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| County of San Diego Mental Health Plan**Prior Authorization Day Services Request (DSR)**Submit At Least 5 Business Days Prior To Projected Start Date

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| **Please Check:** | [ ]  **Initial Request (prior to services)** |
| [ ]  **Continuing Request (STRTP required every**  **90 Days, SPA every 180 Days)** |
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 | **FAX TO: (866) 220-4495** Optum Public Sector San DiegoPhone: (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:**       **Fax**:       | **Program Name:**      **Unit#:**       | **Phone**:      **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):**

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|  | [ ]  STRTP Hybrid Day Rehab and Outpatient Services  (Up to 90 days) |  | Sa[ ]  [ ] 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 |

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| **MEDICAL NECESSITY CRITERIA FOR DAY SERVICES** |
| **DIAGNOSIS**: Provide the DSM/ICD Mental Health diagnoses that are the focus of mental health treatment.

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

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|  **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 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:
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| **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) Ancillary Specialty Mental Health Services (SMHS) Request Form 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 day1. **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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| **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:      1. **Describe the impact of these services towards the achievement of Client Plan Goals (include progress toward goals of transitioning to lower level of care):**
2. **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):
3. **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** 1. **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**
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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**

**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**: