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| County of San Diego Mental Health Plan**IOP & PHP Prior Authorization - Day Services Request (DSR)**Submit at least 5 business days prior to projected start date**Initial Request (prior to services)**: [ ] IOP (DIH) or [ ] PHP (DIF)**Continuing Request:** [ ] IOP (beyond initial 3 months) or [ ] PHP (beyond initial 1 month) | **IOP & PHP - DSR****FAX TO: (866) 220-4495**Optum Public Sector San DiegoPhone: (800) 798-2254Option 3, then Option 4 |
| **Out of County Client – Must Include**[ ] AB1299 – Attach Notice of Presumptive Transfer, OR[ ] AAP/KinGAP – Attach SAR & written COR approval to serve youth under County contract due intent to discharge youth to San Diego residence[ ] Written COR exception |
| **CLIENT INFORMATION** |
| **Client Name**:       | **Client ID**:       | **Client Date of Birth:**       |
|  **DAY PROGRAM INFORMATION** |
|  **Legal Entity:**       **Fax**:       | **Program Name:**      **Unit#:**       | **Phone**:      **Subunit#**:       |
| **SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST**Day Intensive Half (DIH) at least 3 hours | Day Intensive Full (DIF) more than 4 hours |
| **SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):**[ ] Intensive Outpatient Program (IOP – DIH up to 12 weeks) [ ] Partial Hospitalization Program (PHP – DIF up to 4 weeks)**AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)**[ ] Up to 3 Days Per Week [ ] Up to 5 Days Per Week [ ] Up to 7 Days Per Week |
| **MEDICAL NECESSITY CRITERIA FOR DAY SERVICES**  |
| **DIAGNOSIS**: Provide the ICD 10 mental health diagnoses that are the focus of mental health treatment

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| **Diagnosis 1:**       | **Diagnosis 2:**       | **Diagnosis 3:**       |

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|  **Medical Necessity Criteria (**[**BHIN 21-073**](https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf)**)****Client has a condition placing them at high risk for a mental health disorder due to experience of trauma** (*choose at least one*): [ ]  Scoring in the high-risk range under a trauma screening tool | Score:       [ ]  Involvement in the child welfare system [ ]  Juvenile justice involvement [ ]  Experiencing homelessness Additional information as needed:      **OR****Client has at least one of the following:**[ ]  A significant impairment or reasonable probability of significant deterioration in an important area of life functioning Explain:     [ ]  A reasonable probability of not progressing developmentally as appropriate | Explain:     [ ]  A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide | Explain:      **AND****The client’s condition is due to one of the following:**[ ]  A diagnosed mental health disorder, according to the criteria of current editions of the DSM and the ICD-10 classifications[ ]  A suspected mental health disorder that has not yet been diagnosed | Suspected DSM/ICD Mental Health Diagnosis:      [ ]  Significant trauma placing the beneficiary at risk of a future mental health condition | Explain:      |

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| **ANCILLARY SERVICES REQUEST (INTERNAL)**IOP must request ancillary authorization (through this form) if client is going to receiveDay Services and Outpatient Services from the same provider/program |
|  **Outpatient Subunit#**:      1. **SELECT THE AMOUNT OF OUTPATIENT SMHS REQUESTED PER DAY** (Inclusive of all Individual, Collateral, ICC, IHBS and Group SMHS provided by Day Service provider in addition to Day Program Services):

 [ ]  Up to 8 hours per day [ ]  Other:      1. **MEDICAL NECESSITY FOR OUTPATIENT SMHS** (must select at least one):

 [ ]  Requested service(s) is not available during day program hours. Describe why service is not available:       [ ]  Continuity or transition issues make these services necessary for a limited time. Describe the need:       [ ]  These concurrent services are essential for coordination of care. Describe why services are essential:       |

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| **When a client is concurrently receiving SMHS from another provider, the IOP/PHP must request, obtain, and submit to Optum a** **stand-alone (external) Ancillary Specialty Mental Health Services (SMHS) Request Form**  |

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| **Program Clinician (Print):**        **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Licensed Clinician (Print):**       **Co-Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **Credentials:**      **Date:**      **Credentials:**      **Date:**       |

* Co-Signature required if Program Clinician is not a Licensed Mental Health Professional

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| **FOR OPTUM USE ONLY****Optum completes and retains. Within 5 business days of Optum receipt, authorization determination status will be viewable to the requesting provider in the CCBH Clinicians Home Page Authorizations Tab.**  |

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| **DAY SERVICES PRIOR AUTHORIZATION DETERMINATION**[ ]  **Day Services scope, amount and duration authorized with** **START DATE**:       **END DATE**:       **Day Services request** is [ ]  **denied** [ ]  **modified** [ ]  **reduced** [ ]  **terminated or** [ ]  **suspended as follows**:       *NOABD was issued to the beneficiary and provider on the following date:*        |
| **ANCILLARY SERVICES DETERMINATION (INTERNAL)** |
| [ ]  **Internal Ancillary OP SMHS authorized: START DATE**:       **END DATE**:      **Internal Ancillary OP SMHS request is** [ ]  **denied** [ ]  **modified** [ ]  **reduced** [ ]  **terminated or** [ ]  **suspended as follows:**      *NOABD was issued to the beneficiary and provider on the following date:*       |
| **ANCILLARY SERVICES DETERMINATION (EXTERNAL)** |
| **(External authorization requests are submitted to Optum when indicated through a separate Ancillary SMHS Request Form)**[ ]  **External Ancillary SMHS authorized: START DATE**:       **END DATE**:      **External Ancillary SMHS request is** [ ]  **denied** [ ]  **modified** [ ]  **reduced** [ ]  **terminated or** [ ]  **suspended as follows:**      *NOABD was issued to the beneficiary and provider on the following date:*       |

**Optum** **clinician Signature/Date/Licensure**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_