COUNTY OF Placer
HEALTH & HUMAN SERVICES
ADULT SYSTEM OF CARE

Mental Health
Substance Use Disorder
Adult Protective Services
In-Home Supportive Services
Public Guardian/Administrator

March 12, 2021

Facility Name
Attn:
Street Address
City, State Zip

Re: Placer-Sierra County MHP Concurrent Authorization for Psychiatric Inpatient Services

To:

On May 31, 2019, California Department of Healthcare Services (DHCS) issued DHCS IN 19-026 requirement for concurrent review authorization of psychiatric inpatient hospital services and psychiatric health facility services. We are excited to announce Placer-Sierra MHP will begin the concurrent review process effective **April 12, 2021**.

Placer/Sierra County is responsible to ensure services provided by an inpatient psychiatric hospital are medically necessary and must comply with all requirements necessary for Medi-Cal reimbursement through concurrent documentation review. The change from retrospective authorization to concurrent review and authorization should not impact your process for accepting/admitting and discharging/placing Placer/Sierra County responsible clients. When discharging/placing a Placer-Sierra County adult client, please continue to contact Terry Lopez to coordinate their aftercare appointment.

After the 24hour notification of a Placer/Sierra County Beneficiary has been given, a clinician will contact the hospital for concurrent review. Admissions taking place on the weekend, or County holiday, shall be authorized until the next available business day. Upon the next available business day, days of service(s) shall be reviewed concurrently going forward.

Concurrent review will be completed Monday-Friday from 8:30-11:00 am. Client's documentation is to be faxed, emailed, or called in by 11:00 on the day the authorization ends to request additional authorization days.

The final confirmation and approval of all inpatient hospital services will be completed when the TAR is received from the hospital. Hospitals are required to submit the TAR to Placer/Sierra County per Title 9 regulations.

Adult System of Care ▪ 11512 B Avenue, Auburn, CA 95603 ▪ PlacerQM@placer.ca.gov
(530) 889-2929 office ▪ www.placer.ca.gov ▪ (530) 886-2940 fax

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Documents Required for Concurrent Review
See attachment – *List of Required Documents for Concurrent Review 04.12.2021*.

Placer/Sierra County Authorization Form
For your reference. See attachment – *Placer IP MH concurrent review worksheet (1-pager)*

Contact Information for Document Submission
Phone: 530-886-2929 to be redirected to reviewing clinician.
Fax: 530-886-2940
Email: PlacerQM@placer.ca.gov, all emails must be encrypted.

Reviewing Clinicians
Danielle Gold
Debbie DiIanni
Julia Soto
Kaitlyn Brown

Please see the enclosed overview of the process that will occur between the facility and Placer/Sierra County UR clinicians.

For additional support or questions regarding the Concurrent Review Process, please contact PlacerQM@placer.ca.gov or Kaitlyn Brown at (530) 886-2925, Quality Management Supervisor.

Sincerely,

Stacie Dunn
Senior Administrative Clerk
Quality Management | SOC | HHS
(530) 886-2929 | Fax (530) 886-2940
placer.ca.gov | sdunn@placer.ca.gov

COUNTY OF Placer
HEALTH & HUMAN SERVICES
ADULT SYSTEM OF CARE

Concurrent Review and Authorization of Psychiatric Hospitalizations, Crisis Residential Programs, and Adult Residential Facilities.

Effective April 12, 2021

PURPOSE

The purpose of this policy is to outline the process for authorization for Specialty Mental Health Acute residential services (except STRTP) provided to Placer/Sierra County Medi-Cal beneficiaries through the MHP when medical necessity is established. This policy refers to the following services: All Inpatient psychiatric hospitalizations, Crisis Residential Programs and Adult Residential Facilities.

This policy also outlines the responsibility and timelines of the MHP to complete concurrent reviews in order to determine whether medical necessity supports additional authorizations for services.

DEFINITIONS

Acute day: Psychiatric inpatient care and services provided to all persons, from Placer County who, due to a mental disorder cannot resolve his/her problems in a less restrictive, available community setting and, who require the level of protection and security available in an acute, 24-hour setting.

Administrative day: A standard inpatient service type used when a patient is eligible for discharge. Medical necessity is no longer evident, but a suitable placement cannot be located.

Beneficiary: A person who is entitled to Covered Services and who on the date of health care services are rendered has satisfied the eligibility requirements and provisions of a Treatment Plan. May also be referred to as the “Patient.”

Benefits: The dollar amount payable for a Covered Service after application of deductibles and co-insurance.

Concurrent review: The process of completing periodic documentation reviews during the delivery of services to determine medical necessity for services is still met.

Covered services: Any health care services authorized and provided under the beneficiary’s treatment plan.

Day of service: A measure of time during which a beneficiary receives Covered Services and which occurs when a bed is occupied as of 12:00 midnight, or when a patient is admitted and discharged within the same day, provided that such admission and discharge are not within twenty-four (24) hours of a prior discharge.

Covered services: Any health care services authorized and provided under the beneficiary’s treatment plan.

Host county: The county where the facility is physically located, and treatment of county patients is occurring.

Medical necessity: Clinical documentation shall be provided by the hospital to the POA for each day of service and must meet the following Medical Necessity criteria for admission to a psychiatric inpatient hospital per Title 9:

A. Have an included diagnosis
B. Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion
C. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:
    a. Has symptoms or behaviors due to a mental disorder that (one of the following):
        i. Represent a current danger to self or 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.
    b. Require admission for one of the following:
        i. Further psychiatric evaluation.
        ii. Medication treatment.
        iii. Other treatment that can be reasonably provided only if the beneficiary is hospitalized.

Notice of Adverse Benefit Determination (NOABD): Determinations made by the Placer-Sierra MHP involving medical necessity, appropriateness and setting of covered benefits, and financial liability (see policy RE 210). A NOABD is defined to mean any of the following actions:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
B. The reduction, suspension, or termination of a previously authorized service;
C. The denial, in whole or in part, of payment for a service;
D. The failure to provide services in a timely manner;
E. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
F. The denial of a beneficiary's request to dispute financial liability.

Provider: The legal entity providing the Short-Doyle or Medi-Cal Services.

Point of Authorization (POA): Staff member or authorization committee who receives notice of inpatient hospitalizations 24 hours per day and reviews the requests for payment authorization

relating to the Treatment Authorization Request (TAR) to approve, deny, and/or modify those requests for Placer and Sierra County as a partnership MHP. The POA must be a licensed mental health professional or licensed waivered/registered professional. The POA can delegate the authorization function to another qualified staff member of the MHP when necessary.

The Placer/Sierra County MHP has one central point of contact. The TARs are logged by the assigned Senior Administrative Clerk and then forwarded to the appropriate POA clinician, or designee, for review and approval, denial and/or modification. Placer/Sierra County POA is:

Placer County Mental Health
ATTN: TAR Processing
11512 B Avenue
Auburn, CA 95603
Phone: (530) 886-2929
Fax: (530) 886-2940

Qualified designee: A qualified designee of the Placer/Sierra County POA is an individual who does not directly report to the POA but has been identified and credentialed (see policy QM 311) to meet the professional requirements of a licensed practitioner of the healing arts (LPHA) or a waivered LPHA for the purposes of reviewing and approving medically necessary services. Qualified designees for the purpose of denying or modifying services due to not meeting medical necessity criteria shall be credentialed to meet the professional requirements of a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or when permissible a psychologist.

Treatment plan: The agreed upon plan of health care services to be rendered to the beneficiary by the provider agency.

PROCEDURE

I. Authorization for Emergency Admissions to Inpatient Facilities

A. Emergency admissions of Medi-Cal beneficiaries, whether voluntary or involuntary, are exempt from pre-authorization requirements for psychiatric inpatient hospital services or to a psychiatric health facility (PHF)

B. (CCR Title 9, Chapter 11, §1820.225), when the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter, or clothing. Upon notification by a hospital, the Qualified Designee, shall authorize payment for out-of-network services when a beneficiary of the Placer-Sierra MHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services. After the date of admission, hospitals must request authorization for continued stay services for the beneficiary subject to concurrent review.

1. Notification of admission - The provider is to notify the Placer/Sierra County MHP Point of Authorization within 24 hours of admission or within the

timelines established in the hospital contract, if applicable. When requests for authorization for a hospital admission are received by the POA, they are reviewed by the POA clinical staff, or qualified designee, during regular business hours, Monday through Friday. Hospitals will call or fax the POA notifying of the admission, followed by sending clinical documentation either by fax or secure email to the Placer County POA for review.

2. Weekend/Holiday admissions – Admissions taking place on the weekend, or County holiday, shall be authorized until the next available business day. Upon the next available business day, days of service(s) shall be reviewed concurrently going forward.

3. Authorization of multiple days – Placer County POA, or a qualified designee, will automatically authorize upon admission, not to exceed the first 72 hours of the beneficiary's involuntary hold. Additionally, the POA will authorize multiple days of service that overlap into a weekend or holiday. Example: beneficiary is admitted on Thursday and Friday is a holiday. The POA will authorize for Friday and the weekend, followed by concurrent review on Monday (or the next available business day).

4. Concurrent review – It is the responsibility of the Placer County POA, or qualified designee, to ensure services provided by an inpatient psychiatric hospital, or PHF, are medically necessary and must comply with all requirements necessary for Medi-Cal reimbursement through concurrent documentation review. Daily concurrent review may be waived if services receive prior approval through the weekend and/or holiday or should the beneficiary be admitted on a weekend and/or holiday. Admissions and services rendered on a weekend or holiday shall not be subject to denial or modification.

5. Continued stay services – A hospital will be reimbursed when a beneficiary experiences one of the following:

    a. Continued presence of indications that meet the medical necessity criteria;
    b. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization;
    c. Presence of new indications that meet medical necessity criteria; and,
    d. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

6. Administrative days – The Qualified Designee will authorize inpatient Administrative Days in accordance with Title 9. Beneficiaries who no longer meet acute care criteria (see above medical necessity definition), but who are

waiting for discharge to a placement such as a group home or a non-acute residential treatment facility, must meet administrative day criteria. A Qualified Designee shall review documentation sufficient to determine the criteria are met for administrative days claimed for reimbursement of Federal Financial Participation in accordance to Title9.

7. Authorization of administrative day: In order to authorize for administrative day service claims, the POA, or a qualified designee, shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative days status can be authorized. A Qualified Designee may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The psychiatric inpatient facility/provider shall document the lack of appropriate facilities to include the status of the placement, date of the contact and the signature of the person making the contact. Examples of appropriate placement status options include, but may not be limited to, the following:

    a. The beneficiary's information packet is under review;
    b. An interview with the beneficiary has been scheduled for [date];
    c. No bed available at the non-acute treatment facility;
    d. The beneficiary has been put on a waitlist;
    e. The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
    f. The patient has been rejected from a facility due to [reason]; and/or
    g. A conservator deems the facility to be inappropriate for placement.

8. TAR acceptance – The final confirmation and approval of all inpatient hospital services will be completed when the TAR is received from the hospital. Hospitals are required to submit the TAR to the Placer County POA per Title 9 regulations. Placer County POA staff will scan the TAR, and all clinical documentation received pertaining to the beneficiary's inpatient services, into the Placer County Electronic Health Record (EHR). If during review by the Placer County POA, the TAR appears to have been altered in any way, the TAR will be returned to the hospital and a corrected TAR will be requested from the hospital. Upon submission (or resubmission if necessary), Placer County POA reviews and submits the reviewed and completed TAR to the Medi-Cal fiscal intermediary when completed.

II. Denial and Modification for Psychiatric Inpatient Hospital and PHF Services

A. All denials or modifications as a result of a beneficiary not meeting Medical Necessity criteria per Title 9 shall be determined by an MD, DO, or when permissible, a psychologist and communicated in writing within 24 hours of the decision to treating providers, including both the hospital and the treating physician.
B. Care shall not be discontinued until the treating provider(s) have been notified and a care plan has been agreed upon by the provider that is appropriate for the medical needs of the beneficiary.
C. When the Placer County POA, or qualified designee, denies, modifies or reduces services an appropriate NOABD shall be issued to the beneficiary in accordance with County policy (see RE 210).

III. Retrospective Authorization

A. Placer County SOC shall provide retrospective authorization when requests are made to the POA only during the following circumstances:

a. Retroactive Medi-Cal: When a beneficiary's Medi-Cal eligibility retroactively changes. For example, when the POA receives a TAR for an individual that had a different county of responsibility at the time of hospitalization but may be in the process of transitioning to Placer County Medi-Cal. Once the transition is complete, Medi-Cal eligibility will retro back to the first of the month they applied for Placer Medi-Cal making the responsibility Placer County's.

b. Inaccuracies in Medi-Cal Eligibility Data System (MEDS): When a beneficiary's eligibility in the MEDS system is inaccurate and they are in fact the responsibility of Placer or Sierra County Medi-Cal. These instances may include, but are not limited, to a beneficiary already set up and receiving services from Placer County, evidence of the beneficiary's desire to be established in Placer/Sierra County, issues from MEDS inaccuracies or changes in the social security numbers that may impact the adopted population, foster youth population, or undocumented status.

c. Other health Care coverage: When issues arise due to authorization of inpatient services with other health care coverage is pending evidence of billing, including dual-eligible beneficiaries.

d. Beneficiary's failure to identify payer: Due to circumstances when a beneficiary is unable or refuses to identify health care coverage or information that would allow the provider to make a determination.

B. Once one of the four conditions are met, a Qualified Designee will conduct a retrospective review to ensure Medi-Cal necessity was met. Retrospective authorization

requests that do not meet the retroactive criteria listed above or do not meet medical necessity shall be denied (or modified if partially met).

C. In cases where the review is retrospective, Placer County SOC's authorization decision shall be communicated by the POA to the beneficiary, or designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated with the hospital consistent with state regulation.