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| County of San Diego Mental Health Plan  **IOP & PHP Prior Authorization - Day Services Request (DSR)**  Submit at least 5 business days prior to projected start date  **Initial Request (prior to services)**: IOP (DIH) or PHP (DIF)  **Continuing Request:** IOP (beyond initial 3 months) or PHP (beyond initial 1 month) | | | **IOP & PHP - DSR**  **FAX TO: (866) 220-4495**  Optum Public Sector San Diego  Phone: (800) 798-2254  Option 3, then Option 4 |
| **Out of County Client – Must Include**  AB1299 – Attach Notice of Presumptive Transfer, OR  AAP/KinGAP – Attach SAR & written COR approval to serve youth under County contract due intent to discharge youth to San Diego residence  Written COR exception | | | |
| **CLIENT INFORMATION** | | | |
| **Client Name**: | **Client ID**: | | **Client Date of Birth:** |
| **DAY PROGRAM INFORMATION** | | | |
| **Legal Entity:**  **Fax**: | **Program Name:**  **Unit#:** | **Phone**:  **Subunit#**: | |
| **SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST**  Day Intensive Half (DIH) at least 3 hours | Day Intensive Full (DIF) more than 4 hours | | | |
| **SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):**  Intensive Outpatient Program (IOP – DIH up to 12 weeks) Partial Hospitalization Program (PHP – DIF up to 4 weeks)  **AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)**  Up to 3 Days Per Week Up to 5 Days Per Week Up to 7 Days Per Week | | | |
| **MEDICAL NECESSITY CRITERIA FOR DAY SERVICES** | | | |
| **DIAGNOSIS**: Provide the ICD 10 mental health diagnoses that are the focus of mental health treatment   |  |  |  | | --- | --- | --- | | **Diagnosis 1:** | **Diagnosis 2:** | **Diagnosis 3:** | | | | |
| **Medical Necessity Criteria (**[**BHIN 21-073**](https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf)**)**  **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 one of the following:**  A diagnosed mental health disorder, according to the criteria of 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: | | | |

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| **ANCILLARY SERVICES REQUEST (INTERNAL)**  IOP must request ancillary authorization (through this form) if client is going to receive  Day Services and Outpatient Services from the same 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  Other:   1. **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: |

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| **When a client is concurrently receiving SMHS from another provider, the IOP/PHP must request, obtain, and submit to Optum a**  **stand-alone (external) Ancillary Specialty Mental Health Services (SMHS) Request Form** |

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| **Program Clinician (Print):**         **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Licensed Clinician (Print):**  **Co-Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Credentials:**  **Date:**        **Credentials:**  **Date:** |

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

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| **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.** |

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| **DAY SERVICES PRIOR AUTHORIZATION DETERMINATION**  **Day Services scope, amount and duration authorized with** **START DATE**:       **END DATE**:  **Day Services 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:* |
| **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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_