

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

POLICY NO. : 0704.671	POLICY TITLE: AUTHORIZATION OF CRISIS RESIDENTIAL TREATMENT SERVICES (CRTS)	EFFECTIVE DATE: 7/13/2020
PROGRAM:	PERFORMANCE MANAGEMENT UNIT – QUALITY IMPROVEMENT	REVISION DATES:
AFFECTS:	ALL ADULT MH PROGRAMS	REVIEW DATES:

POLICY

Humboldt County Department of Health and Human Services – Behavioral Health (DHHS-BH) provides Crisis Residential Treatment Services (CRTS) through contracted Organizational Providers. DHHS-BH will provide authorization for these services for Humboldt County (HC) Medi-Cal beneficiaries, as these services are considered Specialty Mental Health Services (SMHS).

For all HC Medi-Cal beneficiaries who receive CRTS, DHHS-BH conducts concurrent reviews of service documentation to verify medical necessity in order to provide appropriate authorizations.

The Managed Care Line 707-268-2955, option 2, is accessible 24 hours, 7 days a week for notification for facilities that provide CRTS to HC Medi-Cal beneficiaries. Facilities may also fax the Managed Care at 707-476-4096 or email at MHB-QI_QA@co.humboldt.ca.us.

DEFINITION(S)

Humboldt County Medi-Cal Beneficiary: Any person with current Humboldt County Medi-Cal.

Authorization: Approval of request to render SMHS including amount, duration, and/or scope of services. Authorization is based on client meeting medical necessity criteria for the level of SMHS for duration of the stay, per Title 9 of the California Code of Regulations (CCR), section 1830.205.

Concurrent Review: Review of treatment documentation to ensure medical necessity is met for the entirety of the authorization period. Concurrent review occurs during the beneficiary’s stay in order to either grant, modify, or deny continued authorization.

PROCEDURE

1. Authorizations will be provided based on Medi-Cal medical necessity criteria, as defined in CCR, Title 9, Section 1830.205, and will be consistent with current clinical practice guidelines, principles, and processes. If at any point during a client’s authorization period, the facility determines that the client no longer requires that level of service, transition plans will be made per section 1.2.1.
 - 1.1 Initial Authorization: When DHHS-BH places a client in a facility for CRTS, the referral acts as initial authorization.
 - 1.2 Continued Stay Authorization: DHHS-BH will have regular contact with CRTS providers to check in on the status of clients placed in these facilities, including current medical necessity and continued need. These contacts, which may occur over the phone, via telehealth, or in person, are to facilitate CRTS Providers’ requests for continued authorization and will provide DHHS-BH with the necessary information to authorize continued stay at the CRTS facility.
 - 1.2.1 If during this contact medical necessity for continued stay is determined to not be met, DHHS-BH will work with CRTS Provider to facilitate transition to a lower level of care. Services will not be discontinued until after the facility/provider has been notified and an appropriate care plan based on the beneficiary’s needs has been agreed upon.

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- 1.2.2 DHHS-BH will communicate authorization decisions to the facility/provider within 24 hours of the decision. This often occurs during contacts described in 1.2.

 - 2. Authorizations will use [1242-ARTS/CRTS Authorization form](#), which will include an authorization number and dates the authorization covers.
 - 2.1 Authorizations for CRTS will generally be 10-30 days, but are individualized to the client's specific needs.
 - 2.2 All Authorizations will be included in the client's chart.
 - 2.3 Any denial or modification of authorization, or termination of previously authorized services, will follow Notice of Adverse Benefit Determination requirements, as described in policy [0704.500 Notice of Adverse Benefit Determination](#).

 - 3. Retrospective Authorization:
 - 3.1 DHHS-BH may conduct retrospective authorization for CRTS under the following circumstances:
 - 3.1.1 Retroactive Medi-Cal eligibility determinations;
 - 3.1.2 Inaccuracies in the Medi-Cal Eligibility Data System (MEDS)
 - 3.1.3 Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
 - 3.1.4 Beneficiary's failure to identify payor
 - 3.2 In cases where the review is retrospective, DHHS-BH will notify the beneficiary, or designee, and the provider in writing within 30 days of the receipt of information that is necessary to make this determination.
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FORM(S)/
ATTACHMENTS

[1242-ARTS/CRTS Authorization form](#)

REFERENCE

[CCR Title 9, Div. 1, Chapter 11, Subchapter 2, Art. 2, Section 1830.205](#)
[MHSUDS INFORMATION NOTICE NO.: 19-026](#)
[0704.500 Notice of Adverse Benefit Determination \(NOABD\)](#)
