7.2.14 AUTHORIZATION FOR CRISIS RESIDENTIAL AND ADULT RESIDENTIAL TREATMENT SERVICES

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References: Behavioral Health Information Notice 22-016 and Welfare and Institutions Code (W&I) sections 14197.1(b)1 and 14184.402(i)2

Policy Owner: QAPI, QA Manager

Director Signature: **Signature on File**

I. Policy Statement

The Sonoma County Department of Health Services – Behavioral Health Division (DHS-BHD) maintains utilization management mechanisms to ensure that delivered services are medically necessary, appropriate, timely, cost-effective, and culturally competent. Consistent applications of review criteria standards for initial and continuing service authorizations are met through referral and/or concurrent review. DHS-BHD utilization management is also employed to detect underutilization and overutilization, as well as to detect and prevent fraud, waste, and abuse.

II. Scope

This policy applies to all "Covered Persons", which includes all County of Sonoma employees (full-time, part-time, extra help), and all additional persons who are performing services for DHS-BHD, with the exception of Community Based Organization (CBO) staff involved with authorization and utilization review of Crisis Residential Treatment Services (CRTS) & Adult Residential Treatment Services (ARTS) for beneficiaries.

III. Definitions

A. **Adult Residential Treatment Services (ARTS)** are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for members who would be at risk of hospitalization or another institutional

placement if they were not in a residential program. The population served consists of adult (ages 18 and older) members experiencing a mental health condition and/or co-occurring disorder. Services are available 24 hours a day, seven days a week, with structured day and evening services available all seven days.

1. Transitional residential treatment has a maximum length of stay of 12 months.

2. Long-Term residential treatment has a maximum length of stay of 18 months.

B. **Authorized Licensed Professionals** are providers that can formulate or cosign a diagnosis. Per the Department of Health Care Services (DHCS), these providers include Physicians, Psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists and Advanced Practice Nurses, in accordance with the Board of Registered Nursing.

C. **Crisis Residential Treatment Services (CRTS)** are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured short-term program (3 months or less) as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service is available 24 hours a day, seven days a week, and structured day and evening services are available all seven days.

D. **Initial Requests** are the first requests for authorization submitted by a covered person, hospital, Psychiatric Health Facility (PHF), and/or contracted agency for the planned delivery of services to a member.

IV. Policy

A. DHS-BHD is committed to ensuring Medi-Cal members have appropriate access to Specialty Mental Health Services (SMHS). DHS-BHD maintains a policy of authorization of organizational providers' requests for SMHS as a condition of reimbursement for individuals who receive SMHS from DHS-BHD (i.e. members).

B. Authorization and utilization management of service provided by the DHS-BHD adhere to the following principles:

1. Are based on SMHS access criteria, including access criteria for members under age 21 pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate;

2. Are consistent with current evidence-based clinical practice guidelines, principles, and processes;

3. Are 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;

4. Are evaluated and updated, if necessary, at least annually and are disclosed to the DHS-BHD's members and network providers.

C. DHS-BHD shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the member.

D. 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 member's behavioral health needs.

E. 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 member or a provider, may deny, or modify a request for authorization of SMHS for a member for reasons related to medical necessity.

F. A decision to modify an authorization request should:

1. Be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include clear and concise explanation of the reasons for the DHS-BHD decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity;

2. Include the name and direct telephone number of the professional who made the authorization decision;

3. Offer the treating provider the opportunity to consult with the professional who made the authorization decision;

4. Be provided to the member in writing using applicable Notice of Adverse Benefit Determination.

G. DHS-BHD should notify the requesting provider in writing and give the member written notice of the decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested using applicable Notice of Adverse Benefit Determination.

H. DHS-BHD will utilize mechanisms to ensure consistent application of review criteria for authorization decision and will consult with requesting provider when appropriate.

I. DHS-BHD will comply with the following requirements:

1. Notify DHCS and contracting providers in writing of all services that require concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;

2. Disclose to DHCS, DHS-BHD providers, members, and the public, upon request, the utilization management or review policies and procedures that DHS-BHD uses to authorize, modify, or deny SMHS.

3. Will make the criteria or guidelines available through electronic communication means by posting online;

4. Ensure the member handbook includes the procedures for obtaining benefits, including any requirements for service authorization and/or referrals for SMHS; and,

5. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

J. Compensation provided to individuals or entities that conduct utilization management activities will not be structured as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

V. Procedures

A. Requirements Applicable to Authorization of SMHS

1. Relevant clinical information shall be obtained and used for authorization decisions including, but not limited to:

   a. Assessments, progress reports, client plans and other clinical documentation; and,

   b. Consultation with treatment provider(s) as necessary.

2. In the case of concurrent review, if DHS-BHD approve, modify, or deny requests for authorization of CRT or ART, care shall not be discontinued until the member's treating provider(s) have 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 member.

3. DHS-BHD staff may concurrently authorize multiple days based on the submitted request if each authorized day meets admission and/or continued stay medical necessity criteria.

4. Members must be notified, in writing, within two (2) business days of the determination of the adverse benefit determination and prior to services being discontinued.

B. Referral and/or Concurrent Review of CRTS and ARTS:

1. DHS-BHD may not require prior authorization CRTS and ARTS.

2. Authorization for all CRTS and ARTS must be by referral and/or concurrent review.

3. Initial authorizations will be made using the Service Authorization Request in SmartCare, which will include the number of days and dates the authorization covers.

4. In the absence of a referral, DHS-BHD will conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. DHS-BHD may elect to authorize multiple days, based on the member's mental health condition, for as long as the services are medically necessary.

5. DHS-BHD shall initiate the CRTS or ARTS referral;

    a. The referring provider will complete the Service Request in SmartCare and specify the number of days to be authorized. Multiple days may be authorized if each authorized day meets admission and/or continued stay medical necessity criteria.

        i. CRTS: up to 30 days at a time

        ii. ARTS: up to 1 year at a time

6. All Authorizations will be included in the member's chart.

7. DHS-BHD Section Manager and Client Care Manager, or designee, will approve, modify, or deny provider authorizations. Requests shall be communicated to the CRTS/ARTS admitting placement designee, in writing, within 24 hours of the decision, and care will not be discontinued until the member's treating provider has been notified of DHS-BHD decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the member.

8. Approved requests shall be communicated in the form of an authorization document in the client's chart by the authorizer to the accepting placement.

9. When the initial authorized date range expires, the CRTS or ARTS facility must request authorization for continued stay services for the member subject to the below concurrent review procedures.

10. Any denial or modification of authorization, or termination of previously authorized services, will be communicated to the member in writing using applicable Notice of Adverse Benefit Determination, prior to discontinuing services.

C. **Continued Stay Authorization of CRT or ART Services (Concurrent Review):**

1. DHS-BHD will have regular contact with CRT/ART providers to check in on the status of clients placed in these facilities, including current medical necessity and continued need. Contact may occur over the phone, via telehealth, or in person.

2. DHS-BHD staff shall establish ongoing concurrent review sessions. If CRTS or ARTS, fail to conduct concurrent reviews as scheduled, the MHP may deny continued stay authorization.

3. CRT/ART providers will furnish DHS-BHD with the necessary information to authorize continued stay at the CRT/ART facility.

4. DHS-BHD staff shall ensure that rendered services meet medical necessity criteria through review of CRT/ART documented records sufficient to determine medical necessity, including but not limited to the review of the treating provider's admission evaluation, treatment plan and goals, treatment progress notes and treating physician's notes.

5. Continued services shall be reimbursed/authorized when a member experiences one of the following:

    a. Continued presence of indicators that meet the medical necessity criteria;

    b. Serious adverse reaction to medications or treatment intervention requiring continued stabilization at level of care;

    c. Presence of new indications that meet medical necessity criteria;

    d. Need for continued stabilization or treatment that can only be provided if the member remains in the CRT/ART setting; or,

    e. Lack of appropriate discharge setting increases risk to member's current stability and/or treatment interventions, including medication regime.

6. If medical necessity for continued stay is determined to not be met, DHS-BHD will work with CRT/ART providers to facilitate transition to a lower level of care.

7. In cases where DHS-BHD staff determines medical necessity criteria is not met, yet the CRT/ART provider believes criteria is met, DHS-BHD staff shall initiate physician, or delegate, consultation to resolve authorization dispute.

8. The CRT/ART provider shall document in the medical record when there is a discharge barrier due to lack of appropriate discharge placements for the member's current needs and level of functioning.

9. Services will not be discontinued until after the facility/provider has been notified and an appropriate care plan based on the member's needs have been agreed upon but DHS-BHD and the CRT/ART provider.

10. DHS-BHD staff shall collect and document the CRTS/ARTS placement activity, as well as clinical disposition information, as justification for continued stay approval criteria.

11. DHS-BHD will communicate authorization decisions to the facility/provider within 24 hours of the decision.

12. MHP shall notify the member of any denial or modification of authorization request in writing in accordance with guidance outlined in policy 7.1.4 Appeals and Notice of Adverse Benefit Determinations.

D. **Authorization Appeals**

1. CRT and ART facilities may utilize the appeal process in accordance with state and federal requirements when in disagreement with the MHP findings outlined in policy 7.1.4 Appeals and Notice of Adverse Benefit Determinations.

E. **Utilization Review**

1. Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. DHS-BHD conducts utilization review and/or auditing activities in accordance with state and federal requirements. DHS-BHD retains the right to monitor compliance with any contractual agreements between DHS-BHD and it network providers and may disallow claim and/or recoup funds, as appropriate, in accordance with DHS-BHD's obligations to DHCS, consistent with state and federal requirements. For example, DHS-BHD 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.

VI. Forms

None

VII. Attachments

None