County of San Diego Mental Health Plan

Prior Authorization Day Services Request (DSR)

Submit At Least 5 Business Days Prior To Projected Start Date

Please Check: ☐ **Initial Request (prior to services)**
☐ **Continuing Request (STRTP required every 90 Days, SPA every 180 Days)**

FAX TO: (866) 220-4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then Option 4

CLIENT INFORMATION

Client Name: _____

Client ID: _____

Client Date of Birth: _____

Placing/Referring Agency: ☐CWS ☐Probation ☐ Dual Placement ☐ Other: _____

Qualified Individual Assessment – only for STRTPs

☐QI Assessment has been completed and an STRTP Level of Care was recommended
☐Emergency Placement - QI Assessment shall be completed within 30 days of placement

Out of County Client - Through: ☐ CWS ☐ Probation

Out of County Client - Must Include Either:

☐ AB1299; for STRTP only, a copy of Notice of Presumptive Transfer (foster youth) and a copy of QI Assessment reflecting STRTP level of care determination (foster youth)

☐ AAP/KinGAP; for STRTP must include SAR copy and written COR approval to serve youth under County contract due to discharge to San Diego residence

DAY PROGRAM INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Day Program Subunit#**: _____

SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST

SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):

☐ STRTP Hybrid Day Rehab and Outpatient Services (Up to 90 days)

☐San Pasqual Academy (SPA) Day Rehab (Up to 180 Days)

AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)

☐ Up to 5 Days Per Week ☐ Up to 6 Days Per Week

MEDICAL NECESSITY CRITERIA FOR DAY SERVICES

DIAGNOSIS: Provide the DSM/ICD Mental Health diagnoses that are the focus of mental health treatment.

Diagnosis 1: **Diagnosis 2:** **Diagnosis 3:**

Medical Necessity Criteria (BHIN 21-073)

Client has a condition placing them at high risk for a mental health disorder due to experience of trauma (*choose at least one*):

☐ Scoring in the high-risk range under a trauma screening tool
Score: _____

☐ Involvement in the child welfare system

☐ Juvenile justice involvement

☐ Experiencing homelessness
Additional Information As Needed: _____

OR

Client has at least one of the following:

☐ A significant impairment or reasonable probability of significant deterioration in an important area of life functioning
Explain: _____

☐ A reasonable probability of not progressing developmentally as appropriate
Explain: _____

☐ A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.
Explain: _____

AND

The client's condition is due to <u>one</u> of the following:

☐ A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD-10 classifications

☐ A suspected mental health disorder that has not yet been diagnosed
Suspected DSM/ICD Mental Health Diagnosis: _____

☐ Significant trauma placing the beneficiary at risk of a future mental health condition
Explain: _____

Day Services Necessity Criteria: *(Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01)*

1. Client requires structured Day Services in order to move from higher level of care to lower level of care or to prevent deterioration and admission to a higher level of care. Describe: _____
2. **Continuing service requests only -** Current treatment goals have not been met. **Describe progress** toward treatment goals or how progress is expected to be made during the next authorization cycle: _____

ANCILLARY SERVICES REQUEST (INTERNAL)

STRTP and SPA must request ancillary authorization if client is going to receive Day Services and Outpatient Services from the same provider/program

STRTP/SPA must submit a stand-alone (external) <u>Ancillary Specialty Mental Health Services (SMHS) Request Form</u> for any client receiving Day Services and SMHS from another provider/program

Outpatient Subunit#: _____

1. **SELECT THE AMOUNT OF OUTPATIENT SMHS REQUESTED PER DAY (Inclusive of all Individual, Collateral, ICC, IHBS and Group SMHS provided by Day Service provider in addition to Day Program Services):**

   ☐ Up to 8 hours per day

2. **MEDICAL NECESSITY FOR OUTPATIENT SMHS (must select at least one):**

   ☐ Requested service(s) is not available during day program hours. Describe why service is not available: _____

   ☐ Continuity or transition issues make these services necessary for a limited time. Describe the need: _____

   ☐ These concurrent services are essential for coordination of care. Describe why services are essential: _____

CLINICAL REVIEW REPORT: Section 14 of Interim Mental Health Program Approval for STRTP

FOR STRTP CONTINUING (90 DAY) REQUESTS ONLY

1. **Describe the type and frequency of services that have been provided by the STRTP during the previous 90-day review period:**

   ☐ Day Services - Describe the type and frequency of Day Services provided by the STRTP during the past 90 days:
   _____

   ☐ Outpatient Services (OP) - Describe the type and frequency of OP services provided by the STRTP during the past 90 days:
   _____

2. **Describe the impact of these services towards the achievement of Client Plan Goals (include progress toward goals of transitioning to lower level of care):** _____

3. **Date of most recent mental health program staff meeting, which must include Head of Service or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed** (must occur at least every 90 days and prior to submittal of DSR): _____

4. **Date of most recent CFT meeting** (must occur at least every 90 days and prior to submittal of DSR): _____

   The CFT/mental health program staff agree that the STRTP continues to meet the specific therapeutic needs of the youth:
   ☐ **Yes** ☐ **No** ☐ **Other** _____

   The CFT Meeting Summary and Action Plan is available based on UM reviewer request: ☐ **Yes** ☐ **No**

5. **Clinical Review Recommendation**: ☐ Continued treatment in STRTP ☐ Transition from the STRTP, include transition recommendation _____ ☐ Other _____
   - ❖ **Recommendation for transition or continued treatment must be supported in client record and CFT documentation**

Program Clinician (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Licensed Clinician (Print): _____ **Credentials:** _____

Co-Signature: _____ **Date:** _____

- ❖ **Co-Signature required if Program Clinician is not a Licensed Mental Health Professional**

FOR OPTUM USE ONLY

Optum completes and retains. Within 5 business days of Optum receipt, authorization determination status will be viewable to the requesting provider in the CCBH Clinicians Home Page Authorizations Tab.

DAY SERVICES PRIOR AUTHORIZATION DETERMINATION

☐ **Day Services scope, amount and duration authorized: START DATE:_____END DATE: _____**

Day Service request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____
NOABD was issued to the beneficiary and provider on the following date: _____

ANCILLARY SERVICES DETERMINATION (INTERNAL)

☐ **Internal Ancillary OP SMHS authorized: START DATE:_____END DATE: _____**

Internal Ancillary OP SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____
NOABD was issued to the beneficiary and provider on the following date: _____

CLINICAL REVIEW REPORT DETERMINATION

☐ **Clinical Review Report is complete and addresses all four components; see Clinical Review Report section**

Follow up for the Clinical Review Report will occur through the County CCR team when indicated.

ANCILLARY SERVICES DETERMINATION (EXTERNAL)

(External authorization requests are submitted to Optum when indicated through a separate Ancillary SMHS Request Form)

☐ **External Ancillary SMHS authorized: START DATE:_____END DATE: _____**

External Ancillary SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

Optum clinician Signature/Date/Licensure: