Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Referral 01.01.05 New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	7/23/2019

SUBJECT:	Substance Use Disorder (SUD) Residential Treatment Authorization and Re-authorization

PURPOSE:

To establish a policy and procedures for authorizing requests for initial and continuing treatment in residential level of care for the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

POLICY:

- Behavioral Health Services (BHS) will ensure that medically necessary services provided are sufficient in amount, duration, and/or scope to reasonably achieve the purpose for which the services are being provided.
- BHS will ensure that the amount, duration, and/or scope of a medically necessary service are not arbitrarily denied or reduced.
- BHS will ensure that clients receive timely and adequate notice of adverse benefit determinations.

SCOPE:

These procedures apply to Orange County Health Care Agency (HCA) BHS staff responsible for authorizing residential treatment, as well as, County contracted DMC-ODS Residential treatment providers requesting authorization for residential treatment.

REFERENCES:

Intergovernmental Agreement, 17-94065, Exhibit A, Attachment I

The Special Terms and Conditions (STCs), California Medi-Cal 2020 Demonstration

42 Code of Federal Regulations (CFR) §§ 438.10, 438.402 b-c, 438.404, 438.210 (d1ii-2)

DEFINITIONS:

Authorization – the approval process for DMC-ODS services prior to the submission of a DMC-ODS claim.

Licensed Practitioner of the Healing Arts (LPHA) – Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians and within their scope of practice.

Medical Necessity and Medically Necessary Services – those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR § 438.210(a)(4) or, in the case of Early and Periodic Screening, Diagnosis and Treatment (EPSDT), services that meet the criteria specified in Title 22, § 51303 and § 51340.1.

Medical Necessity Criteria – adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition (DSM-5) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 years of age may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Beneficiaries under age 21 are eligible to receive Medicaid/Medi-Cal services pursuant to the EPSDT mandate and are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

Notice of Adverse Benefit Determination (NOABD) – a formal communication of any action and consistent with 42 CFR § 438.404 and § 438.10.

Residential Placement Coordinator (RPC) – working title for HCA BHS staff responsible for authorizing residential treatment. This individual is a healthcare professional with appropriate clinical expertise in treating the beneficiary's condition or disease.

PROCEDURE:

I. Consistent Application of Review Criteria for Authorization Decisions

A. All County operated and county contracted DMC-ODS providers shall utilize HCA BHS SUD Assessment, a standardized assessment tool based on the ASAM Criteria, or a BHS approved tool which includes BHS SUD Assessment content to determine level of care and medical necessity.

1. All County operated and county contracted DMC-ODS providers utilizing the standardized assessment tool shall complete ASAM training. This includes RPC who are responsible for processing residential treatment authorization requests.

B. RPC shall ensure the following when reviewing residential treatment authorization requests:

1. The standardized assessment tool has been filled out completely.

2. The DSM-5 Substance Use Disorder diagnosis or diagnoses is supported by the information documented in the assessment tool.

3. The severity ratings in the ASAM dimensions include an appropriate clinical rationale and support medical necessity for residential treatment.

4. Medical necessity for residential treatment has been established by an LPHA or Medical Director.

C. RPC will consult with the requesting provider when appropriate.

D. RPC will process prior authorization determinations for residential treatment services within 24 hours of the authorization request being submitted by the provider.

II. Length of Authorized Residential Services

A. HCA BHS will ensure compliance with the following time restrictions for residential treatment authorizations:

1. Adults, ages 21 and over, may receive up to two (2) continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a Department of Health Care Services (DHCS) licensed facility for a maximum of 90 days per 365-day period.

2. An adult client may receive one 30-day extension, if that extension is medically necessary, per 365-day period. A treatment authorization request must be submitted for extension requests. Review of re-authorization requests will follow the procedures outlined above in Section I, A-D.

3. Adolescents, under the age of 21, shall receive continuous residential services for a maximum of two (2) 30 days stays per 365-day period. Adolescent clients may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent clients are limited to one extension per year, within the requirements of EPSDT. Adolescent clients receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment. Nothing in the DMC-ODS or in this paragraph overrides any EPSDT requirements. Adolescent clients may receive authorization for a longer length of stay based on medical necessity. A treatment authorization request must be submitted for extension requests. Review of re-authorization requests will follow the procedures outlined above in Section I, A-D.

4. If determined to be medically necessary, perinatal clients may receive longer lengths of stay than those described above.

III. Timely and Adequate Notice of Adverse Benefit Determination (NOABD) (42 CFR §438.404)

A. In the event that a beneficiary request for residential treatment services is denied or authorized in an amount that was less than requested, HCA BHS will ensure that beneficiaries are given timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in 42 CFR §438.10.

1. Content of Notice – the notice shall explain the following:

a) The adverse benefit decision the RPC has made or intends to make.

b) The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the client's adverse benefit determination.

c) Information about the beneficiary's right to request an appeal (42 CFR §438.402(b) and 42 CFR §438.402(c)); procedures for exercising appeal rights; expedited appeal requests; and continuation of benefits during the appeal process.

2. Timing of Notice

a) HCA BHS will ensure that NOABD are mailed to beneficiaries within the following timeframes:

i. Shall not exceed 14 calendar days following the receipt of the request for service for standard authorization decisions that deny or limit services.

ii. For authorization decisions not reached within the timeframes as specified in 42 CFR § 438.210(d), on the date that the timeframes expire.

iii. For expedited authorization decisions, within the timeframes specified in 42 CFR § 438.210(d) (2).