	Shasta County Health and Human Services Agency Managed Care, Compliance and Quality Management
	Therapeutic Behavioral Services: Referral and Authorization

1.0 Persons/Programs Affected *(Check all that apply)*

☒ All Staff	☐ All Managers	☐ All Supervisors	
☒ Children's			

*Each branch to have unique Persons/Programs Affected

**All employees include all employees--full-time, part-time and extra-help.*

2.0 Definitions

Early and Periodic Screening Diagnosis, Treatment (EPSDT): For the purposes of this policy, EPSDT is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility that allows for periodic screenings to diagnose and identify behavioral health care needs. Treatment services are provided based on the identified diagnosis and health care needs.

Functional Behavioral Analysis: Analysis of the client's behaviors and antecedents that will be the focus of treatment for Therapeutic Behavioral Services (TBS).

Notice of Action (NOA): For the purposes of this policy, a NOA is a form provided to the client when any of the following occur:

- The client is determined not to meet medical necessity;
- Payment authorization of a requested service is denied or modified;
- Services are not provided in a timely manner.

Treatment Authorization Request (TAR): Form utilized for pre-authorization of specialty mental health services.

3.0 Policy

The following information describes the updated procedures for the referral and authorization of Therapeutic Behavioral Services (TBS), including the service eligibility requirements, the referral completion steps, and the internal review process for this referral. All eligible individuals and their parent/guardian/legal representative will be provided the most current California Department of Health Care notice regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Therapeutic Behavioral Services (TBS).

Therapeutic Behavioral Services: Referral and Authorization

TBS Class Eligibility

To be eligible for TBS, individuals must be full-scope Medi-Cal beneficiaries, under 21 years of age, and meet medical necessity criteria for Medi-Cal funded specialty mental health services. Further, individuals must meet one or more of the criteria for the class, as defined in the court order that guides the implementation of TBS in California. Criteria for being a member of the class are:

1. Children/youth currently placed in Rate Classification Level (RCL) facilities 12 or above, and/or a locked treatment facility for the treatment of mental health needs; and/or

2. Children/youth are being considered for placement in these facilities; and/or

3. Children/youth who have received psychiatric inpatient hospitalization services at least once in the last 24 months; and/or

4. Child/youth has previously received TBS as a certified member of the class; and satisfy the following criteria:

    - TBS are available to beneficiaries who are at risk of admission to a hospital for acute psychiatric inpatient hospital services or to a psychiatric health facility for acute care as a result of behaviors that may benefit from TBS interventions.

    - The operational definition of being considered for placement at RCL 12 or higher is that the full-scope Medi-Cal beneficiary under 21 years of age is eligible for services from an agency with statutory responsibility for out-of-home placement of youth; that agency has staffed the youth being considered for TBS with the Placement Prevention and Resource Team (PPRT) and PPRT has determined that placement at a level 12 or higher facility is highly likely if TBS and other interventions are not effective in stabilizing the current placement.

    - In a case where an Adopted Youth is receiving Specialty Mental Health Services (SMHS) and is at risk of placement through their Adoption Assistance Program (AAP) funding, the clinician or case-manager could request a Clinical Care

meeting (CC) to look at all pertinent information and determine the need for TBS services. Documentation by the presenting clinician or case-manager in a progress note, as well as CC notes would provide the justification for TBS.

- The child/youth meets the requirements of "at risk of" hospitalization in an acute care psychiatric facility when hospitalization is one option (not necessarily the only option) that is being considered as part of a set of possible solutions to address the child/youth needs. Additionally, a child/youth meets the requirements when his or her behavior could result in hospitalization in such a facility if the facility were actually available, regardless of whether hospitalization is available.

- The operational definition of being at risk of placement in a hospital for the treatment of mental health needs is that the child/youth is presenting symptoms of a mental disorder resulting in behaviors that are placing the individual or others at risk of harm.

- A child/youth meets the requirements of "being considered for" placement in an RCL 12 or above when an RCL 12 or above placement is one option (not necessarily the only option) that is being considered as part of a set of possible solutions to address the child/youth's needs. Additionally, a child/youth meets the requirements when his or her behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available.

Criteria for TBS Eligibility

TBS is a short-term intervention designed to be part of a comprehensive mental health treatment plan. Therefore, prior to consideration for TBS the client must have received a comprehensive mental health diagnostic assessment that results in a determination of medical necessity for specialty mental health services and is the basis for the comprehensive mental health treatment plan.

Once the child/youth is identified as meeting the requirements for class eligibility, the need for TBS is based upon the following criteria:

1. The child/youth is receiving other specialty mental health services; and

2. The clinical judgment of the mental health provider indicates that it is highly likely that without the additional short-term support of TBS that:

    a. The child/youth will need to be placed in an RCL level 12 or higher residential care, including acute care (hospital inpatient services, psychiatric health facility services, and crisis residential treatment services), because of the child/youth's behaviors or symptoms which jeopardize continued placement in the current facility or;

    b. The child/youth is transitioning from any of the above listed placements and needs this additional support to transition to a home or foster home or lower level of residential placement.

Initial Authorization and Re-Authorization of TBS

The authorization/re-authorization processes shall not include staff involved in providing TBS.

Authorization/re-authorization decisions are subject to the Notice of Action (NOA) requirements, including advising the beneficiary of the right to request continuation of previously authorized services pending the outcome of a Medi-Cal fair hearing.

All TBS will be initially authorized for a maximum of 30 days. Prior to the end of the initial 30 day authorization period the following must be completed by the TBS Provider and submitted for approval:

- Functional Behavioral Analysis (Attachment A);
- TBS Client Treatment Plan per Title 9;
- Treatment Authorization Request (TAR) for TBS. (Attachment B)

TBS may be re-authorized for up to 60 days per TAR based upon documentation submitted by the provider that supports continued medical necessity for services.

Therapeutic Behavioral Services: Referral and Authorization

4.0 Procedure

A. Referral Procedure

1. The client must have an initial mental health assessment, by the Mental Health Plan (MHP), or a contracted MHP Medi-Cal provider, establishing that the client meets medical necessity requirements for and is in need of specialty mental health services.

2. The primary clinician consults with the family regarding their desire to participate in TBS and with their input, identifies and documents the risk behaviors that would be addressed by TBS.

3. The TBS Assessment/Referral and Authorization Form (Attachment C) is completed and forwarded to Shasta County Managed Care Program, along with a copy of the updated Client Treatment Plan, with TBS added as an intervention, and the PPRT Review Request (if the class eligibility was determined by a PPRT) (Attachment D) or the progress note date of the Clinical Care meeting (if the class eligibility was determined by a Clinical Care).

4. If the primary clinician is an out-of-plan provider, the most recent mental health assessment will be forwarded to Shasta County Managed Care Program. Refer to Shasta County Managed Care Procedures for further detail.

5. In cases in which a provider indicates or the MHP determines that the normal delays that may occur in the authorization process could seriously jeopardize the welfare of the beneficiary, an expedited review may be requested (Expedited Review Request Form - Attachment E).

B. Procedure for Functional Behavioral Analysis and TBS Plan Development

1. If the Referral/Assessment is authorized, Managed Care Program with input from the family and primary clinician/Single Accountable Individual (SAI), or Organizational Provider, initiates the referral to a TBS provider.

2. When the referral for TBS is accepted by the provider, an initial 30-day authorization period begins. During this period the following should be completed: an initial coordination meeting with the client's service team, the completion of the Functional Behavioral Analysis (FBA) (Attachment A) of target behaviors, and identification of TBS interventions to address them, and the subsequent formulation of a TBS Client Plan.

C. Authorization of ongoing TBS:

1. The TBS Provider submits the FBA, a TBS Client Plan and an initial TBS TAR to Shasta County Managed Care Program.

2. Managed Care Program makes a determination to authorize TBS based on their review of the FBA, TBS Client Plan, and the TAR, which should demonstrate medical necessity for services and contain other elements required by the State Department of Health Care Services Mental Health Plan contract and regulations.

3. TBS may be reauthorized subsequently, for a maximum period of 60 days, if the provider completes a second TAR documenting continuing medical necessity and, if needed, a TBS Client Plan amendment.

4. If a third authorization is submitted for continuation of TBS it must continue documentation of the client progress on the TBS plan to date; the medical necessity for an additional TAR; and a TBS Client Plan/Transition Plan amendment if needed, and a specific plan for termination of TBS.

5. If a fourth authorization is requested, it should be accompanied by a progress report that includes a summary of the TBS services provided thus far and justification for the additional authorization (See TBS Documentation Procedure for Content requirement). Reauthorization may be granted if the client continues to meet medical necessity criteria for TBS, the interventions demonstrate effectiveness, and progress toward the specific measurable goals and a decrease in the risk behaviors is expected.

6. Weekly progress notes and discharge summaries will be submitted to Managed Care Program for review.

7. If the TBS is intensive over a period of time without additional improvement toward the treatment goals, the following steps may take place:
   a. Conduct a service team meeting including the TBS provider, client and family to explore obstacles, plateaus, or completion. If necessary, revise the TBS Client Plan or create a discharge plan. If the client/family declines the revised treatment plan, services may be discontinued.

   b. The benefit of the current residential placement/living situation may be addressed at this time.

   c. If services are to be discontinued, the following will take place:
      1) A discharge meeting with the service team will be conducted; and
      2) When appropriate, a NOA will be issued by Managed Care Program.

References and Citations

DMH Information Notice No: 08-38
DMH Information Notice No: 04-05
DMH Information Letter: 99-03
Federal Court Case: Emily Q vs. Bonta' – November 14, 2008

5.0 Attachments

Attachment A - Functional Behavior Analysis
Attachment B - TAR
Attachment C - TBS Assessment/Referral & Authorization Form
Attachment D - Placement Prevention & Resource Team Review Request
Attachment E - Expedited Review Request

6.0 Revision History

Date	No.	Action:
5/31/11	6500	Adopted
05/28/2014	2014-21	Revision to new format, procedural updates & renumbered from 6500 to 2014-21
08/02/2016	2014-21.2	Updated language re Adoptive Youth

7.0. Other Agency Involvement

NA

8.0 Authorization/Signatures

The above policy and procedure has been reviewed and is authorized for immediate implementation:

Donnell Ewert, MPH, Director
Health and Human Services Agency

8/18/16
Date

Dianna L. Wagner, MS, LMFT, Director
HHSA Children's Services

8.8.16
Date

Tracy Tedder, Director
HHSA Business & Support Services
Managed Care Compliance Program

8/16/16
Date

Attachment A

TBS
FUNCTIONAL ANALYSIS AND BEHAVIOR PLAN

Client: _____ **Staff:** _____ **Date:** _____

Team Members:

_____ _____

_____ _____

_____ _____

Identified Target Problem Behavior:

Client Strengths:

Summary of Behavioral Observations and Data Collection: (including frequency, duration, interval and intensity:

Setting(s)/Components of the Situation: (where behavior occurs - note activities, people present, proximity to other, time of day, length of activity, requirements of the task, triggers and antecedents.)

Consequences & Outcomes of Behavior: (what happens as a result of the behavior? Is there something reinforcing the client?)

Assumptions Regarding Communicative Intent/Functions of the Behavior:

☐: Attention	☐: Power	☐: Asking for a Break
☐: Revenge	☐: Stimulation	☐: Asking for Help
☐: Arousal	☐: Avoidance/Escape	☐: _____

Comments:

Health/Medical Related to Behavior:

Replacement or Alternative Behavior: (any realistic positive behavior which serves the same function and could be substituted for the problem behavior, may be coupled with an alternative activity.)

MODIFICATIONS THAT WILL SUPPORT POSITIVE BEHAVIOR CHANGE

ENVIRONMENTAL MODIFICATIONS: (caregiver support of training)

TASK MODIFICATIONS:

MANIPULATION OF ANTECEDENTS / CONSEQUENCES:

HOW DESIRED NEW BEHAVIOR WILL BE TAUGHT AND REINFORCED:

BENCHMARKS AND TIME LINE:	
BENCHMARK Measurement of Behavior	**TIMELINE** Date by which to be achieved

Transition Plan:

The undersigned have read and agree to the above Behavior Intervention Plan.

Signature	Date	Signature	Date
Signature	Date	Signature	Date
Signature	Date	Signature	Date

Attachment B

SHASTA COUNTY MENTAL HEALTH PLAN
CONFIDENTIAL

Client Name _____ Medical Record No. _____

ORGANIZATIONAL PROVIDER TREATMENT AUTHORIZATION REQUEST

☒ Condition not expected to be responsive to physical health care based treatment.

Complete the appropriate space for type of service.

_____Mental Health Services
_____Day Rehabilitation
_____Day Treatment Intensive
_____Medication Support (MD only)
_____Case Management

Specify frequency & duration as appropriate.

Number of Weeks _____
#Days per Week (Day Rehab/Intensive Only) ____
From Date _____
To Date _____

********** ********** ********** ********** ********** ********** **********

_____TBS Added to Treatment Plan

Note: PAYMENT FOR ANY OF THE ABOVE SERVICES IS CONTINGENT UPON MEDI-CAL ELIGIBILITY AND PROVIDER ELIGIBILITY FOR PARTICIPATION IN THE MEDI-CAL PROGRAM.

MENTAL HEALTH PLAN SCAMP COMMITTEE USE ONLY

Services are authorized as follows:

_____Mental Health Services
_____Day Rehabilitation
_____Day Treatment Intensive
_____Medication Support (MD only)
_____Case Management

Number of Weeks _____
#Days per Week (Day Rehab/Intensive Only) _____
From Date _____
To Date _____

********** ********** ********** ********** ********** ********** **********

_____TBS Referral Approved By_____ Date _____

Authorization Status: ☐ 14 calendar day extension ☐ Denied ☐ Modified

by _____ Date _____
name of reviewer (Print)

EXTENSION PENDING RECEIPT OF FOLLOWING INFORMATION / REASON FOR DENIAL:

☐ To avoid disruption of service, decision deadline is extended 14 calendar days pending receipt of the following information:

_____

_____

☐ Reason for denial: _____

_____

NOA ☐A ☐B ☐ Other: ___- completed_____

☐ Authorized _____Date _____

County Code _____Aid Code _____ Verified by _____
Date _____MediCal Eligible _____ Medicare Eligible _____

Previous Authorization Expiration Date (If applicable) _____

DISTRIBUTION
Original - Organizational Provider
Copies to: □ Business Office □ Fiscal Data Services □ Medical Records □ File

Changes or alterations to this form by the Provider are not permitted. Authorization Does Not Guarantee Payment. Payment Is Subject To Eligibility.

SHASTA COUNTY MENTAL HEALTH SERVICES
THERAPEUTIC BEHAVIORAL SERVICES (TBS)
ASSESSMENT/REFERRAL & AUTHORIZATION FORM

Name of Referring Clinician:_____ Phone_____

Client Name: _____ Medi-Cal #_____

Soc. Sec. #:_____ Date of Birth_____

Ethnicity: _____ Gender _____

Parent/Caregiver Name:_____ Phone _____

Address:_____

Primary Clinician/Coordinator (if different than above):_____

Agency:_____ Phone:_____

Current Residence:
_____Family home _____Foster home _____Group home: Level _____

_____Other-specify:_____

Placing Agency (if applicable):_____

Treating Psychiatrist:_____ Phone:_____

Current Medications:_____

_____

Service providers in addition to primary clinician/Clinical Coordinator who may be part of the treatment team:_____

_____

_____

Eligibility Criteria

_____Confirmed with Business Office that client is a full scope Medi-Cal beneficiary under 21 years of age.

_____Client has received diagnostic assessment, which has established that the client meets medical necessity criteria for specialty mental health services in addition to TBS.

_____Client meets Initial 30 Day TBS criteria and copy of Risk Tool data (Pilot) is attached.

Assessment date:_____

(Referrals from Organizational Providers must be accompanied by a copy of the initial diagnostic assessment)

Diagnosis:

Disorders & Conditions: _____

Psychosocial & Contextual Factors: _____

Client Name_____ Chart #_____

Functional Impairments

_____

_____

Client meets one or more of the following certified class criteria:

_____Client has received a psychiatric inpatient hospitalization services at least once in the last two (2) years; Date of Hospitalization:_____

_____Client is currently placed in a Rate Classification Level (RCL) 12 or above facility;

_____Client is being considered for placement in RCL 12 or above and has been reviewed and certified by Placement Prevention and Resource Team (PPRT) or the CCM for placement at this level (attach documentation) Date of PPRT or CCM review:_____

_____; **and/or**

_____Client has previously received TBS as a certified member of the class.

Need for this level of services:

It is highly likely in the clinical judgment of the referring clinician that without additional short-term support of TBS:

_____The client living situation is in jeopardy due to mental illness symptoms, **and/or;**

_____The client will need to be placed in a higher level of residential care, including level 12-14 group home or a locked facility for the treatment of mental health needs, because of changes in the child/youth's behaviors or symptoms that places a risk of removal from the home or residential placement; **or**

_____The child/youth needs this additional support to transition to a lower level of residential placement or return to the natural home from level 12-14 group home care or a locked facility for the treatment of mental health needs; **and**

_____The client is currently receiving specialty mental health services other than TBS.

List the current mental health services: (include intensity and duration):_____

_____

_____

_____

_____

Describe critical factors jeopardizing placement and why less intensive services than TBS are not appropriate or have not been tried:

_____

_____

_____

_____

_____

Explain why TBS is necessary to sustain the living situation and how it is expected to stabilize the youth in the existing living situation or facilitate transition to a lower level of care:

_____

_____

_____

Client Name_____ Chart #_____

Behavioral Clinical Data

Target Behavior(s) - Describe one or two specific behavior(s) and/or symptom(s) that jeopardize continuation of the current living situation or that are expected to interfere with transition to a lower level of care (include frequency and duration of target behaviors):

_____
_____
_____
_____

Describe what changes in behavior and/or symptoms TBS is expected to achieve:

_____
_____
_____
_____

Suggested Behavioral Treatment Goals/Replacement behaviors to be achieved through TBS (Identify specific measurable benchmarks with target dates to guide the reduction and termination of TBS services):

_____
_____
_____
_____

Child's Coping Skills/Strengths (In collaboration with child's caregivers/significant others identify and describe in *behavioral terms* how the child sometimes effectively copes with the targeted behavior(s), or what transferable skills he has in coping with other challenging situations):

_____
_____
_____
_____

Substance Use/Abuse

_____ Past _____ Current _____ None

Describe (type, frequency, and amount):_____
_____
_____

Functioning in school (identify behavioral issues and strengths, type of educational placement):

_____
_____
_____

Individualized Education Plan for Special Education services:_____Yes _____No

_____**TBS has been incorporated into the Client's Treatment Plan (attach a copy)**

Referring Clinician's Signature _____ Date _____

Client's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

MENTAL HEALTH PLAN UM/UR TEAM USE ONLY

Functional Behavioral Analysis and TBS Client Plan Development Authorization

Treatment Plan: Development of TBS Client Plan using evaluation of client's target behaviors through Functional Behavioral Analysis (FBA) and response to initial 30 day TBS interventions. If TBS Class Eligible services are indicated, submit Client Plan, and initial TAR for Class TBS services to Shasta County Mental Health.

Provider_____

Authorization Period: From Date_____ To Date_____

Authorized by:_____ Date:_____

Comments: _____

_____

_____

_____

_____ TBS Approved on Client Service Plan

Client Name: _____ Chart#_____

Distribution List:

1) Managed Care Clerk
2) Medical Records
3) Provider Enrollment
4) Fiscal Data (Page 4 only)

Shasta County Placement Prevention & Resource Team Review Request

Please complete all areas of this form Attachment D

Date: _____ **Child's Name:** _____ **DOB:** _____

Social Worker/PO: _____ **Clinician:** _____

What is being requested? _____

If Wraparound is being requested, is this child's parent an Options client? ☐ Yes ☐ No

Has relative placement been ruled out? (Family Finding) ☐ Yes ☐ No

Why is placement at this level appropriate & necessary? (Include description of other interventions utilized and outcomes): _____

Current placement considerations: _____

*** Please attach placement history, including current placement.**

Brief overview of child's entry into the system: _____

Family Considerations (ongoing issues/concerns, views, placement potential, commitment, involvement): _____

Child Considerations (strengths/challenges, attitude, goals): _____

For children between 15.5 and 18 years of age:

☐ **Child is participating in ILP. If not, why:** _____

☐ **There has been a screening for SSI. If not, please see supervisor.**

Child is receiving Special Education Services: ☐ Yes ☐ No **If yes, please explain:**

_____

Date of last IEP: _____ **Primary Educ. Disability:** _____

Child's Grade Level: _____ **Holder of Educ. Rights:** _____

Child has NPS or GC26.5 designation: ☐ **Yes** ☐ **No**

You have consulted with Educational Liaison, Mental Health Sup./Clinician, and Public Health Nurse.

☐ **Yes** ☐ **No**

Brief description of relevant issues and plan to address them: _____

Plan for Transition/Discharge (description of child's permanent plan, where child will go upon discharge; with whom): _____

- **Child's support team:** _____
- **Child will be ready for transition when:** _____
- **Anticipated timeframes for transition process:** _____
- **Others who will be involved in transition planning/process:** _____

Supervisor Signature: _____ **Date:** _____

Shasta County Placement Prevention & Resource Team Review Request:

Directive/Recommendations/Feedback to Presenter

Date: _____ **Child's Name:** _____ **DOB:** _____

Social Worker/PO: _____ **Clinician:** _____

EACH SOCIAL WORKER/PROBATION OFFICER IS EXPECTED TO DISCUSS ALL COMMITTEE RECOMMENDATIONS/DIRECTIVES WITH HIS/HER SUPERVISOR. THESE RECOMMENDATIONS AND DIRECTIVES DO NOT SUPERSEDE ANY OTHER MANDATES OF THE RESPECTIVE DEPARTMENTS, OF SHASTA COUNTY, OR OF THE LAW.

Committee Directives/Recommendations/Feedback (This section for Committee use only):

Authorization given:

- ☐ **GH at RCL** _____
- ☐ **THPP**
- ☐ **Wraparound (at risk of placement at RCL10 or above)**
- ☐ **Therapeutic Foster Care**
- ☐ **Out of State Placement**
- ☐ **Child is at risk of placement at RCL12 or above. (This does not qualify as authorization for GH, which must be additionally requested/given.)**

If applicable, reason(s) for denial of request for authorization: _____

- **Please return to PPRT for next review in:**
  - ☐ **Six months**
  - ☐ **Three months**
  - ☐ **Other** _____
  - ☐ **Not applicable**

- **Please include the following documentation/information at next review:**

_____

_____

_____

Distribution of this form: (Attach copy of this form to PPRT Review Request.)
Social Worker/PO: _____
Clinician: _____
Other: _____

Attachment 28C

EXPEDITED REVIEW REQUEST
Mental Health Plan Payment Authorization
For Therapeutic Behavioral Services
Mental Health Plan Name: _____

Initial Authorization Request _____ Reauthorization Request _____

Provider Information	**Beneficiary Information**
Provider Name	Beneficiary Name
Provider Address	Beneficiary Medi-Cal Number
Provider Number_____ Phone Number _____	DOB _____

Provider Certification:

I certify under penalty of perjury that an expedited review of the accompanying MHP payment authorization request is necessary because the standard 14 day authorization timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

Signature of Provider _____ Date _____

Examples of Reasons for an Expedited Request

Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14 days.

The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.

The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap in services, and the request is being made before the end of the previously authorized service period.