COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Fax request to: Optum Public Sector SD
Phone: (800) 798-2254, option 3 then 4
Fax: (866) 220-4495

County of San Diego Behavioral Health Plan

IOP & PHP Prior Authorization – Day Services Request (DSR)

Initial Request (prior to services): ☐IOP (DIH) or ☐PHP (DIF)

Continuing Request: ☐IOP (DIH) (beyond initial 3 months) or ☐PHP (DIF) (beyond initial 1 month)

CLIENT INFORMATION		
Client Name: _____	**Client ID**: _____	**Client Date of Birth:** _____
DAY PROGRAM INFORMATION		
Legal Entity: _____	**Program Name:** _____	**Phone**: _____
Program Manager: _____	**SmartCare ID:** _____	**Fax**: _____

SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST

Day Intensive Half (DIH / IOP) at least 3 hours per day | Day Intensive Full (DIF / PHP) more than 4 hours per day

SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):

☐Intensive Outpatient Program (IOP – DIH up to 12 weeks) | ☐Partial Hospitalization Program (PHP – DIF up to 4 weeks)

AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)

☐Up to 3 Days Per Week ☐Up to 5 Days Per Week ☐Up to 7 Days Per Week

SUBMISSION DATE: _____

REQUESTED START DATE OF AUTHORIZATION: _____

Requested start date may be one business day after submission date.

When requested start date & initiation of services was prior to submission date, County COR approval required (through Optum).

Out of County Youth

☐Attach Notice of Presumptive Transfer (AB1299), OR

☐AAP/KinGAP – Attach SAR & written COR approval to serve youth under County contract due to intent to discharge youth to San Diego residence

MEDICAL NECESSITY CRITERIA FOR DAY SERVICES

Medical Necessity Criteria BHIN 26-002 Access Criteria or current guidance

DIAGNOSIS: Provide the ICD-10 mental health diagnoses that are the focus of mental health treatment

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

For beneficiaries **under 21 years of age**

1) 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 DHCS approved trauma screening tool | Score: _____
- ☐ Involvement in the child welfare system
- ☐ Juvenile justice involvement
- ☐ Experiencing homelessness

Additional information as needed: _____

OR

2a) Client has at least one of the following:

For beneficiaries **21 years of age or older**

1) The beneficiary has one or both of the following:

- ☐ Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities. | Explain: _____
- ☐ A reasonable probability of significant deterioration in an important area of life functioning. | Explain: _____

AND

2) The beneficiary's condition as described above is due to either of the following:

- ☐ A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD-10.

☐ 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

2b) The client's condition is due to <u>one</u> of the following:

☐ A diagnosed mental health disorder, according to the criteria of current editions of the DSM and the ICD-10.

☐ 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: _____

☐ A suspected mental disorder that has not yet been diagnosed. Suspected DSM/ICD Mental Health Diagnosis:

ANCILLARY SERVICES REQUEST (INTERNAL)

IOP (DIH) must request ancillary authorization (through this form) if client is going to receive Day Services and Outpatient Services from the same provider/program

Outpatient SmartCare Program ID #: _____

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 ☐ Other: _____
2. **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: _____

When a client is concurrently receiving SMHS from another provider, the IOP (DIH)/PHP (DIF) must request, obtain, and submit to Optum a stand-alone (external) <u>Ancillary Specialty Mental Health Services (SMHS) Request Form</u>

Program Clinician (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Licensed Clinician (Print): _____ **Credentials:** _____

Co-Signature: _____ **Date:** _____

Co-Signature required when Program Clinician is not a Licensed Mental Health Professional

FOR OPTUM USE ONLY

Optum completes and retains Prior Authorization Request. Within 5 business days of Optum receipt, authorization determination status will be visible to the requesting provider in SmartCare. Optum will also fax completed authorization to provider.

DAY SERVICES PRIOR AUTHORIZATION DETERMINATION

☐ **Day Services scope, amount and duration authorized with START DATE**: _____ **END DATE**: _____
☐IOP (DIH) or ☐PHP (DIF) | _____ maximum days/units | _____ maximum times per week

Day Services 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 Outpatient SMHS authorized: START DATE**: _____ **END DATE**: _____
_____ maximum units/encounters | _____ maximum times per day

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: _____

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**: _____
_____ maximum units/encounters | _____ maximum times per day

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 Name, Credentials, and Date: _____

Finalized authorization form, inclusive of Optum's determination shall be uploaded by the Contractor to SmartCare within 5 business days of receipt, under the following naming convention utilizing the date signed by Optum:

"xx.xx.xx Prior Authorization – Day Services Request"