SECTION 2: SERVICES REQUIRING AUTHORIZATION

The Fresno County Mental Health Plan (FCMHP) is strongly committed to providing quality services to its beneficiaries, while supporting a philosophy of brief, problem solving treatment, utilizing specific treatment goals. The FCMHP's authorization processes are driven by this philosophy.

Pre-authorization of services is only required for Therapeutic Behavioral Services, Day Treatment/Day Rehabilitation, and for minors who are court dependents of other counties placed in foster care or group homes in Fresno County. The FCMHP does not require pre-authorization for any other services.

2.0 Service Authorization Requests

The Service Authorization Request (SAR) Process is an authorization process for minors who are court dependents of other counties placed in foster care or group homes in Fresno County.

2.0.1 Requests for SARs

In order to bill for mental health services provided to minors who are court dependents of other counties and are placed in foster care or group homes in Fresno County, permission to treat must be received from the County of Financial Responsibility (CFR).

The provider must check the minor's Medi-Cal eligibility and if the county indicated as the county of financial responsibility is not county 10, Fresno, the provider must check the Medi-Cal aid code to determine eligibility for the SAR process.

SAR eligible aid codes are:

Adoptive Aid: 03, 04, 06, 07
Kinship Guardianship: 4F, 4G, 4K, 4S, 4T
Foster Care: 4H, 4L, 4N, 40, 42, 43, 46, 49, 5K

The provider may contact the SAR Coordinator at (559) 600-4645 for consultation or questions about an Assessment or Plan of Care. The provider must fax or mail the Assessment and Plan of Care as soon as possible to the SAR Coordinator for service authorization review.

2.0.2 Requesting an initial SAR:

If the minor has a SAR eligible aid code, the following information needs to be sent to the SAR Coordinator in the Managed Care Division:

- Client Name
- Client DOB
- SSN or CIN
- Copy of the minute order or other form of court order that authorizes mental health assessment and continuing services as needed.
- Copy of the JV220-JV223 if medications have already been approved by the court.
- Brief summary of the problems/behavioral concerns that have caused the client to seek treatment.
- Residence Address and Phone #
- Caregiver Name
- Social Worker/Probation Officer
- Social Worker/Probation Officer Phone #

The FCMHP SAR Coordinator will complete an initial Service Authorization Request (SAR) for assessment and plan development and fax it to the County of financial responsibility (CFR).

When an approved SAR is received from the CFR, a copy will be faxed to the provider and a copy will be retained in the Managed Care file to allow cross checking of claims received for the minor.

The provider may provide and bill for any services approved on the initial SAR during the approved date range using the claiming process described in Section 4, Eligibility and Claims, of this manual.

2.0.3 Requesting an ongoing SAR:

After assessing the minor, the contracted provider must fax a copy of the completed assessment and treatment plan to the Managed Care Department.

The FCMHP SAR Coordinator will complete an ongoing Service Authorization Request (SAR) for the ongoing services the contracted provider has indicated on the treatment plan. The ongoing SAR, assessment, and treatment plan will be faxed to the County of Financial Responsibility (CFR).

When an approved ongoing SAR is received from the CFR, a copy will be faxed to the provider and a copy will be retained in the Managed Care file to allow cross checking of claims received for the minor.

The contracted provider may provide and bill for any services approved on the ongoing SAR during the approved date range using the claiming processes described in the Eligibility and Claims section of this manual.

2.1 Procedure for Psychiatric Inpatient Hospital Professional Services

- The FCMHP **does not** require pre-authorization of psychiatric inpatient hospital professional services.

- The medical necessity criteria for psychiatric inpatient hospital professional services follow the reimbursement criteria for psychiatric inpatient hospital services. (Refer to Section 3 for medical necessity criteria for inpatient services.)

- Billing for psychiatric inpatient hospital professional services follows the same process outlined in Section 6, Eligibility and Claims, except that claims for professional fees can be submitted up to 60 days beyond the billing month.

- Billing for psychiatric inpatient hospital professional services may be denied if documentation does not support medical necessity for inpatient acute or administrative stay.

- Billing for psychiatric inpatient hospital professional services may be denied if the duration of the service does not match the duration noted in the patient's hospital progress note, or if a duration is not noted on either the claim or the progress note.

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