days.
    c. As described above, the services listed on an AITP are authorized when the AITP contains documentation of the client's (or legally authorized representative's) participation and agreement with the plan (this may be an explanation or may be evidenced by signature) AND signature of an LMHP/RA.

2. Expedited Authorization:
    a. When the assessing LMHP/RA determines that following the standard timeframe could seriously jeopardize the consumer's life, health or ability to attain, maintain or regain maximum function, the LMHP/RA must make an expedited authorization decision within 72 hours of receipt of request

3. Extensions: An extension of up to 14 additional calendar days is possible if:
    a. The beneficiary requests an extension
    b. The assessing therapist determines that an extension to gather additional information is in the beneficiary's best interest and documents the basis for

this decision in a progress note. If the therapist makes this determination, a Notice of Adverse Benefit Determination (Authorization Delay) must be sent to the beneficiary on the same date the decision to extend the authorization period is made.

E. Post Assessment / Authorization Follow-up

1. After completing the assessment and making an authorization decision, the assessing clinician will contact the client to schedule treatment services or to discuss next steps (i.e., referral to a lower level of care or other services)

2. The first treatment service offer date must be within 10 business days of the assessment start date

3. When needed, the assessing clinician will complete a NOABD per current policy

F. Site Approval Team (SAT) or Program Supervisor Review:

1. After completing the assessment and making an authorization decision, the LMHP/RA will route the assessment to the program or clinic where treatment will occur
2. The Program Supervisor will review the assessment and TP to confirm that the record effectively documents medical necessity for SMHS and conforms to SLOBHD guidelines
3. The Program Supervisor will consult with the assessing LMHP/RA and/or the treatment team about the client's needs and available services
4. The Program Supervisor or designee will summarize the results of the consultation on the assessment and is responsible for assigning treatment team members to provide the services on the TP
5. If there is disagreement about whether SMHS are medically necessary, the treatment team and LMHP/RA who completed the assessment will attempt to gather additional information as needed.
6. The SLOBHD Medical Director will be available to assist with resolution of any disagreements not resolved at the clinic or program site

G. Consistency of Treatment Authorizations

1. Program Supervisor/SAT review described above will ensure consistency in authorization decisions
2. The Quality Support Team (QST) clinician will periodically select a sample of completed assessments for review and comparison

H. Notice of Adverse Benefit Determination (NOABD)

1. If services requested by a Medi-Cal beneficiary or provider on behalf of a beneficiary are denied or modified at any point in the assessment or authorization process, an LMHP designated by the Program Supervisor immediately completes and mails an NOABD per the procedure outlined in P&P 3.30 *Notice of Adverse Benefit Determination*

2. An NOABD is issued anytime a beneficiary is referred to a lower level of care.

I. Ongoing Treatment Authorization:

1. See the current Documentation Guidelines for Annual Assessment Update and TP content, renewal, and signature requirements
2. As with the AITP, the services contained in a TP are authorized by documentation of the client's participation in developing and agreement with the TP and the signature of an LMHP/RA and the TP is valid for up to a year, as specified in the TP
3. In most instances, a Program Supervisor will review and sign the TP to ensure consistency in authorization ongoing treatment decision

J. Crisis Residential Treatment Services and Adult Residential Treatment Services

1. Crisis Residential Treatment (CRT) and Adult Residential Treatment (ART) are subject to concurrent review

2. In most instances, SLOBHD will provide an initial referral that will specify the duration of the initial authorization

3. Subsequent authorization periods must be completed concurrently with the beneficiary's stay and based on beneficiary's continued need for services

4. When a CRT or ART provider submits an authorization request (which may be a TP), SLOBHD staff will review and authorize medically necessary services within 24 hours of receipt of request

5. CRT or ART services will not be discontinued until the beneficiary's treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

6. If SLOBHD denies or modifies the request for authorization, SLOBHD must issue an NOABD to the provider and beneficiary prior to discontinuing services

K. Retrospective Authorization

1. SLOBHD may make retrospective authorizations under certain circumstances
2. Examples include:
    a. When an individual was denied a service due to Medi-Cal ineligibility, but later becomes retroactively eligible
    b. When SLOBHD discovers a Medi-Cal eligibility error in MEDS
    c. When a beneficiary's primary or other health care payor makes a payment decision that affects Medi-Cal responsibility
3. SLOBHD will notify the provider and beneficiary within 30 days of receiving information needed to make a retrospective authorization decision

L. Utilization Review (UR)

1. UR is the process whereby SLOBHD staff review documentation to determine if the documentation meets SLOBHD's and/or DHCS' documentation/medical necessity standards for claiming. UR is retrospective, whereas authorization processes (sometimes called Utilization Management or UM) described in this Policy are prospective.

2. UR includes an examination of under/over claiming, documentation timeliness, proper coding, and quality

3. SLOBHD will reserve the right and responsibility to review documentation and to make determinations about whether documentation supports claiming for payment. At times this process will require services to be voided, paid back to the payor, and recouped from the provider.

4. SLOBHD will provide providers and beneficiaries with the applicable NOABD when disallowing a service so that SLOBHD's Problem Resolution Processes are available to any affected party

M. Additional Administrative Requirements

1. SLOBHD will make providers aware of documentation requirements and UR processes at the time of contracting and contract renewal.
2. SLOBHD will post documentation requirements and policies related to authorization on its public website so that providers and beneficiaries may access information related to authorization
3. SLOBHD will review its authorization processes and policy on at least an annual basis and will revise and repost as necessary

VII. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
11/06/2014	Medical Necessity section	Reformatted text; added clinical decision support and expanded explanations
12/27/2017	Entire Policy	Formatting
09/20/2018	V G, I, J, K All	Updated language Reformatting
7/25/2019	Entire Policy	Revised to comply with Managed Care Final Rule
Prior Approval dates:		
03/30/2009, 08/30/2010, 09/21/2012		

Signature on file		*7/25/2019*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date