Optum

San Diego Inpatient Concurrent Review Authorization Process

Updates from BHIN 22-017, issued April 15, 2022

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Psychiatric Inpatient Hospital or Psychiatric Health Facility (PHF) to be referred to hereafter as "Hospital" in this document

For questions, please visit optumsandiego.com, "BHS Provider Resources", then "Fee For Service Providers" and "Inpatient Authorization Requests". There you will also find the "San Diego County Inpatient Operations Handbook" or you may contact the Optum Provider Line 24/7 at 800-798-2254, Option 3, then Option 1 for an Inpatient Utilization Management representative.

1. Psychiatric Inpatient Hospital Admission Criteria and Continued Stay Criteria
Hospital* authorization request for acute admission or acute continued stay will be based on whether the beneficiary meets Inpatient Medical Necessity Criteria and will result in a determination to grant, modify, or deny the request.

-Title 9 CCR, Section 1820.205 (see MHSUDS INFORMATION NOTICE: 19-026), and;
-WIC Section 14184.02(a) for 21 years of age or older (see Appendix 6), and;
-Title 42 of the United States Code, Section 1396d(r)(5) for under 21 years of age (see Appendix 6).

Admission Criteria:

A. Have a Title 9 included ICD-10 diagnosis;
B. Cannot be safely and effectively treated at a lower level of care.
C. Requires Psychiatric Inpatient Hospital* services, as a result of a mental disorder, due to **one of the following (a. or b.)**:
    a. Has symptoms or behaviors due to a mental disorder that (**one** of the following):
        i. Pose danger to self or danger to others, or significant property destruction;
        ii. Prevent the beneficiary from appropriately providing or utilizing food, clothing, or shelter;
        iii. Pose a severe risk to the beneficiary's physical health;
        iv. Pose 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 reasonably only be provided if the beneficiary is hospitalized.

Continued Stay Criteria:
Continued stay in an acute psychiatric inpatient hospital* shall only be reimbursed when a beneficiary experiences **one** of the following:

A. Continued presence of indications that meet the medical necessity criteria as specified in **Admission Criteria.**
B. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
C. Presence of new indications that meets medical necessity criteria specified in **Admission Criteria.**
D. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital*.

2. Process for Admission Authorization and Continued Stay Authorization
Hospital* will contact Optum for initial admission and continued stay authorization requests for acute days and administrative (admin) days and notify Optum if client is admitting to a freestanding/Short Doyle hospital (see Appendix 8 for Visual Workflows). Optum will maintain **telephone access** to receive admission notification and authorization requests from hospitals* **24 hours a day, 7 days a week** at **800-798-2254, Option 3, then Option 1**.

A. **Admission** Notification and Authorization Request to Optum (up to 3 acute days and up to 1 admin day may be requested by the hospital).

Within 24 hours of admission of a San Diego Medi-Cal beneficiary to a psychiatric inpatient hospital*, the provider shall notify Optum via phone and also send a **FAX** to Optum at 866-220-4495, to provide a completed "Optum Inpatient Auth Request Fax Cover Sheet" (see Appendix 7) and all of the following minimally necessary information:

1) A completed face sheet (see Appendix 1)
2) Admission orders (see Appendix 2)
3) Initial plan for care (see Appendix 2)
4) A request from the hospital to Optum to authorize the beneficiary's treatment (with start date of authorization request, specifying number/type of days requested)

Hospital* initial treatment authorization request determinations to grant, modify, or deny the request will be communicated in writing to the requesting hospital* within 24 hours of receipt of all the items in section A. 1) through A. 4).

If upon admission, a beneficiary is experiencing a psychiatric emergency medical condition, the time period for hospital* to request authorization shall begin when the beneficiary's condition is stabilized. For emergency care, no prior authorization is required.

B. **Continued** Stay Authorization Request to Optum (up to 4 acute days and up to 7 admin days may be requested by the hospital).

Continued Stay Authorization Requests from San Diego County contracted hospitals, with all information reasonably necessary to make a determination, will be reviewed by Optum licensed clinician within 24-hours of receipt (fax request to 866-220-4495). When medically necessary for the beneficiary, **before** the end of the initial authorization period or a subsequent authorization period, the hospital* shall submit to Optum a continued stay authorization request. Request shall specify: type of day (acute or admin), number of days, and start date for the authorization**.** Hospital may use the "Optum Inpatient Auth Request Fax Cover Sheet." The treating provider(s) at the hospital* may request information from Optum needed to determine the appropriate length of stay for the beneficiary; Optum will identify and authenticate the caller before exchanging such information.

Optum will issue a decision in writing to grant, modify, or deny the San Diego County contracted hospital's* continued authorization request **within 24 hours** of receipt of the request and all information reasonably necessary to make a determination, including:

1) Continued plan for care which includes the beneficiary's relevant clinical information (see Appendix 3).
2) Information outlined in the "Optum Inpatient Auth Request Fax Cover Sheet", which specifies type of day (acute or admin), number of days, and start date of authorization request.

i. For acute day requests: please refer to the **Continued Stay Criteria.**
ii. For administrative day requests, please review the following a) to f):

a) Beneficiary must have at least **one** clinically approved acute psychiatric hospital* service AND the beneficiary no longer meets medical necessity criteria for acute psychiatric hospital* services, but has not yet been accepted for or is awaiting placement at a non-acute residential treatment facility (as determined by the County of San Diego) in a reasonable geographic area.

b) **Starting with the day the beneficiary is placed on administrative day status**, hospital* will provide proof of 5+ contacts to the non-acute residential treatment facilities per week, by making **at least one contact per day** (except weekends and holidays) to the non-acute residential treatment facility (specific examples in Appendix 5). Document each contact, including:

- The status and outcome of the potential discharge placement
- Date of the contact;
- Name & signature of the person making the contact;

To be eligible for administrative days during retroactive authorization request, hospitals* still need to make required calls to non-acute residential treatment facilities, even if Medi-Cal funding is not active at time of admission.

c) A non-acute residential treatment facility includes:
For Adult and Older Adult:

i. Crisis Residential Treatment Services/CRTS (**requires daily contacts, including weekends and holidays**)/Adult Residential Treatment Services (ARTS), or
ii. Skilled Nursing Facility (SNF), or
iii. Institution for Mental Disease (IMD)/Special Treatment Program (STP)
iv. Administrative Days may **not** be used for clients awaiting placement in non-mental health treatment settings such as Board and Care facilities, Independent Living Facilities, or Substance Use Disorder (SUD) treatment programs.
v. For more information regarding San Diego County-funded LTC facilities for adults, please call Optum Provider Line at (800)798-2254, option 3 for Authorizations, then option 5 for Long Term Care.

For Children and Adolescents:

i. Placements through probation, Child Welfare Services, or San Diego and Imperial County Regional Center as outlined by the County of San Diego. **see "San Diego County Inpatient Operations Handbook" for additional placement options,* by visiting optumsandiego.com, "BHS Provider Resources", then "Fee For Service Providers" and "Manuals" or you may contact the Optum Provider Line 24/7 at 800-798-2254, Option 3, then Option 1 for an Inpatient Utilization Management representative.

Note: For Regional Center consumers, psychiatric hospitals will be paid for administrative days by the Regional Center in accordance with written agreements with each hospital.*

d) 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 admin day status can be authorized.
e) Hospital* **will not** receive authorization for the days in which a contact has not been made **until and unless all five required contacts are completed and documented**.
f) Optum may waive the requirement of five contacts per week if there are fewer than 5 appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. However, hospitals* still need to make at least 1 call and document each contact.

3. Clinical Consultation

While reviewing an authorization request, Optum may communicate with the treating provider(s) and the treating provider(s) may adjust the authorization request in writing prior to Optum rendering a formal decision. Treating provider(s) may also request a clinical consultation with an Optum Medical Director or Associate Medical Director(s) when appropriate to determine whether they would like to submit an authorization request.

4. Adverse Decision, Developing Plan of Care, Expedited/Informal Appeal Review, Formal Appeal

A. When an Optum Medical Director or Associate Medical Director(s) modifies or denies an admission or continued stay authorization request, Optum will do both 1) and 2)
   1) Notify the treating provider(s) initially by telephone, and then in writing with a letter of Non-Authorization of Reimbursement for Psychiatric Inpatient Hospital* Services. The denial letter will include a clear and concise explanation of the reasons for the decision regarding medical necessity and the name and direct telephone number of the professional who made the authorization decision and offer the treating provider an opportunity to consult.
   2) Notify the beneficiary in writing of the adverse benefit determination (NOABD)/denial via mail within two business days of the determination.

B. If an Optum Medical Director or Associate Medical Director(s) denies a hospital's* authorization request, Optum will work with the treating provider(s) to develop a plan of care. For example, Optum may provide discharge placement suggestions that may qualify for administrative days. **Hospital* may choose to do an Expedited/Informal Appeal Review** if they disagree with the authorization denial. Services and payment for services shall not be discontinued until the beneficiary's treating provider(s) has been notified of Optum's decision and a care plan has been agreed upon by the treating provider(s) that is appropriate for the medical and behavioral health needs of the beneficiary.

Expedited/Informal Appeal Review

An Expedited/Informal Appeal Review of a denial/non-authorization may be requested by the attending physician or the treating provider at the hospital*. To request such a review, the following circumstances apply:

1) The beneficiary must still be inpatient at the psychiatric facility. If the beneficiary has discharged from the facility, the Expedited/Informal Appeal Review is invalid, and the facility may utilize the formal appeal process.
2) The attending physician or the treating provider may submit to Optum **complete information and supporting documentation** for Expedited/ Informal Appeal Review within two (2) business days of the date on the notification of denial/non-authorization. If Expedited/Informal Appeal request is received by Optum beyond two (2) business days, request is invalid and the facility may utilize the formal appeal process.
3) Only **one** Expedited/Informal Appeal Review can be submitted per denied authorization request. The facility may utilize the formal appeal process in the event that a second denial is issued.
4) Once an Optum Medical Director or Associate Medical Director has reviewed the request and supporting documentation for Inpatient Medical Necessity criteria, a determination to uphold or overturn the denied authorization request is made.
5) The UM clinician shall notify the hospital* of the determination within two (2) business days of the date request was received. Requests may result in one of the following outcomes:

    i. Denial is **overturned**: Optum staff will enter the authorization, provide verbal notification and then written notification within 24 hours of the determination to the hospital*.

    ii. Denial is **upheld:** hospital* may utilize the formal appeal process. See "Non-Authorization of Reimbursement for Psychiatric Inpatient Hospital Services" letter for detailed instructions on the formal appeal process.

C. Denial of an authorization request and consultation between the treating provider(s) and Optum may result in one of the following outcomes:
    1) Optum and the treating provider(s) agree the beneficiary shall continue inpatient treatment at specified level of care, and the denial is reversed.
    2) Optum and the treating provider(s) agree to discharge the beneficiary from the inpatient level of care, and a plan of care is established prior to the beneficiary transitioning to services at another level of care.
    3) Optum and the treating provider(s) agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down level of care bed is not available AND the beneficiary remains in the hospital*, on administrative day level of care.
    4) If Optum suggests an alternate plan of care for beneficiary discharge (such as providing step-down options that qualify for administrative days), and the treating provider(s) do not agree on a plan of care, the beneficiary, or the treating provider on behalf of the beneficiary, may informally or formally appeal the decision to Optum.

5. Retroactive Authorization Request After Client Discharges

To request a retroactive authorization, hospital* will submit to Optum clinical documentation for the whole stay **via physical mail (Optum Public Sector Utilization Management, PO BOX 601370, San Diego, CA 92160-1370)** with **ALL** the below required items (see **Appendix 4** for more details):

A. Hospital* will include a letter **explaining the reason why the request is being submitted retroactively**, along with the admit and discharge dates of the stay and client demographic information. Include proof of **San Diego Medi-Cal eligibility** covering the dates of service. Please include chart notes for the entire stay.

B. Retroactive authorization requests to Optum should occur only under one or more of the following limited circumstances **per MHSUDS Info Notice 19-026**:
    1) Retroactive Medi-Cal eligibility determinations;
    2) Inaccuracies in the Medi-Cal Eligibility Data System;
    3) Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries;
        a. If the patient has other health coverage, psychiatric inpatient hospital* or Psychiatric Health Facility (PHF) must bill them first prior to billing Medi-Cal. If denied by other health coverage, please include your remittance sheet or denial from other health coverage.
    4) Beneficiary's failure to identify payer.
C. Submission of retroactive authorization requests should be received by Optum **within 4 months** from the date of discharge, or from the date the hospital was notified of the client's retroactive eligibility, or circumstance outlined in **section B.1) through B.4) above**.
D. See Appendix 4 for TAR/UB04 submission instructions
E. Failure to submit within 4 months of discovering circumstances outlined in **section B.1) through B.4) above** may result in administrative denial which involves no clinical review for medical necessity.
F. If request meets the requirements outlined in **section B.1) through B.4) above,** Optum licensed clinician will review the clinical documentation and make a determination to grant, modify, or deny the authorization request based on Medical Necessity Criteria outlined in step 1, "Psychiatric Inpatient Hospital Admission Criteria and Continued Stay Criteria".
    1) Authorization decision will be made **within 30 days** of receipt of clinical documentation.
    2) Optum will notify the hospital* of the authorization decision **in writing**.
        a. Optum will send a copy of the completed TAR to the hospital and on to the fiscal intermediary. If any part of the authorization request does not meet medical necessity and is denied by the Optum Medical Director, an Optum clinician will complete the hospital denial letter and NOABD. Optum will mail the denial letter and NOABD to the requesting facility. Client will be mailed the NOABD within two business days of the determination.
        b. If denied, the program may utilize the formal appeal process.

Appendix 1: Face Sheet Information

The face sheet shall include the following information (if available):

1. Hospital* name and address
2. Patient name and DOB
3. Insurance coverage
4. Medi-Cal number and county of eligibility determination
5. Current address/place of residence
6. Date and time of admission
7. Working (provisional) diagnosis
8. Name and contact information of admitting qualified and licensed practitioner
9. Utilization Review staff contact information

Appendix 2: Clinical Information in Admission Order and Initial Plan of Care

This section must be completed by a qualified and licensed practitioner with hospital* admitting privileges who is knowledgeable about the beneficiary's condition and medical plan of care. The admission order/initial plan of care will include the following information (when applicable and available):

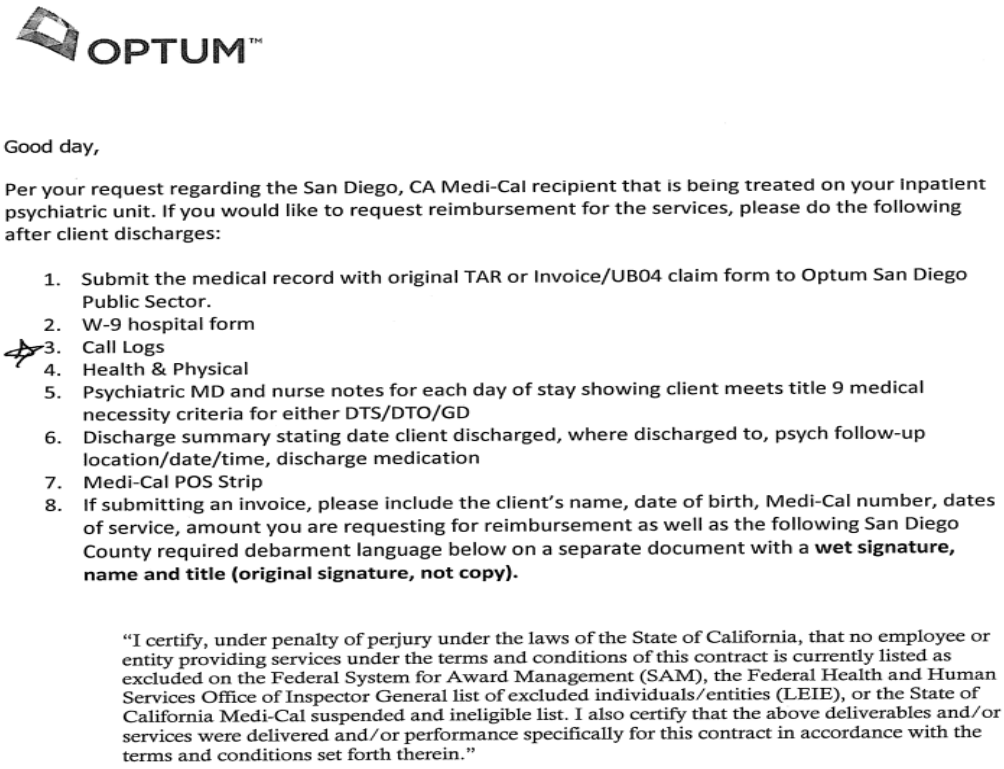
1. Diagnosis
2. Summary of symptoms and complaints
3. Complications that support admission
4. Functional description- both mental and physical
5. Medical History
6. Initial objectives for treatment
7. Medications and recommended treatment activities including restorative and rehabilitative services
8. Activities and therapies
9. Social services
10. Diet
11. Special patient safety procedures
12. Prognosis
13. Initial plans for continued care
14. Initial plans for discharge

Appendix 3: Recommended Clinical Information for Continued Stay Authorization(s)

1. **CURRENT NEED FOR TREATMENT** to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
2. **RISK ASSESSMENT** to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in D/C planning; updates regarding changes to SI/HI since admission; aggression/self-harm since admission; behavioral observations; historical trauma.
3. **PRECIPITATING EVENTS** if further identified/clarified by the treating hospital* after MHP admission notice.
4. **KNOWN TREATMENT HISTORY** as relates to this episode of care to include daily status (i.e., MD orders, daily progress notes, nursing notes, MD notes, social work notes, rounds sheet) of the treating hospital*.
5. **KNOWN MEDICAL HISTORY** to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.
6. **HOSPITAL* INFORMATION ON PRIOR EPISODE HISTORY** that is relevant to current stay. Optum may also share any relevant and clinically appropriate client history with the submitting hospital*.
7. **MEDICATIONS** to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
8. **SUBSTANCE USE** to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.
9. **TREATMENT PLAN** including any updates and changes to the initial treatment plan and evidence of progress/symptom management.
10. **DISCHARGE/AFTERCARE PLAN** to include recommended follow up care, social, and community supports, and a recommended timeline for these activities.
11. **NUMBER OF CONTINUING DAYS REQUESTED AND TYPE OF DAY (ACUTE/ADMIN) WITH REQUESTED START DATE OF AUTHORIZATION**

Appendix 4: TAR or UB04 Submission

1. Submit original TARs or UB04s from concurrent review along with Medi-Cal eligibility to Optum via mail within 14 days of discharge date to the following address:
   PO Box 601370 San Diego, CA 92160-1370
   - Please ensure to notate: Attn. UM Dept
2. Submit retroactive request TARs or UB04s along with Medi-Cal eligibility and "clinical packet" (see below) to Optum via mail within 4 months of discharge date.



OPTUM™

Good day,

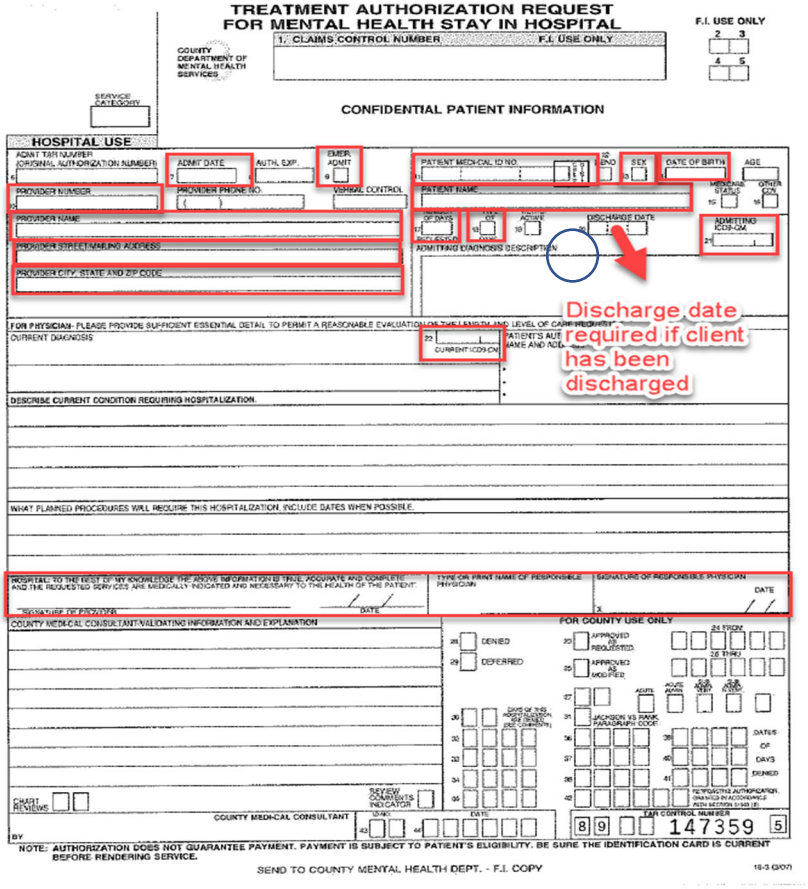
Per your request regarding the San Diego, CA Medi-Cal recipient that is being treated on your Inpatient psychiatric unit. If you would like to request reimbursement for the services, please do the following after client discharges:

1. Submit the medical record with original TAR or Invoice/UB04 claim form to Optum San Diego Public Sector.
2. W-9 hospital form
3. Call Logs
4. Health & Physical
5. Psychiatric MD and nurse notes for each day of stay showing client meets title 9 medical necessity criteria for either DTS/DTO/GD
6. Discharge summary stating date client discharged, where discharged to, psych follow-up location/date/time, discharge medication
7. Medi-Cal POS Strip
8. If submitting an invoice, please include the client's name, date of birth, Medi-Cal number, dates of service, amount you are requesting for reimbursement as well as the following San Diego County required debarment language below on a separate document with a **wet signature, name and title (original signature, not copy).**

"I certify, under penalty of perjury under the laws of the State of California, that no employee or entity providing services under the terms and conditions of this contract is currently listed as excluded on the Federal System for Award Management (SAM), the Federal Health and Human Services Office of Inspector General list of excluded individuals/entities (LEIE), or the State of California Medi-Cal suspended and ineligible list. I also certify that the above deliverables and/or services were delivered and/or performance specifically for this contract in accordance with the terms and conditions set forth therein."

3. If Medi-Cal is secondary insurance, please submit an Explanation of Benefits (EOB) or denial from primary insurance. Should the hospital discover after discharge that a client had Medi-Cal coverage as secondary coverage, the hospital is to submit:
   a) Completed TAR
   b) Verification of Medi-Cal for the dates of service
   c) Complete medical record
   d) Written explanation of why the TAR is being submitted retroactively

4. The following highlighted information is required for Optum to process your TAR:



5. Once Optum receives TAR, we will audit for completeness. If something is missing, we will return the TAR to the hospital* with a correction slip asking for a field to be corrected. Please correct the missing item and return to Optum **via mail**.

6. Optum will process complete TARs and fill out the bottom portion to send on to the state's fiscal intermediary within 14 calendar days. Optum will mail TARs to fiscal intermediary and fax hospital* a copy of processed TAR (to notify the hospital what day TAR was sent on for payment.)

7. Please allow the state <u>one month</u> to process TARs, starting from a week after Optum notifies hospital of processed TAR. If TAR is not showing on the Master File or is showing incorrectly on the Master File, please fax a copy of the TAR along with what needs to be corrected to Optum at 1-866-220-4495.

8. For questions about TAR submission, please contact the Optum Provider Line at 800-798-2254, Option 3, then Option 1 for an Inpatient Utilization Management representative.

Appendix 5: Administrative Day Call Log Examples for Clients awaiting Skilled Nursing Facility

Example #1 Week Day	**Sunday**	**Monday (Holiday)**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Contacts	Administrative Days Start requested by hospital* 0 Contacts made	0 Contacts made	3 Contacts made	0 Contacts made	2 Contacts made	0 Contacts made	0 Contacts made
Auth Decision	Authorized	Authorized	Authorized	Not Authorized	Authorized	Authorized	Authorized
Rationale	This is a weekend, no contact is required	This is a holiday, no contact is required	At least one contact was made	At least one contact was not made and the five contact requirement was not already met	At least one contact was made	The five contact requirement has been met, no contact required	This is a weekend, no contact is required

Example #2 **Week Day**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Monday**
Contacts	Administrative days start requested by hospital* 5 Contacts made	0 Contacts made	0 Contacts made	0 Contacts made	0 Contacts made	0 Contacts made	0 Contacts made
Auth Decision	Authorized	Authorized	Authorized	Authorized	Authorized	Authorized	Authorized
Rationale	At least one contact was made	The five contact requirement has been met, no contact required	The five contact requirement has been met, no contact required	The five contact requirement has been met, no contact required	The five contact requirement has been met, no contact required	This is a weekend, no contact is required	The five contact requirement has been met, no contact required

Example #3 **Week Day**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Monday**
Contacts	Administrative days start requested by hospital* 1 Contact made	0 Contacts made	1 Contact made	3 Contacts made	0 Contacts made	0 Contacts made	0 Contacts made
Auth Decision	Authorized	Not Authorized	Authorized	Authorized	Authorized	Authorized	Authorized
Rationale	At least one contact was made	At least one contact was not made and the five contact requirement has not been met	At least one contact was made	At least one contact was made	The five contact requirement has been met, no contact required	This is a weekend, no contact is required	The five contact requirement has been met, no contact required

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Appendix 6: WIC Section 14184.02(a) and Title 42 of the United States Code, Section 1396d(r)(5)

Welfare and Institutions Code section 14184.402(a), for individuals **21 years of age or older**, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary **to protect life**, **to prevent significant illness** or **significant disability**, or to **alleviate severe pain**.

For individuals **under 21 years of age**, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in **Section 1396d(r)(5) of Title 42** of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that **sustain, support, improve, or make more tolerable a mental health condition** are considered to ameliorate the mental health condition and are thus covered as EPSDT

Welfare and Institutions Code section 14184.402(a) for 21 years of age or older

14184.402 (a) Notwithstanding any other law, including, but not limited to, the applicable provisions of Chapter 11 (commencing with Section 1810.100) of Division 1 of Title 9, and Chapter 3 (commencing with Section 51000) of Subdivision 1 of Division 3 of Title 22, of the California Code of Regulations, commencing no sooner than January 1, 2022, all medically necessary determinations for covered specialty mental health services and substance use disorder services provided by a Medi-Cal behavioral health delivery system shall be made in accordance with Section 14059.5, except as provided in this section and any written instructions issued by the department pursuant to subdivision (j) until such time that regulations are promulgated or amended.

Section 1396d(r)(5) of Title 42 of the United States Code for under 21 years of age

(r)EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

Appendix 7: Inpatient Auth Request Fax Cover Sheet
Most updated version available at optumsandiego.com, “BHS Provider Resources”, then “Fee For Service Providers” and “Inpatient Authorization Requests”

Inpatient Auth Request Fax Cover Sheet

Call Provider Line at 800-798-2254, Option 3, then fax to 866-220-4495

Date:
Client name: # of pages (including cover sheet):
Hospital name Facility type: ☐ Fee for Service ☐ Short Doyle
Intake point of contact:
Phone #: Fax #:
UR point of contact:
Phone #: Fax #:

Admission & Insurance Information (required upon initial request and as changes occur)

Admit date: Medi-Cal or SSN:
Attending physician: Client DOB:
Legal status: San Diego Medi-Cal: ☐ Yes ☐ No
(72 hr/ 14 day/ 30 day/ T-Con/ P-Con/ Voluntary) If Medicare/OHC – Start date of Medi-Cal coverage:
(Must include EOB or letter of non-coverage)

Reason for admission: ☐ DTS ☐ DTO ☐ GD ☐ OTHER

☐ **Admit Auth Request**
Days requested (up to 3 Acute, up to 1 Admin)
Acute #: Start date Acute:
Admin #: Start date Admin:

Documents required:
- Complete face sheet (see Appendix 1 of Optum Auth Request Process)
- Admission orders
- Initial plan of care (see Appendix 2 of Optum Auth Request Process)
- If Admin Day, disposition plan/location – Call logs (if applicable)

☐ **Continued Auth Request**
Days requested (up to 4 Acute, up to 7 Admin)
End date of previous authorization:
Acute #: Start date Acute:
Admin #: Start date Admin:

Documents required:
- Continued plan of care (see Appendix 3 of Optum Auth Request Process)
- Additional information
- If Admin Day, disposition plan/location – Call log (if applicable)

☐ **Expedited/Informal appeal**
(Submit within 2 business days of NOABD fax date)

First denied date of service(s) on NOABD:

Documents required:
- Updated plan of care/additional information

☐ **Discharge**
Admission date:
Dates of Acute Days:
Dates of Admin Days:
Discharge date:

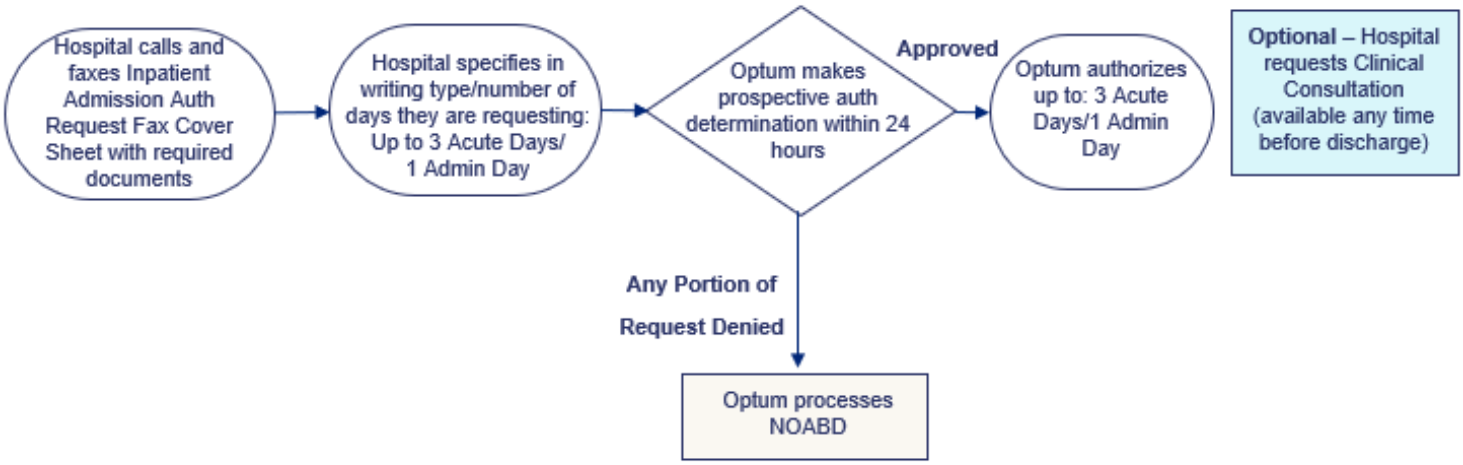
Documents required:
- Discharge plan/summary

☐ **Clinical consultation (unrelated to NOABD)**
Updated # of days requested (up to 4 Acute, up to 1 Admin)
Acute #: Start date Acute:
Admin #: Start date Admin:

Documents required:
- Updated plan of care/additional information

Appendix 8: Visual Workflows

Initial admission authorization request



Continued authorization request