



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



GAVIN NEWSOM
GOVERNOR

DATE: November 23, 2021

Behavioral Health Information Notice No: 21-XXX

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 and Updated Criteria for Psychiatric
Inpatient Hospital Services and Psychiatric Health Facility Services

REFERENCE: Welfare & Institutions Code Sections 14197.1 subd. (b)¹; 14184.402,
subd. (i)²; [MHSUDS IN 19-026](#)

PURPOSE: To provide guidance to county Mental Health Plans (MHPs)
regarding concurrent review standards and updates to criteria for
psychiatric inpatient hospital services and psychiatric health facility
services, based on implementation of the California Advancing and
Innovating Medi-Cal initiative (CalAIM).

¹ W&I 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 W&I Code section 14184.402, subdivision (a) requires the department to ensure that all medical necessity determinations for covered specialty mental health services and substance use disorder services are made in accordance with W&I Code section 14059.5. Subdivision (i) authorizes the department to implement and interpret section 14184.402 by information notice until regulations are promulgated.

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).³ 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 procedures.⁴ 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.⁵ MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to beneficiaries.⁶ This program must include mechanisms to detect both underutilization and overutilization.⁷ 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.⁸

MHPs are responsible for certifying that claims for all covered SMHS meet federal and state requirements.⁹ MHPs provide or arrange for the provision of SMHS to Medi-Cal beneficiaries that meet criteria for SMHS, and approve, and authorize these services according to state requirements.¹⁰

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.¹¹ 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.¹²

³ Cal. Code Regs., tit. 9, § 1810.440(b); 42 C.F.R., § 438.210, subd. (b)(1),(2)

⁴ See MHP Contract, Ex. A, Att. 6.1 B.

⁵ 42 C.F.R., § 438.210(e)

⁶ 42 C.F.R., § 438.330(a)(1)

⁷ 42 C.F.R., § 438.330(b)(3)

⁸ 42 C.F.R., § 438.608(a)(1)

⁹ MHP Contract, Ex. B, Sec. 5.B; 42 C.F.R., § 433.51; Cal. Code Regs., tit. 9, §1840.112

¹⁰ See State Plan, section 3, Supplement 3 to Attachment 3.1-A, page 2c

¹¹ 42 CFR, § 438.210 (a)(4)(ii)

¹² 42 CFR, § 438.210 (a)(3)(ii)

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.¹³ 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 limitations imposed for Medicaid MH and SUD services are no more restrictive than the predominant limitations imposed for substantially all medical and surgical services within a benefit classification.¹⁴ 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.¹⁵

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.¹⁶

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.¹⁷ 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.¹⁸

¹³ 81. Fed. Reg. 18390 (March 30, 2016); see Medicaid Mental Health Parity Final Rule Federal Register: [Federal Register](#)

¹⁴ 42 CFR, § 438.910(b)(1)

¹⁵ 42 CFR, § 438.910(d)(1)

¹⁶ W&I, § 14197.1(a)

¹⁷ 42 CFR, § 438.920(b)(1)

¹⁸ 42 CFR, § 438.910(d)(1)

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 IN addresses the inconsistencies for inpatient 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 21-069.

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.

Beneficiary Access Criteria for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services

A Medi-Cal beneficiary must meet the following criteria to receive acute psychiatric inpatient hospital services or psychiatric health facility (PHF) services. This section supersedes California Code of Regulations, title 9, sections 1820.205, 1830.230, 1830.245 1830.250, subdivisions (b)-(g) and any other sections to the extent there is a conflict.

Admission Criteria

The beneficiary shall meet each of the admission criteria below, which shall be documented in the patient record:

1. The beneficiary cannot be safely and effectively treated at a lower level of care.
2. The beneficiary has mental health or substance use-induced mental health symptom(s) and/or behavior(s) that meet one of the following criteria:
 - a. Pose danger to self or others;
 - b. Prevent the beneficiary from appropriately utilizing food, clothing, or shelter;
 - c. Pose a significant health risk or potential loss of life;
 - d. Pose a severe risk of significant deterioration in life functioning that would result in exacerbation of the psychiatric illness to a degree that would necessitate hospitalization.
3. Psychiatric Inpatient Services or PHF services are required to ensure the beneficiary can receive one or more of the following:
 - a. Further assessment or specialty mental health service necessary for acute psychiatric stabilization;
 - b. Medication support services;
 - c. Other specialty mental health services that can reasonably be provided only if the beneficiary is hospitalized.

Continued Stay Criteria for Psychiatric Inpatient Hospitalization and PHFs:

The documentation shall reflect both continued stay criteria below:

1. The treating clinician(s) continues to identify the symptoms or behaviors in admission criteria as follows:
 - a. Pose danger to self or others;
 - b. Prevent the beneficiary from appropriately utilizing food, clothing, or shelter;
 - c. Pose a significant health risk or potential loss of life;
 - d. Pose a severe risk of significant deterioration in life functioning that would result in exacerbation of the psychiatric illness to a degree that would necessitate hospitalization.

2. Psychiatric inpatient services or PHF services continue to be required to address any of the following: serious adverse medication reactions, need for continued psychiatric evaluation and specialty mental health services, or the presence of a new risk to psychiatric stability.

Requirements Applicable to Authorization of Inpatient and Outpatient SMHS

MHPs shall establish and implement written policies and procedures for the authorization of SMHS in accordance with this BHIN.²⁰ Authorization procedures and utilization management criteria shall:

- Be based on [SMHS access criteria](#) 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.

MHPs shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.²¹ No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a beneficiary or a provider, may deny, or modify a request for authorization of SMHS for a beneficiary. MHPs shall notify the requesting provider in writing and give the beneficiary written notice of any decision by the MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.²² The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.²³

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.²⁴

²⁰ 42 CFR, § 438.210(b)(1)

²¹ 42 CFR, § 438.210(b)(3)

²² 42 CFR, § 438.210(c)

²³ 42 CFR, §§ 438.210(c), 438.404; MHP Contract, Ex. A, Att 12; see also [MHSUDS IN 18-010E](#)

²⁴ 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;
- Maintain telephone access 24 hours a day, 7 days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization;
- A physician shall be available for consultation and to resolve disputed requests for authorizations;
- 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;²⁵ 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, Psychiatric Health Facility 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. To the extent there is a conflict, this section supersedes California Code of Regulations, title 9, sections 1820.215, 1820.220, 1820.225 and 1820.230.

A MHP's decision to grant, modify or deny a treatment authorization request shall be made based on whether the beneficiary meets the access criteria for psychiatric inpatient hospital and PHF services set forth in this BHIN.²⁶ Specifically, the decision to

²⁵ 42 CFR, § 438.10(g)(2)(iv)

²⁶ See W&I section 14184.402(a)

grant, modify or deny a request to authorize the first 48 hours of the beneficiary's treatment shall be based on whether the beneficiary meets the Admission Criteria set forth on page 5. The decision to grant, modify or deny a continued stay authorization request shall be based on whether the beneficiary meets the Continued Stay Criteria for Psychiatric Inpatient Hospitalization and PHFs set forth on page 6. The professional reviewing a treatment authorization request shall consult with the beneficiary's treating provider as appropriate.²⁷

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.

I. Admission and Authorization First 48 Hours

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

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, initial plan of care, a request to authorize the first 48 hours of 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

b. Review of initial 48 hour authorization request.

MHPs shall maintain telephone access to receive admission notifications and authorization requests 24 hours a day and 7 days a week. The MHP shall decide whether to grant, modify or deny the

²⁷ 42 C.F.R. § 438.210(b)(2)(ii)

hospital or PHFs initial treatment authorization request (for the first 48 hours of the beneficiary's treatment) and communicate the decision to the requesting hospital or PHF within 24 hours of receipt of the request and the admission orders and initial plan of care.

II. Continued Stay Authorization

a. Continued Stay Authorization Request

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, 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 the documents and information necessary to make a determination.²⁸

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:

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;
Or,

²⁸ 42 C.F.R. § 438.210(d)(2)

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.

d. Beneficiary Notifications

If a MHP modifies or denies a treatment authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services.²⁹

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

- a. 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. When a physician or psychologist modifies a continued stay authorization request, the professional will contact the treating provider(s) and offer the opportunity for clinical consultation when appropriate.
- c. If a MHP denies a hospital's continued stay authorization request, the MHP must work with the treating provider to develop a plan of care. Services and payment for 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 needs of the beneficiary. 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,³¹ appeal the denial to the MHP, as provided for in the notice of adverse benefit determination.³² The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

²⁹ 42 C.F.R. § 438.404(c), 42 C.F.R. § 431.213(c); [MHSUDS IN 18-010E, page 6](#)

³⁰ 42 C.F.R. § 438.210(b)

³¹ Welf. & Inst. Code, §§ 14184.402

³² Welf. & Inst. Code, §§ 14184.102 and 14184.400.

- d. The following are possible outcomes following a MHPs denial of a treatment authorization and the hospital's appeal:
- 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.

Authorizing Administrative Days

A hospital may claim for administrative day services when a beneficiary no longer meets criteria 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.³¹ 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 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.

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.³³ The lack of appropriate, non-acute treatment facilities

³¹ Welf. & Inst. Code, §§ 14184.402

³³ Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400

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.³⁴

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.

UTILIZATION REVIEW

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.

³⁴ Welf. & Inst. Code, §§ 14184.402 and 14184.102 and 14184.400.

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

Sincerely,

Original signed by

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Medi-Cal Behavioral Health Division

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