State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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Behavioral Health Information Notice No: 22-017

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services

PURPOSE: To provide guidance to county Mental Health Plans (MHPs) regarding concurrent review standards for psychiatric inpatient hospital services and psychiatric health facility services.

REFERENCE: Welfare & Institutions Code Sections 14197.1 subd. (b)[1] ; 14184.402, subd. (i).

BACKGROUND:
Pursuant to existing state and federal requirements, MHPs are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to specialty mental health services (SMHS).[2] The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization review

[1] Welfare & Institutions Code section 14197.1, subdivision (a), requires the department to ensure Medi-Cal mental health benefits are provided in compliance with the federal mental health parity regulations. Subdivision (b) authorizes the department to implement and interpret section 14197.1 by information notice.
[2] Cal. Code Regs., tit. 9, § 1810.440(b); 42 C.F.R. § 438.210 (a)(4), (b)(1),(2)

procedures.[3] Compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for the individuals or entities to deny, limit, or discontinue medically necessary services to a beneficiary.[4] MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to beneficiaries.[5] This program must include mechanisms to detect both underutilization and overutilization.[6] Additionally, MHPs must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.[7]

MHPs are responsible for certifying that claims for all covered SMHS meet federal and state requirements.[8] MHPs provide or arrange for the provision of SMHS to Medi-Cal beneficiaries that meet medical necessity and access criteria for SMHS, and approve, and authorize these services according to state requirements.[9]

MHPs may place appropriate limits on a service for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports.[10] Further, MHPs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.[11]

Parity Final Rule

On March 30, 2016, CMS issued the Parity Rule to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries.[12] It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule requires states to ensure that treatment limitations imposed for Medicaid MH and SUD services are no more restrictive than the predominant treatment limitations imposed for

[3] See MHP Contract, Ex. A, Att. 6 A1,Sec. 1.B.
[4] 42 C.F.R., § 438.210(e)
[5] 42 C.F.R, § 438.330(a)(1)
[6] 42 C.F.R, § 438.330(b)(3)
[7] 42 C.F.R, § 438.608(a)(1)
[8] MHP Contract, Ex. B, Sec. 5.B; 42 C.F.R, § 433.51; Cal. Code Regs., tit. 9, §1840.112
[9] See State Plan, section 3, Supplement 3 to Attachment 3.1-A, page 2c; section 3, Supplement 2 to Attachment 3.1-B, page 5
[10] 42 C.F.R., § 438.210 (a)(4)(ii)
[11] 42 C.F.R., § 438.210 (a)(3)(ii)
[12] 81. Fed. Reg. 18390 (March 30, 2016)

substantially all medical and surgical services within a benefit classification.[13] In addition, the Parity Rule prohibits an MHP from applying a non-quantitative treatment limitation (a requirement that limits the scope or duration of a benefit) to a mental health benefit unless the limitation is comparable to, and applied no more stringently, than it is applied to corresponding medical benefits.[14]

Welfare and Institutions Code (W&I) section 14197.1 requires DHCS to ensure that all covered mental health benefits and substance use disorder benefits, as those terms are defined in section 438.900 of Title 42 of the CFR, are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the CFR, as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by CMS.[15]

Parity Assessment and Compliance Plan

The Parity Rule required DHCS to conduct an analysis of its delivery systems to determine if any applicable limitations exist.[16] This included a review of quantitative treatment limitations, financial and information requirements, and non-quantitative treatment limitations (NQTL). An NQTL is a limit on the scope or duration of benefits, which is not expressed numerically, such as authorization requirements. An NQTL may not be applied to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.[17]

DHCS submitted its Parity Compliance Plan to CMS to demonstrate compliance with the Parity Rule by the implementation deadline of October 2, 2017, and updated the plan in October 2019. The Parity Compliance Plan outlines the findings from DHCS' parity assessment. During its assessment of the State's authorization policies across delivery systems, DHCS identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs and Medi-Cal Managed Care Plans (MCPs). Pursuant to DHCS' Parity Compliance Plan and federal Parity Rule requirements, this BHIN addresses the inconsistencies for inpatient

[13] 42 C.F.R., § 438.910(b)(1)
[14] 42 C.F.R., § 438.910(d)(1)
[15] Welf. & Inst. Code, § 14197.1(a)
[16] 42 C.F.R., § 438.920(b)(1)
[17] 42 C.F.R., § 438.910(d)(1)

services by implementing policy changes related to authorization of inpatient psychiatric hospital services and psychiatric health facility services to align the policies with those governing the MCPs. Policy related to outpatient SMHS is provided in BHIN 21-016.

POLICY:
Pursuant to 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, 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.

Requirements Applicable to Authorization of Inpatient SMHS
MHPs shall establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with this BHIN.[18] MHPs shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.[19] MHPs may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the MHP's contract for specialty mental health services.

Authorization procedures and utilization management criteria shall:

- Be based on medical necessity and consistent with current evidence- based clinical practice guidelines, principles, and processes;
- Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice ;
- Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's beneficiaries and network providers.

[18] 42 C.F.R., § 438.210(b)(1), MHP Contract, Ex. A, Att. 12
[19] 42 CFR, § 438.210(b)(2)(i-ii)

MHPs shall comply with the following communication requirements:

- Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
- Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;
- Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS;[20] and,
- Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

All of the MHP's authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

Concurrent Review for Psychiatric Inpatient Hospital Services
This concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and psychiatric health facilities (PHFs) certified by DHCS as Medi-Cal providers of inpatient hospital services. For ease of reference, general acute care hospitals, psychiatric hospitals and PHFs are collectively referred to as "hospital or PHF" below. This authorization process applies to all inpatient admissions, whether voluntary or involuntary. To the extent there is a conflict, this section supersedes California Code of Regulations, title 9, sections1820.215, 1820.220, 1820.225 and 1820.230.

MHPs, hospitals and PHFs shall exchange protected health information by any method compliant with the Health Insurance Portability and Accountability Act (HIPAA) and agreed upon by both parties to the exchange, which may include fax, telephone and electronic transmission. The MHP shall consult with the beneficiary's treating provider as appropriate.[21] While reviewing an authorization request, the MHP may communicate with the treating provider and the treating provider may adjust the authorization request prior to the MHP rending a formal decision regarding the authorization request.

[20] 42 C.F.R., § 438.10(g)(2)(iv)
[21] 42 C.F.R. § 438.210(b)(2)(ii)

I. Admission and Authorization

a. Notification of beneficiary admission and request for treatment authorization.

MHPs shall maintain telephone access to receive admission notifications and initial authorization requests 24-hours a day and 7 days a week.[22] Within 24 hours of admission of a Medi-Cal beneficiary for psychiatric inpatient hospital services, the hospital or PHF shall provide the responsible county MHP (or MHP of beneficiary) the beneficiary's admission orders,[23] initial plan of care,[24] a request to authorize the beneficiary's treatment, and a completed face sheet. The face sheet shall include the following information (if available):

- Hospital name and address
- Patient name and DOB
- Insurance coverage
- Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System
- Current address/place of residence
- Date and time of admission
- Working (provisional) diagnosis
- Date and time of admission
- Name and contact information of admitting, qualified and licensed practitioner
- Utilization review staff contact information

If, upon admission, a beneficiary is in a psychiatric emergency medical condition, as defined in Health & Safety Code section 1317.1(k), the time period for the hospital to request authorization shall begin when the beneficiary's condition is stabilized, as defined in Health & Safety Code section 1317.1(j). For emergency care, no prior authorization is required, following the reasonable person standard to determine that the presenting complaint might be an emergency.[25]

b. Review of initial authorization request.

The MHP shall decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the

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[22] Welf. & Inst. Code, § 14197.1; Health & Saf. Code, §§ 1367.01(i), 1371.4(a); Managed Care boilerplate contract Exh. A, Att. 9, provision 7 C ["Contractor shall ensure that a plan or contracting physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary."]
[23] 42 CFR § 456.170;
[24] 42 CFR § 456.180; 42 CFR § 441.155
[25] Managed Care Two-Plan CCI Boilerplate exh. A, Att. 5.

requesting hospital or PHF per managed care requirements for expedited authorizations following recipe of all information specified in I.a., above. The MHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services.[26]

II. Continued Stay Authorization

a. Continued Stay Authorization Request

When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay- authorization request for a specified number of days to the responsible county MHP.

b. Exchange of information between hospital or PHF and MHP.

The treating provider at the hospital or PHF may request information and records from the MHP needed to determine the appropriate length of stay for the beneficiary. The MHP may request only information from the hospital and treating provider that is reasonably necessary to decide whether to grant, modify or deny the request. The exchange of information is intended to occur flexibly, with MHPs and hospitals exchanging relevant client and clinical information as needed to complete concurrent review procedures and for discharge planning and aftercare support.

Clinical information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- 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 discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.
- Precipitating events if further identified or clarified by the treating hospital after MHP admission notice.
- Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes,

[26] Managed Care Two-Plan CCI Boilerplate exh. A, Att. 5.

nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.
- Hospital information on prior episode history that is relevant to current stay.
- MHP information of relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
- Substance use information 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.
- 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.
- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.
- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.
- Number of continuing stay days requested.

c. Review of Continued Stay Authorization Request

The responsible county MHP shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.[27]

The MHP remains responsible to cover the cost of each day of an inpatient hospital stay, at the applicable rate for acute psychiatric inpatient hospital services, until the requirements in paragraph 1 or 2 have been met:

[27] Welf. & Inst. Code 14197.1 [MCPs in practice issue a decision on a continued stay authorization request within 24 hours of receipt of the request]; See Also Health & Saf. Code, §1367.01(h)(2) specifying the timeframe for a decision begins ["after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination."]

1. The existing treatment authorization expires and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider[28]; Or,
2. The MHP denies a hospital's continued stay authorization request and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider.[29]

III. Adverse Decision, Clinical Consultation, Plan of Care, and Appeal.

a. While LMHPs/LPHAs may review authorization requests and issue approvals within their scope of practice, all MHP decisions to modify or deny a treatment request shall be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs.[30] A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent with the psychologist's scope of practice.

b. A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.[31]

c. If a MHP modifies or denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services.[32] The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.[33]

d. If a MHP denies a hospital's authorization request, the MHP must work with the treating provider to develop a plan of care. Services and payment for

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[28] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3)
[29] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3)
[30] 42 C.F.R. § 438.210(b)(3); Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(e)
[31] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(4)
[32] 42 C.F.R. § 438.404(c), 42 C.F.R. § 431.213(c);
[33] See generally 42 C.F.R., §§ 438.210(c), 438.404; MHSUDS IN 18-010E

services shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary.[34] If the MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent,[35] appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

e. An MHPs denial of an authorization request and a consultation between the treating provider and the MHP may result in one of the following outcomes:

- The MHP and the hospital treating provider agree that the beneficiary shall continue inpatient treatment at the acute level of care, and the denial is reversed.
- The MHP and the hospital treating provider agree to discharge the beneficiary from the acute level of care and a plan of care is established prior to the beneficiary transitioning services to another level of care.
- The MHP and the hospital treating provider agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down facility bed is not available and the beneficiary remains in the hospital, on administrative day level of care.
- The MHP and treating hospital provider do not agree on a plan of care and the beneficiary, or the treating provider on behalf of the beneficiary, appeals the decision to the MHP.[36]

Authorizing Administrative Days

A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area.[37] In order to conduct concurrent review and authorization for administrative day service claims, the MHP 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

[34] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3)
[35] 42 C.F.R., § 438.402(c)(1)(ii)
[36] 42 C.F.R., § 438.402(c)(1)(ii)
[37] Cal. Code Regs., tit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400

administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the 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. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.[38]

MHPs 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.[39] The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.[40]

Examples of appropriate placement status options include, but may not be limited to, the following:

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

RETROSPECTIVE AUTHORIZATION REQUIREMENTS

MHPs must establish written policies and procedures regarding retrospective authorization of SMHS. MHPs may conduct retrospective authorization of inpatient SMHS under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payer.

UTILIZATION REVIEW

[38] Cal. Code Regs., tit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400
[39] Cal. Code Regs., tit. 9, § 1820.230(d)(2)(B)(1); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400
[40] Cal. Code Regs., tit. 9, § 1820.230(d)(2)(B)(2); Welf. & Inst. Code, §§ 14184.402 and 14184.102 and 14184.400

Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. Nothing in this BHIN prohibits the MHPs from conducting utilization review and/or auditing activities in accordance with state and federal requirements. MHPs retain the right to monitor compliance with any contractual agreements between an MHP and the MHP's network providers and may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS. For example, the MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the beneficiary, or in other instances where there is evidence of fraud, waste, or abuse.

ONGOING MONITORING REQUIREMENTS

MHPs are responsible for demonstrating ongoing compliance with the Parity Rule and this IN. MHPs are required to maintain policies and procedures and to provide additional evidence of compliance with requirements upon request by DHCS and during compliance reviews and/or External Quality Review Organization reviews of each MHP.

If, at any time, DHCS determines the MHP to be out of compliance with requirements outlined in this IN, the MHP will be required to submit a Plan of Correction, as well as evidence of correction, to the Department.

Please direct any questions to Medi-Cal Behavioral Health Division at countysupport@dhcs.ca.gov.

Sincerely,

Original signed by

Shaina Zurlin, LCSW, PsyD, Chief
Medi-Cal Behavioral Health Division