Authorization Request Form Directions

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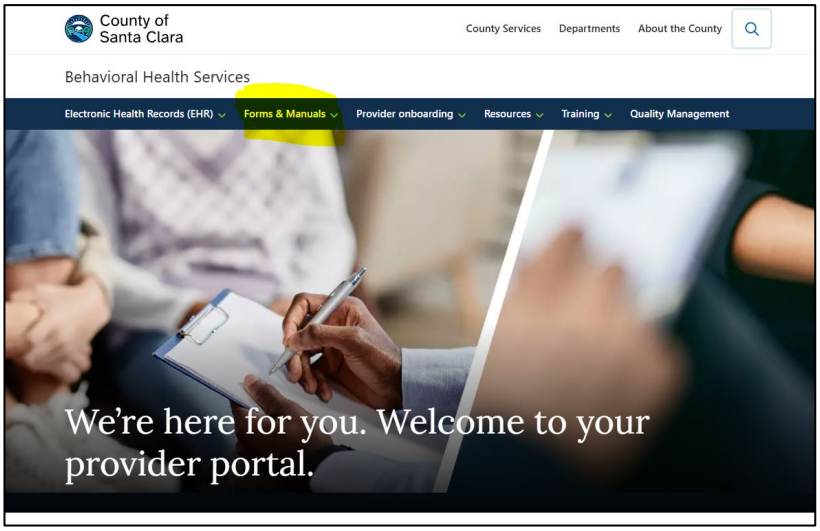
I. Authorization Request Form

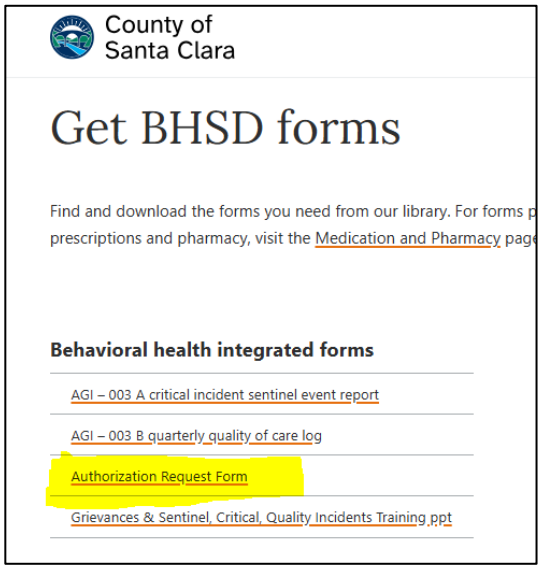
1. Where do I find the authorization Form:

a) Go to the **County of Santa Clara Provider Portal**

b) Use the **Forms & Manuals** dropdown arrow and select **Get BHSD Forms.**



c) Click on the **Authorization Request Form**, this will bring up a DocuSign page to begin signing.



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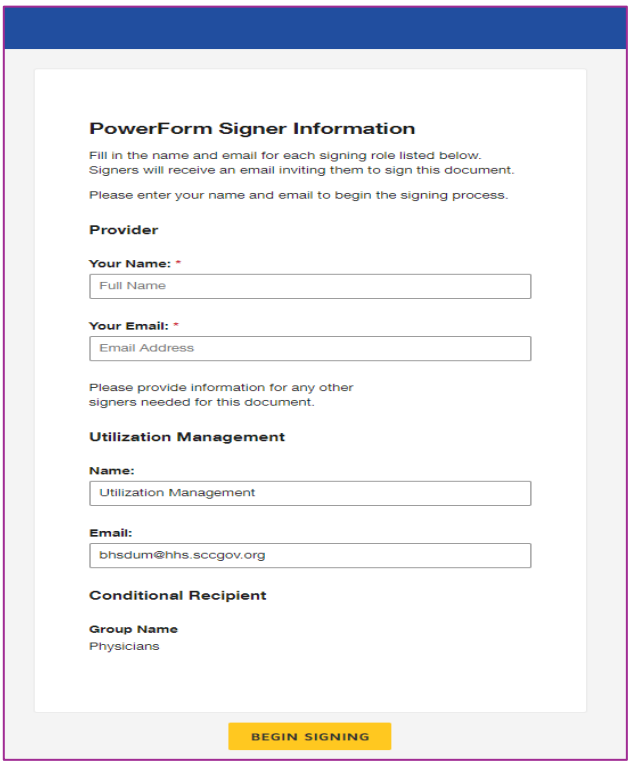
d) Enter the **Full Name** and **work email** of the person who will receive the response from County of Santa Clara Utilization Management regarding the authorization decision. (This secure email can be a group email for instance: TBSAuthorizations@agency.org). Then click on **Begin Signing**.



2. Which Type of Authorization are you requesting?

a) **Prior Authorization** is for a **member who is not yet in the services being requested**, this includes someone going from WM to Residential, everyone from outpatient to residential, In-Custody to Residential, TBS, IHBS, etc.
b) **Initial Authorization** is **ONLY** for a member who is in Substance Use Treatment Services (SUTS) Residential services, who has been referred for 3 days and needs an initial authorization.
c) **Re-Authorization** is for a member who is in the service and has already had an authorization and **needs additional services**.
d) **Concurrent Review** is for crisis residential treatment.

II. Requesting Provider Information

1. Provider Status

a) **County of Santa Clara Behavioral Health Services Department (CSC-BHSD)** means all county and contracted clinics in CSC-BHSD.
b) **Other (PCP, Outside Therapist, etc.)** is for a primary care physician not part of BHSD or a therapist that provides services independently for Medi-Cal members, generally private practice.

2. Date of Request

a) **Date** the form is being filled out and submitted.

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3. Request Type

a) **Routine authorization** request is when a response is needed within 5 business days.
b) **Expedited/Urgent** will need a justification as to why it is urgent and needs a response within 72 hours.
c) **Retrospective Authorization** can be requested for SMHS under the following limited circumstances (per BHIN 22-016, Page 9): **You will be prompted to choose one circumstance from the drop down menu when this is selected.**
    a. Retroactive Medi-Cal eligibility determinations.
    b. Inaccuracies in the Medi-Cal Eligibility Data System.
    c. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries.
    d. and/or, Beneficiary's failure to identify payer.

4. Provider/Agency Name PROGRAM NAME

a) **The Company Name** (Please include the program specific name (Outpatient, Intensive Outpatient, Residential, Wraparound, Katie A., FSP etc.)

5. Provider/Agency Service Location

a) Location of the program is the address of the clinic site, even if the services are provided in the home.

6. Provider/Agency Contact Name; Email, Phone Number

a) This is the contact information of the person should there be any questions about the authorization request.
    a. Confidential work email of the individual with knowledge of the referral.
    b. Confidential phone number of the individual with knowledge of the referral.
b) This will not be where the final decision is sent, that is the email entered at the beginning of DocuSign in section 1d.

III. Member Information: Please ensure information is accurate and pertains to the specific client in need of services.

1. Demographics (all those not required will have an * at the end, however, if the information is available, please include it).

a) **Name**, please enter First and Last Name of the member being referred.
    a. If you are **testing** the process, please indicate test for first and last name.
b) **Date of Birth (DOB)**, of the member xx/xx/xxxx.
c) **Social Security Number (SSN)**, this is not required for all services xxx-xx-xxxx.*
d) **Avatar #**, if available this will be the electronic records number for Avatar of the member*
e) **Gender**, please choose an item from the list. If another gender, then one on the list is identified please type it in the next section. Please ensure you are asking their gender identity, always get the information directly from the individual.
f) **Current Address**, this is the member's current address.

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g) **Language Preference**, please choose an item from the list to identify any specific language needs for the member. If the language is not identified, please indicate in an attachment.
h) **Phone number**, xxx-xxx-xxxx, Member's phone number for the provider to be able to contact them. There must be a number included so that the member can be contacted.
i) **Insurance Information**, Medi-Cal, Medicare, Uninsured.
j) **Insurance Plan**, Anthem Blue Cross Partnership Plan, Santa Clara Family Health Plan, Kaiser Medi-Cal.
k) Medi-Cal ID, this is their Medi-Cal/subscriber ID this is generally 9 digits, and has at least one letter, for example 92345678G.

IV. Service Request

1. SMH or SUTS?

a) **Specialty Mental Health (SMH)** is for all mental health only service requests.
b) **Substance Use Treatment Services (SUTS)** requires an additional non redisclosure statement and should be checked for any substance use treatment services.

2. Specific Service Requested.

a) Please choose from the drop down which specific service is being requested **(if this is not chosen, the referral will be marked as pending the submission of a corrected authorization)**.

Service Type YOUTH	**Authorization Form Requirement Prior Authorization (Days/Months)**	**Authorization Form Requirement Re-Authorization (Days/Months)**	**Additional Information to Attach to Authorization Form**	**LPHA Signed Diagnosis (Dx) and need for continued care required for all authorizations and re-authorizations.**
Youth - Intensive Home-Based Services (IHBS)	Up to 12 Months	Up to 3 months	ICC/IHBS Screening Form, Medi-Cal Verification Form and ROI. Re-auth: Medi-Cal Verification and con't need.	Required
Youth – Intensive Home-Based Services (IHBS) Short Term Stabilization	*Up to 60 days/Up to 2 Months PSS (Placement Supportive Services), ISS (Immediate Stabilization Services*	*Up to 60 days/Up to 2 Months* / *Up to 90 days/3 Months*	*This is for short term stabilization and can be used concurrently, with clinical justification and explanation of how services will not be duplicated. Please indicate if there are additional IHBS providers who are providing those services and that there is communication with the other provider. ICC/IHBS Screening form, Medi-Cal verification. For re-auth. Medi-Cal Verification and justification for con't need.*	*Required*
	Or up to 90 days/Up to 3 Months for PCSS (Post-Crisis Stabilization Services)	*Up to 90 days/Up to 3 Months*		

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Youth -Therapeutic Behavioral Services (TBS)	Up to 6 Months	UP to 3 Months	TBS Screening form and all additional documentation required by form, ROI, and Medi-Cal Verification. Re-auth: Medi-Cal verification and con't need.	Required
Youth - Therapeutic Behavioral Services - Intellectual Disability (TBS - ID)	Up to 6 Months	Up to 3 Months	TBS Screening form and all additional documentation required by form, ROI, and Medi-Cal Verification. Re-auth: Medi-Cal verification and con't need.	Required, must also have dx showing need for ID
Youth - Substance Residential Treatment (SUTS)	Up to 45 days	Up to 45 days	Brief ASAM, IEP (if there is one), County Release of Information has two pages, SUTs own release, and Medi-Cal Verification. Re-auth: Medi-Cal verification and con't need.	Required, must have dx showing need for substance use treatment
Youth -Eating Disorder Residential	30 days	30 days	Updated Clinical information, Medi-Cal Verification	Required, LPHA must show client has eating disorder diagnosis

Service Type ADULT	**Authorization Form Requirement Prior Authorization (Days/Months)**	**Authorization Form Requirement Re-Authorization (Days/Months)**	**Additional Information to Attach to Authorization Form**	**LPHA Signed Diagnosis (Dx) and need for continued care required for all authorizations and re-authorizations.**
Adult - Substance Residential Treatment (SUTS)	Up to 30 days	Up to 30 days	Full ASAM, Medi-Cal Verification	Required, LPHA must have dx showing need for substance use treatment. In custody/hospital/CRT to SUTS Res: Medical D/C
	Up to 3 days		Brief ASAM, Medi-Cal Verification, New Care Plan for additional days	
Adult - Substance Residential Treatment (SUTS) Perinatal	Women with young children 90 days; Pregnant Women postpartum 60 days	Up to 30 days	ASAM, documentation showing children's ages and/or term of pregnancy, Medi-Cal Verification	Required, LPHA must have dx showing need for substance use treatment and Perinatal services
	Up to 3 Days		Brief ASAM, Medi-Cal Verification, and New Care Plan for additional days	
Adult -Eating Disorder Residential	Up to 30 days	Up to 30 days	Updated Clinical information, Medi-Cal Verification	Required, must have eating disorder diagnosis
Electro Convulsive Therapy	Number of units/ CPT Code needs to be included (see below) for up to 3 months (actively receiving services	Number of units/ CPT Code needs to be included (see below) for up to 3 months (actively receiving services with Outpatient Psych.)	Information signed by MD showing treatment resistant Depression, Medi-Cal verification, El Camino ECT Referral Form. Re-auth, documentation showing update and for holistic	Required by MD showing treatment resistance depression

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	with Outpatient Psych.)		treatment coordination of care with outpatient psychiatrist.	
Transcranial Magnetic Stimulation	Number of units/ CPT Code needs to be included (see below) for up to 2 months (actively receiving services with OP Psych.)	Number of units/ CPT Code needs to be included (see below) for up to 2 months (actively receiving services with OP Psych.)	Information signed by MD showing treatment resistant Depression, Medi-Cal verification. Re-auth, documentation con't need.	Required by MD showing treatment resistance depression
Crisis Residential Treatment (CRT)	First concurrent Review up to 21 Days (no changes to the initial auth process).	In instances where there are additional Concurrent Review days, request the number of days medically necessary.	Initial/updated Assessment, Progress Notes since the last authorization cycle, problem list including diagnosis signed by an LPHA, Medi-Cal verification.	Required

a) For ECT: CPT Codes should be included:
90792- 1 unit- ECT Evaluation
90870- 12 units- ECT Treatment
99213- Outpatient ECT Capacity Clinic
99214- 6 units- State Mandated ECT Monthly Clinic

b) For TMS: CPTS Codes should be included:
99203 - 1 unit - Psychiatric Eval (clearance for TMS)
99213 - 6 units - Weekly wellness checks
90867 - 1 unit - Initial TMS (Cortical Mapping, motor threshold determination, delivery, and management)
90868 - 35 units - TMS
90869 - 2 units - Subsequent mot threshold re-determination with delivery and management

3. Requested Start Date or Dates of Service.

a) This will be the date the service will begin after authorization is received from the county. Services rendered prior to authorization cannot be billed.

4. Attached Documentation (Medically Necessary Services Signed by LPHA)

a) Attach **all documents** needed for authorization, listed above in Table 1/Youth or Table 2/Adult.
b) Attach Medi-Cal Verification.
c) Attach a document that is signed by a Licensed Practitioner of the Healing Arts (LPHA) that shows the services are medically necessary. For some this will include a diagnosis, for instance, substance use residential treatment (SUTS) requires a substance use diagnosis. For Therapeutic Behavioral Services with Intellectual Disability (TBS-ID) a diagnosis showing the person has an intellectual disability is required.

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d) TBS, TBS-ID and IHBS screening forms have been developed that are attached to the authorization request.

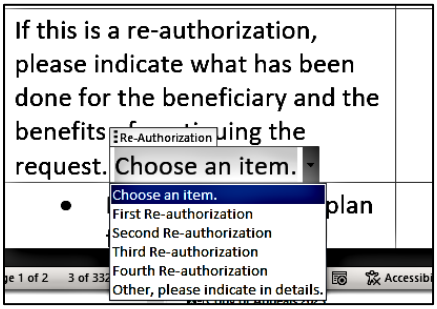
e) SUTS, if from a lower level of care, require a brief ASAM. The information must be signed by an LPHA, if it cannot be signed, a note showing medical necessity is required stating they have reviewed and agree with diagnosis, for instance: "LPHA has reviewed client's information with certified counselor and agrees with their diagnostic impression of: (add diagnosis, (F code). Additionally, it's the opinion of this LPHA that treatment services continue to be appropriate and medically necessary as preventive healthcare to continue to address the identified problems, and/or alleviate symptoms through the ongoing treatment of the substance use disorder."

f) For ECT, **a referral needs to be made by the attending psychiatrist** using the El Camino ECT Referral Form. **Please include the number of Units Requested.**

g) For ECT and TMS, **members must have a current treating psychiatrist** in an outpatient setting. **Please include the number of Units Requested.**

5. If this is a re-authorization, please indicate what has been done for the beneficiary and the benefits of continuing the request.

a) First indicate if this is the first request for additional days, second, third, fourth or other, (any more than four indicate in the details).



b) Briefly describe what has been done and why this member needs additional authorized days of service.

c) Share a care plan or treatment plan that shows what new interventions and/or plans will move this member towards their discharge plan.

6. Please indicate the discharge plan.

a) Briefly describe how throughout the service the provider will work with the member towards a plan of discharge. Even if this is the first authorization, what would be needed for this person to support them to move to a lower level of care?

V. UM Only/Authorization Determination

1. Services Authorized; this should match the requested services.

a) Pending will be indicated if this request is not authorized yet due to needing more information or incorrect information provided.

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b) Denied will be indicated if the member does not meet medical necessity or for specific reasons noted by MD (Medical Doctor) why the member is not authorized for this level of care.

2. Total Days ___Months ____ Units _____Authorized:
   a) This will sometimes be 0 days and 6 months, for instance for an initial TBS authorization, or 12 months for IHBS authorization,
   b) **or 30 (adults) to 45 (youth) days** and 0 months for a SUTS residential authorization.
3. Rendering Provider will be the provider of the new service being requested.
4. Service is denied due to:
   a) This is where the notes from Utilization Management regarding the denial reason is located.
5. Additional information requested/Pending status:
   a) If the authorization request is incomplete, new information or requested information should be securely emailed to BHSDUM@hhs.sccgov.org
6. UM Clinician Signature
   a) This is the LPHA from our Utilization Management Team that authorized the service.
   b) MD Signature will be for denials or modifications to the requested authorization.

VI. County Contracted Provider – Disposition Page

1. Accept: signature is needed after selecting this option.
2. Decline: the provider will be prompted to select a reason to decline.
3. Reason to decline:
   - "Not Medically Cleared"
   - "Needs WM First" needs Withdrawal Management (WM) prior to Substance Use Treatment Residential
   - "Cannot Accommodate Client's Needs", please indicate in note what this means.
   - "Recent Inappropriate Behaviors", please indicate.
   - "Needs Further Stabilization of Symptoms", please indicate.
   - "More Information Needed, See Note Below"
4. Decline due to: Once you select one of the options in the Reason to decline, you will be expected to provide a more detailed response. Please also include what would be required of the member in order for them to be accepted into the program, including the specific timeline (if applicable).
5. Staff Name/Signature: This will be the name of the staff member that is either accepting or declining the UM approved authorization.

No signature is needed for initial, re-authorization, concurrent review, or internal transfer authorization.

VII. Additional Information

a) Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and **are not a guarantee of payment**. The

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provider is responsible for verifying member's eligibility on the date of service and throughout the treatment.

b) Once the service has been authorized it is important to keep the authorization in the member's chart.

c) Please note the date of the start of the service that was authorized and date the service authorization will expire. **You are responsible** for knowing when the re-authorization is due prior to expiring; expedited/urgent requests are based on the member's need.

d) After a Prior Authorization request is authorized, what is next?

1. The timeline starts at the first service after the authorization date.
   - This means that a request for services sent on 1/29/25, that says service start date for 1/2/25 would not be a start date. If services were provided prior to the authorization, they cannot be billed. If the authorization is sent back on 1/30/25, then 1/30/25 forward may be billed.
2. What if the services do not start until 2/24/25?
   - The authorization is good for up to 30 days. If the authorization was sent to the rendering provider on 1/30/25, as long as the member starts services by 2/27/25, the authorization remains valid.
   - After 30 days of no services initiated, a new authorization is required.

e) If additional time is needed, re-authorization shall be provided to the Utilization Management team **no later than five business days prior to the authorization expiring**.

f) Failing to submit a re-authorization of a service on-time is not a condition for a retrospective authorization, this means that the service is not authorized for the dates where there was not an authorization form signed by the utilization management team.

g) When requesting a service, be sure to ask folks where they feel safest obtaining their services, and provide all available options, ie. gender-segregated rooming, rooming with a roommate, or rooming in a private room, allergic to animals, anything that will help in securing an appropriate placement.

h) In gender-segregated settings, individuals are to be roomed according to their self-determined safety needs. Do not assume to place individuals in a room based on sex assigned at birth, appearance, surgical history, genitalia, or legal sex.