



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

DATE: February 4, 2020

BHRS POLICY: 20-06

SUBJECT: Utilization Management of Inpatient Psychiatric Services

AUTHORITY: Code of Federal Regulations (CCR), Title 42, §438.210, §438.330, §438.608; CCR Title 9, §1820.100 – 1820.230; CCR Title 22, §77113, §77135; California Health and Safety Code (HSC) §1367. Contract with Department of Health Care Services (DHCS), Exhibits A, B MHSUDS Information Notice [19-026](#); BHRS Policy 19-01: Consumer Problem Resolution and Notice of Adverse Benefit Determination

NEW POLICY: February 4, 2020; Technical Edit February 24, 2020; Amended November 5, 2020
Attachment A: Technical Edit February 10, 2023

SUPERSEDES: 99-08: Procedures for Non-SMMC Inpatient Psychiatric Treatment
00-09: Inpatient Services to Beneficiaries of Other Counties

ATTACHMENTS: A: Acknowledgment of Notification for Inpatient Admission
B: List of Required Documentation for Concurrent Inpatient Reviews
C: Acknowledgment of Notification/Non-Responsible

PURPOSE:

Behavioral Health and Recovery Services (BHRS) licensed clinicians review and authorize all requests for psychiatric inpatient hospital and psychiatric health facility (PHF) inpatient services for child, adolescent, and adult Medi-Cal beneficiaries for all contracted psychiatric inpatient hospitals, out of county hospitals providing services to San Mateo county beneficiaries, PHF's and non-contracted hospitals within San Mateo County.

BACKGROUND:

BHRS complies with all state and federal regulations that apply to psychiatric hospital inpatient services and services provided at PHF's, including those itemized within the California Department of Health Care Services (DHCS) Mental Health & Substance Use Disorder Services (MHSUDS) Information Notice (IN) 19-026. This IN explains that Mental Health Plans (MHP) including BHRS, must conduct concurrent review and authorization for all psychiatric inpatient hospital and PHF services.

www.smchealth.org/BHRSComplianceProgram

<http://smchealth.org/bhrs-documents>

Policy 20-06 Concurrent Inpatient Review and Authorization_11-5-20

POLICY:

San Mateo County authorizations for reimbursement of psychiatric inpatient hospital and PHF services are conducted in accordance with the above authorities. San Mateo County staff are available to receive inpatient admission notifications through San Mateo County Psychiatric Emergency Services (PES) from hospitals and PHF's 24 hours per day, 7 days per week. Emergency psychiatric services do not require prior authorization for the first 3 days of admission, provided the beneficiary meets medical necessity criteria (see definition below).

Inpatient psychiatric must meet medical necessity (from CCR, Title 9, [§ 1820.205](#)) must be met. Beneficiaries must have an included DSM 5/ICD 10 diagnosis ([Inpatient Included List](#)) and be unable to be treated at a lower level of care based on clinical characteristics laid out in statute. Continued care services past the first day must meet acute day criteria and, if on hold for placement, they must meet administrative day criteria.

DEFINITIONS:

Medical Necessity is a set of criteria established in CCR, Title 9, [§ 1820.205](#):

Admission:

1. Must have an included DSM 5/ICD 10 diagnosis ([Inpatient Included List](#)) AND
2. Both the following criteria:
 - A. Cannot be safely treated at a lower level of care AND
 - B. Requires psychiatric inpatient hospital services
 1. Has symptoms or behaviors due to a mental disorder that (one or more):
 - i. Represent a current danger to self, others, or significant property destruction
 - ii. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
 - iii. Present a severe risk to the beneficiary's physical health
 - iv. Represent a recent, significant deterioration in ability to function
 2. Requires admission for one of the following:
 - i. Further psychiatric evaluation
 - ii. Medication treatment
 - iii. Other treatment that can reasonably be provided only if the patient is hospitalized

Continued stay services:

1. Continued presence of indications that meet the admission medical necessity criteria
2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
3. Presence of new indications that meet medical necessity criteria specified in (a)
4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital

Concurrent Authorization is permission from BHRS to a provider to deliver specific services in a specified time frame. It is an agreement to authorize inpatient psychiatric services when the information provided indicates that the services are medically necessary. Concurrent authorization occurs promptly upon receipt of information necessary to establish medical necessity. Concurrent authorization is prospective, meaning it applies to services on the day of decision and future service dates.

Utilization Review (UR) is retrospective and is part of BHRS's compliance program to prevent waste, fraud, and abuse. Adverse Benefit Determinations that result from UR decisions will result in denial of payment or payment recoupment and will be documented, in writing, using the most current version of Notice of Adverse Benefit Determinations (NOABD).

Retrospective Authorization may be granted after the service was provided when concurrent authorization was not possible:

1. When Medi-Cal eligibility is determined retroactively after the service was provided;
2. When errors in the Medi-Cal Eligibility Data System (MEDS) are identified after the service;
3. When a beneficiary fails to identify a payor, which is later determined to be Medi-Cal; or
4. When a beneficiary has more than one type of health care coverage and a payment determination cannot be made until after the service has been provided and another payor processed the claim.

PROCEDURES:

A. Notification of Admission

1. When a facility admits a San Mateo County resident who is a San Mateo Medi-Cal client for Psychiatric Inpatient Hospital Services or (PHF) Services, the admitting facility must notify San Mateo Psychiatric Emergency Services (PES) at the San Mateo Medical Center (SMMC) *650-573-2662 (phone) and 650-573-2489 (fax)* as soon as possible upon admission.
 - a) When a client has relocated out-of-county, San Mateo BHRS may not be financially responsible for the care of the beneficiary, even if the State's MEDS file lists San Mateo County as the county of responsibility
 - b) Admitting facilities must identify the client's residence address, which will help determine the current county of responsibility
 - c) In certain instances, with approval of the Staff Psychiatrist, a San Mateo County beneficiary may be transported back to San Mateo County for acute care. In these instances, San Mateo County will authorize acute care until transportation can be arranged.
2. Emergency psychiatric services do not require authorization for the day of admission,

provided the beneficiary meets medical necessity criteria. *(See definitions)*

3. The client's initial authorization will be for up to three (3) days, including the date of admission, provided the beneficiary meets medical necessity criteria for each day of admission (see definition above)
4. Prompt notification is required so that San Mateo County BHRS may provide concurrent authorization for continued stay days. Without which claims for continued days will be denied.
5. Additional days can be authorized during regular business hours Monday-Friday (as outlined in Section B below).

B. Concurrent Review and Authorization

1. BHRS Utilization Management (UM) staff review requests for authorization during regular business hours, Monday through Friday, or on the next business day for notifications that are sent after hours and on weekends and holidays.
2. Relevant clinical information may be discussed by telephone prior to transmittal of documentation. BHRS, at its sole discretion, may provide verbal authorization.
3. The hospital/PHF is required to transmit requested clinical documentation support a determination of medical necessity by BHRS. (See Attachment B: Documentation Checklist.) Failure to submit timely requested documentation may result in an authorization denial.
4. Either telephonic review or receipt of documentation by BHRS is considered a formal authorization request. The hospital/PHF is required to notify at that time the type of authorization being requested (acute or administrative days) when they transmit the written documentation. The hospital/PHF cannot modify the request once a final determination has been made. If a denial has been issued the hospital/PHF may appeal the decision as described in Section C below.
5. Clinical documentation is reviewed by licensed clinical staff and an authorization determination is made based on Title 9 Medical Necessity Criteria. *(See definition)*
6. Hospitals/PHF's will receive an authorization decision within 24 hours (or next business day) from the date and time we receive the request for continued stay services.
7. If denied, BHRS Staff will complete the authorization notification form and issue a Notice of Adverse Benefit Determination (NOABD) as required by BHRS Policy 19-01.
8. BHRS will complete concurrent reviews at a frequency consistent with the clinical status of the beneficiary following the initial three-day authorization but will not exceed 5 business days between reauthorizations. Documentation must establish medical necessity separately for each day requested.
9. **The Hospital/PHF is required to notify BHRS immediately** if the client's status has changed and medical necessity will not be met.

C. Notification of Authorization or Denial

1. A verbal notification of the authorization or denial may be given to the hospital/PHF at the time of determination.
2. BHRS will transmit an authorization notification form to the hospital/PHF indicating all days authorized and/or denied.
3. If days are denied (or modified to administrative instead of acute), BHRS will transmit a NOABD to the beneficiary and the provider within two (2) business day of the determination.
4. Authorizations will be tracked in the BHRS Avatar system.

D. Expedited Appeal of Denial

1. An Expedited Appeal of the denial may be requested by the attending physician.
2. For an Expedited Appeal to occur, the beneficiary must still be hospitalized at the time of the review. If the patient has been discharged the case will follow the standard appeal process.
3. The Medical Director, or their designee, will review the request for Medical Necessity and make a determination to uphold or overturn the denial.
4. The beneficiary and provider will be notified of the outcome within 24 hours of the expedited appeal review.
 - a) If the Medical Director, or their designee, upholds the denial, the provider and beneficiary will receive information on how to file a State Fair Hearing.
 - b) If the Medical Director, or their designee, reverses the denial and authorizes reimbursement for the hospital, the hospital will be notified immediately of the decision.

E. Authorization of Administrative Days

1. A client, over 18 years of age, may be approved for Inpatient Administrative Days if they met medical necessity for at least one (1) acute day during their current hospital stay and they are awaiting placement in one of the following types of facilities:
 - a) Psychiatric augmented Board and Care
 - b) Crisis Residential Treatment (CRT)
 - c) Institute for Mental Disorder (IMD)
 - d) Skilled Nursing Facility (SNF)
 - e) Dual Diagnosis Rehabilitation Facility
 - f) State Hospital
2. A client under 18 years old, who no longer meets Acute Care criteria and who is waiting for discharge to a 24 hour placement facility such as Short Term Residential Therapeutic Program (STRTP), must meet Administrative Day Criteria.

3. Starting with the day the beneficiary is placed on administration day status. Specifically, a hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required, contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.
4. **Procedure**
 - a) A psychiatrist must indicate clearly in a progress note the level of care that a client should be discharged to (e.g. SNF, IMD, etc.)
 - b) The hospital placement worker must document at least five (5) calls per week, or one (1) per day, to placements at the designated level of care. BHRS, at its sole discretion, may waive the requirement of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.
 - c) A BHRS licensed clinician will authorize inpatient Administrative Days in accordance with DHCS MHSUDS Information Notice 19-026 and current County Policy.
 - d) Documentation of the discharge plan and any required actions by the hospitals is needed for authorization of administrative days. This includes documentation of five calls per week for placements; and daily calls for STRTP facilities (children).
 - e) For beneficiaries on Administrative Days, authorization decisions will be reviewed at least every 5 business days.
 - f) If the discharge plan changes and the client no longer meets Administrative Day criteria, further authorization will be denied. The hospital will be notified and a Notice of Adverse Benefit Determination (NOABD) will be sent to the facility and the beneficiary.
 - g) If a beneficiary returns to needing acute care, the hospital must transmit the required clinical documentation to BHRS with a request for this change within one (1) business day. A BHRS licensed clinician will review this request using the standard review process.

F. Discharge and TAR for Payment

1. BHRS will close out the assignment when the client is discharged from the hospital.
2. If a TAR form is required for payment, the hospital/PHF submits a draft Treatment Authorization Request (TAR) at the time of admission.
3. At the end of the authorized stay, the hospital/PHF staff finalize the TAR and submit it to BHRS within 14 days of the beneficiary's discharge.

4. The TAR is entered into the TAR database.
5. The TAR is signed by the BHRS licensed clinician and returned to the hospital/PHF and to the Fiscal Intermediary within 14 calendar days from receipt.
6. The final confirmation and approval/denial of the inpatient services will be completed when the TAR is received from the hospital/PHF.
7. Inpatient Professional Services will not be authorized for adult inpatient hospitalizations that are not authorized.

G. Retrospective Review & Authorization

1. County licensed clinician will perform retrospective reviews for inpatient services that were not concurrently authorized due to one or more of the following reasons:
 - a) a natural disaster
 - b) circumstances beyond the provider's control
 - c) delayed certification of eligibility by the County Welfare Department
 - d) other coverage denied payment of a claim for service
 - e) communication with the field office consultant could not be established or the beneficiary concealed Medi-Cal eligibility at the time of admission.
2. Retrospective review packets must be submitted within 14 calendar days of notification of the beneficiary's Medi-Cal eligible status or from the date on beneficiary's primary insurance denial, or EOB.
3. The Retrospective review packet must include a completed TAR, the complete medical record for the dates of service for which authorization is being requested, and a letter of explanation for not obtaining prior authorization.
4. Retrospective reviews will be denied administratively without clinical review if the retrospective review process is requested beyond the above timelines or for circumstances other than those listed above. Circumstances such as employee negligence, misunderstanding of program requirements, illness or absence of employees trained to prepare requests for review or delays by the US Postal Service do not meet the guidelines for Retrospective review per Title 9 guidelines.
5. The hospital will be informed of the authorization decision on the retrospective TAR within 30 days of receipt of the information that is required to make the determination. Any applicable NOABDs will be mailed to the client within two (2) business days of the determination.

H. Disputed Requests for Authorization

If at any point in the authorization process, there is a dispute about the authorization determination between the requesting entity and BHRS, the Medical Director or their designee will be available for consultation and resolution of the disputed request for authorization.

Approved: Signature on File
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Vanessa de la Cruz, MD
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