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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   |  |  | | --- | --- | | **Please Check:** | **Initial Request (prior to services)** | | **Continuing Request (STRTP required every**  **90 Days, SPA every 180 Days)** | |  | | | | | **FAX TO: (866) 220-4495**  Optum Public Sector San Diego  Phone: (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):**   |  |  |  |  | | --- | --- | --- | --- | |  | 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 | | | | | | | | | |
| **MEDICAL NECESSITY CRITERIA FOR DAY SERVICES** | | | | |
| **DIAGNOSIS**: Provide the DSM/ICD 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 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: | | | | |
| **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 day   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: | | | | |
|  | | | | |
| **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**: