Duncan-Sanford, Judy A

From: Duncan-Sanford, Judy A on behalf of sdu_Provider Services Help
Sent: Friday, August 09, 2019 3:10 PM
Subject: Optum Public Sector - Notification: Therapeutic Behavioral Services Prior Authorization Request & Referral Process
Attachments: TBS Prior Authorization Request & Referral Form Explanation Sheet.pdf; TBS Prior Authorization Request & Referral Form-7.26.19.docx

San Diego Public Sector

Dear Provider:

On May 31, 2019, the Department of Health Care Services (DHCS) issued Information Notice 19-026 outlining specific mental health services requiring prior authorization. Therapeutic Behavioral Services (TBS) is identified as one of the services requiring prior authorization. The County of San Diego Behavioral Health Services (BHS) worked in partnership with Optum Health to create a process for prior authorization with the least disruption to current workflow. The newly established TBS Prior Authorization Request & Referral Form replaces the current TBS Referral Form adding the required elements outlined by the State.

The new TBS Prior Authorization Request & Referral Form includes:

- TBS Class Criteria
- Medical Necessity Criteria
    - Diagnosis
    - Demonstrated Impairment Intervention Criteria
    - Identification of supporting documentation
    - TBS service request including scope, amount and duration

The new TBS Prior Authorization Request & Referral Form serves as both the authorization request and referral to TBS. The process is the following:

- Specialty Mental Health Provider (SMHP) submits the TBS Prior Authorization Request & Referral Form to Optum via FAX
- Optum reviews and provides authorization determination within five business days of receipt
- Optum sends authorization determination to TBS provider with the approved authorization serving as a referral to the TBS provider

Although TBS referral may be initiated by school staff, CWS, probation, etc., it requires that a Specialty Mental Health Provider (SMHP) is serving the youth and billing Medi-Cal; therefore, it is best when SMHP submits the authorization/referral.

Please review the attached TBS Prior Authorization Request & Referral Form and the Explanation Sheet which includes detailed instructions on how to complete the form.

Thank you,

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County of San Diego Mental Health Plan

Therapeutic Behavioral Services (TBS)
Prior Authorization Request & Referral Form

2019

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

Note: TBS referral may be initiated by school staff, CWS, probation, etc., but requires that a Specialty Mental Health Provider (SMHP) is serving the youth and billing Medi-Cal; therefore, it is best when SMHP submits the authorization/referral.

COMPLETION REQUIREMENTS:

1. TBS Prior Authorization Request & Referral Form is completed and submitted to Optum for prior authorization for all clients being referred to TBS
2. Continuing request is completed by TBS provider and must be submitted to Optum at least 7 calendar days before previous authorization expires
3. Prior authorization must be obtained before TBS services are initiated
4. Once authorized by Optum, the form is sent by Optum to TBS provider as an authorized referral

DOCUMENTATION STANDARDS:

The following elements of the TBS Prior Authorization & Referral From must be addressed

1. Youth Information
   - Must include name, DOB, Medi-Cal or SSN, current address, parent/caregiver name and phone number
2. Referring Party/Therapist Information
   - Completed by SMHP including FFS/TERM Therapist who is claiming Medi-Cal services
3. Additional Referring Party Information; when applicable
   - Complete only if referring party is not the SMHP
4. Child Welfare Service or Probation Involvement *(select yes or no)*
   - If 'yes', identify name, phone number, FAX and email of Social Worker or Probation Officer
5. Other Party Involvement; when applicable
   - Identify additional supportive figures; i.e., CASA, Mentor, Big Brother/Sister, Attorney, etc.
6. Specific Request Regarding TBS Coach *(optional)*
   - Identify client's preference regarding language, culture, gender, etc.
7. TBS Class Criteria/Eligibility
   - Must be completed by the SMHP
     1) Confirm the youth is under 21 and a full scope Medi-Cal beneficiary
     2) Confirm the youth is receiving Specialty Mental Health Services from a Medi-Cal provider
     3) Confirm the conditions for eligibility: *(must check a minimum of one)*
        - Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option or has had at least one emergency psychiatric hospitalization within the past 24 months

- Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs Youth may need out of home placement
- Youth may need out of home placement, a higher level of residential or acute care
- Youth is transitioning to a lower level of care and needs TBS to support the transition
- Youth has previously received TBS while a member of the certified class
- Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

8. Medical Necessity Criteria
   - Must be completed by the SMHP
     1) Current diagnosis
     2) Identify the impairment *(one must apply)*
        - Impairment in an area life functioning
        - Significant deterioration in an area of life functioning
        - Probability of not progressing developmentally as individually appropriate
     3) Intervention criteria met by client *(all three must apply)*
        - TBS intervention will address client's condition/impairment
        - TBS will significantly diminish impairment, prevent significant deterioration or allow client to progress developmentally
        - Condition would not be responsive to physical health care- based treatment
     4) Indicate date of Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR) or Progress Note demonstrating impairment criteria so Optum may review in electronic health record
     5) Select the scope, duration and amount of TBS services being requested

   - SMHP enters date authorization request form was submitted to Optum

Please note that the Authorization Determination start date is the first day that TBS may be provided. The end date must be no longer than six months from the start date. A continuing authorization may be submitted for an additional duration of service and will be completed when indicated by the TBS provider.

9. Authorization Determination
   - Optum will make a determination to approve the request when Class Criteria and Medical Necessity are met
   - Optum will send the approved authorization/referral to referring provider and TBS provider which will include:
     - Start and end date for TBS services (scope, amount and duration)
     - Approval of any additional requested hours, when applicable

   or
   - Optum will deny, modify, reduce, terminate or suspend TBS request
     - An NOABD will be sent to beneficiary and referring provider

If Optum is unable to confirm SMHP, the referral will be sent to TBS provider to confirm active SMHP claiming Medi-Cal, which may impact the processing time lines for authorization review

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

THERAPEUTIC BEHAVIORAL SERVICES (TBS)
PRIOR AUTHORIZATION REQUEST & REFERRAL FORM

☐ Initial Request (submitted by SMHP) ☐ Continuing Request (6 mos.) (Submitted by TBS provider)

* Indicates a required section for Initial Requests

Youth Information*:

*Name: _____	*DOB: _____	*Medi-Cal or SSN: _____
*Current Address: _____		
School: _____	School District: _____	
*Parent/Caregiver Name: _____	*Parent/Caregiver Phone: _____	

Referring Party/Therapist Information*: ***Please Note: Client must be receiving services from a Specialty Mental Health Provider (SMHP) billing Medi-Cal.***

*SMHP Name: _____	*SMHP Credential: _____
*SMHP Program Name: _____	*Address: _____
*Phone: _____	*Fax: _____

Additional Referring Party Information: (*If same as SMHP, please leave blank)*

Name: _____	Agency: _____	Relationship: _____
Address: _____		
Phone: _____	Fax: _____	E-Mail: _____

CWS/Probation Involved: ☐ Yes ☐ No CWS Contact Name: _____ Probation Contact Name: _____

Phone: _____	Fax: _____	E-Mail: _____

Other Party Involvement: *(i.e. CASA, Mentor, Attorney, Big Brother/Sister, etc.)*

Name/Relationship: _____	Contact Phone: _____
Name/Relationship: _____	Contact Phone: _____

Specific requests with regard to TBS Coach's language, culture, gender, etc.: _____

TBS Class Criteria / Eligibility (Completed by SMHP)* – *All questions below require completion.*

1. Is Youth a full-scope Medi-Cal beneficiary under age 21? ☐ **Yes** ☐ **No** **AND**
2. Is Youth receiving specialty mental health services from a Medi-Cal funded therapist/case manager? ☐ **Yes** ☐ **No**
3. Which of the following conditions have been met by the Youth? *(*Check all that apply, must check a minimum of 1)*

- ☐ Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** has had at least one emergency psychiatric hospitalization within the past 24 months
- ☐ Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs
- ☐ Youth may need out of home placement, a higher level of residential or acute care
- ☐ Youth is transitioning to a lower level of care and needs TBS to support the transition
- ☐ Youth has previously received TBS while a member of the certified class
- ☐ Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

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Medical Necessity Criteria, completed by the SMHP*:

1. ***Diagnosis for focus of TBS**: _____
2. ***Client demonstrates impairment as a result of the included diagnosis** (*at least one of the following applies*):
   - ☐ significant impairment in an important area of life functioning
     e.g., living situation, daily activities, or social support

     OR
   - ☐ a reasonable probability of significant deterioration in an important area of life functioning

     OR
   - ☐ a reasonable probability a person under 21 years of age will not progress developmentally as individually appropriate
3. ***Client meets each of the intervention criteria listed below:**
   - A. ☐ The focus of the TBS intervention will address the condition/impairment
   - B. Expectation that TBS will:
     - ☐ Significantly diminish the impairment **OR**
     - ☐ Prevent significant deterioration in an important area of life functioning **OR**
     - ☐ Allow the child to progress developmentally as individually appropriate
   - C. ☐ The condition would not be responsive to physical health care-based treatment
4. ***Date of most recent Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR), or Progress Note that demonstrates the above criteria** Click to enter a date.
5. *SMHP Clinician is requesting the following TBS services: ***(Must include amount, scope & duration)***
   - ☐ Up to 25 hours of TBS Intervention per week - **amount**
   - ☐ TBS **scope** inclusive of Assessment (SC48), Plan Development (SC46), Intervention (SC47) and Collateral (SC49)
   - ☐ Up to 6 months of TBS Intervention – **duration**
   - ☐ Other *(explain any changes to amount, scope or duration being requested. Please note each authorization cycle is 6 months- Re-authorization may be obtained for additional services)*:

     _____

SMHP submitted form to Optum on: Click to enter a date.
(Optum shall notify provider of determination within 5 business days of receipt)

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed BHA, OAR or Progress Note**
☐ **TBS scope, amount and duration authorized as requested: START DATE**: _____ **END DATE**: _____
☐ **Additional TBS hours authorized per week** (beyond 25 hours per week): _____
TBS Request is Reduced/Modified as follows: ☐ **scope** _____ ☐ **amount** _____ ☐ **duration** _____
TBS request is ☐ **denied** ☐ **modified** ☐ **reduced** ☐ **terminated or** ☐ **suspended**
NOABD was issued to the beneficiary and provider on the following date: _____
☐ Optum unable to confirm SMHP. Authorization is contingent on TBS provider confirming active SMHP claiming Medi-Cal.

Optum Clinician Signature/Date/Licensure:

Typically, within two business days of Optum clinician signature, authorization will be forwarded to TBS and referring provider

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^Date pre-authorization received by TBS Provider: _____ (^*completed by New Alternatives)*