Los Angeles County Department of Mental Health
Quality Assurance Unit

Pre-Authorization for IHBS/TBS/TFC

Frequently Asked Questions (Updated as of 5/13/21)

Revised QA Bulletin 20-05R**:** QA Bulletins - Department of Mental Health (lacounty.gov)

ICC Training PowerPoint: https://dmh.lacounty.gov/qa/qa-training/

Provider Connect Training:https://web.microsoftstream.com/video/fa9ff94f-6969-4395-bad3-644bee3267e1

Eligibility/Service Provision

1. Would there be a scenario when a client would qualify for ICC but not IHBS?
Yes, it is possible. There may be clients who would benefit from having a CFT to coordinate services but are not in need of IHBS services in the home/community.

2. What is the difference between interventions billed under the ICC/IHBS codes and interventions not billed to these codes?
ICC and IHBS are services that are more intensive and specifically intended for children/youth who are involved in multiple child serving systems. Both of these services require collaboration between agencies through a Child and Family Team (CFT) meeting.

3. If the client is eligible for ICC, are we required to lead CFT's? What if the client is not involved with any other child welfare serving system? Are CFT's still required?
Yes. CFTs are a core component of ICC services. You must have a CFT in order to provide ICC services.

4. When do providers need to complete the ICC Eligibility Form? ***(Added 2/25/21)***
The ICC Eligibility Form must be completed prior to developing the Client Treatment Plan and any time the Client Treatment Plan is being considered for updates based on significant changes in the client's condition or status (e.g., becomes involved in another child serving system). The form is used to assist a provider in determining if ICC services are needed/medically necessary.

5. Are outpatient programs that provide TCM required to transition to ICC services? If so, how do they go about this?
Yes, if any of the clients in the outpatient program are eligible and require ICC services, the outpatient program should consider ICC. For further information, please see the ICC training PowerPoint: https://dmh.lacounty.gov/qa/qa-training/

6. Please define cross-agency collaboration. ***(Added 2/25/21)***
Cross-agency collaboration is when coordination happens between more than one child-serving system (e.g. between DMH and Regional Center).

7. If a family refuses ICC services, are they still eligible for IHBS services? ***(Added 2/25/21)***

There must be a CFT in order to have IHBS services. ICC is a significant component of CFTs; therefore, you must be getting ICC services in order to get IHBS. Providers should discuss with the family the benefit of the cross-agency collaboration amongst the child serving systems.

8. If a client is in wraparound with our agency but has an outside therapist who completed the assessment/care plan/CANS—who submits for authorization? The Wraparound agency or the agency providing the therapy? ***(Added 2/25/21)***
   The agency that is going to provide the IHBS services must submit the authorization request. In the example provided, the Wraparound agency who will be providing the IHBS would submit the authorization request.

9. If a client's DCFS case closes, are they still eligible for ICC/IHBS? ***(Added 2/25/21)***
   Yes, having an open DCFS case is not a requirement for ICC and/or IHBS. However, you should use the ICC Eligibility Form to determine if the client may continue to benefit from ICC and/or IHBS.

10. IHBS is an intensive service. Does this mean we are asked to provide in home services despite COVID19 restrictions? Or can this be done virtually? ***(Added 2/25/21)***
    IHBS may be provided in-person, via telehealth or via telephone.

11. Can PEI clients receive ICC? ***(Added 2/25/21)***
    Yes, as long as ICC services are medically necessary.

12. Can we request IHBS pre-authorization for a client who is indigent or does not have Medi-Cal? ***(Added 2/25/21)***
    Yes, a client who is indigent or who does not have Medi-Cal can still qualify for IHBS. LACDMH made a decision to provide the same services to indigent as to Medi-Cal clients. The Supplemental IHBS Assessment was updated on 2/5/21 to reflect this.

Billing

1. How do we claim for completing the supplemental assessment form?
   It depends on what service is being provided when you are gathering information to complete the form. For example, if it was completed during the mental health assessment session, then claim 90791/2. If it was done during a therapy session, then claim the applicable therapy code. If done while developing the treatment plan, then plan development - H0032.

2. If a practitioner provides IHBS/TBS multiple times in a day, should they lump these services into one note? We've been denied claims by Medi-Cal for a staff member doing two or more IHBS/TBS services in a day.
   A practitioner may provide these services more than once in a day; however, a duplicate override modifier (e.g. 76) is needed for these claims. Adding the modifier prevents these services from looking like duplicate claims. For more information about modifiers, refer to the Procedure Code Modifiers document.

3. If the client meets the criteria for both ICC and IHBS, can ICC be billed prior to IHBS being authorized?

Yes. ICC does not require pre-authorization.

4. Our TBS staff are not AMHD (e.g. Case Manager, Community Worker). Can they bill H2000 for completing the TBS Supplemental Assessment? ***(Added 2/25/21)***
   Yes, they can claim H2000 for completing the TBS Supplemental when done to inform the mental health assessment. When completing the TBS supplemental for reauthorization, you may claim H2019. Keep in mind that the TBS Supplemental Assessment will require a co-signature of an AMHD.

5. How soon can we bill for the authorized services? ***(Added 2/25/21)***
   Once the authorization is approved, providers can start providing and billing for services for any dates of service on or after the start date of the authorization.

6. Can we still bill 90887 (Collateral) when a client is receiving IHBS? ***(Added 2/25/21)***
   Not recommended. Since IHBS includes collateral components, DMH would expect H2015HK (IHBS) to be billed for collateral services when you are working with the significant support person on skills/training to assist the client in attaining their mental health objectives.

Forms and Documentation

1. Are we able to include IHBS language in the client treatment plan prior to receiving authorization to avoid our staff having to go back and update client treatment plan once services are authorized?
   Yes. Given that these services will be provided to address the client's mental health condition, it would be expected that the treatment team would have discussed these services with the client and family and added them to the client's treatment plan prior to requesting authorization.

2. Should TBS Supplemental Assessment be completed every 6 months (vs. every 3 months)?
   Yes, the pre-authorization and the treatment plan requirement is now aligned at 6 months.

3. Are we able to submit existing TBS Supplemental Assessments for our current TBS clients for authorization?
   As long as the TBS Supplemental Assessment is done on the form with revision date 10/1/20, then it may be used.

4. Who can complete the supplemental assessments?
   Practitioners of any discipline can complete supplemental assessments; however, an Authorized Mental Health Discipline (AMHD) must sign them.

5. If we do a re-authorization at 6 months, would we need to submit the CANS again? ***(Updated 2/25/21)***
   No, per QA Bulletin 20-05R, the CANS is no longer required to be submitted as part of the pre-authorization request. The CANS, however, should continue to be completed every 6 months and used as an important element of monitoring and planning.

Provider Connect & M-Auths for Claiming

1. Is there a help line for Provider Connect? ***(Updated 2/25/21)***

   There is not a direct help line for Provider Connect. Providers would submit a DMH HEAT ticket via the SSLVPN site:https://dmh.lacounty.gov/pc/cp/si/

   The Provider Connect Manual and Training Video can be found at the following link: https://dmh.lacounty.gov/pc/cp/provider-connect/

2. Do we need to complete the COLA agreement for acceptable use to get access to Provider Connect? It seems to be a form for county workers only
   Yes, and it applies to both Directly-Operated and Legal Entity providers.

3. Is it possible for the prior authorization for TBS, IHBS, TFC to be tied to the client? ***(Updated 2/25/21)***
   No, member Authorizations (M-Auth) cannot go across Legal Entities since they are tied to funding/payment. However, authorizations can go across provider numbers under the same Legal Entity. Even though you submit the authorization under a provider number, the Department will ensure the authorization is valid for any provider number under that Legal Entity. For example, if a client transferred from one provider (e.g. 1912) to another provider (e.g. 7173) under the same Legal Entity, there is no need to submit a new authorization.

   A new authorization request would be needed when the client switches to a new Funding Source within a Legal Entity since switching between Funding Sources is typically due to significant changes in client needs, there are likely clinical factors that should be reviewed to ensure the services are still appropriate. Refer to QA Bulletin 20-05R.

4. Do we use the P-Auth for all services that do not require pre-authorization (e.g., Medication Support, Mental Health Services) and the M-Auth for services that do require pre-authorization (e.g., IHBS, TBS)?
   Yes. An M-Auth is required for services that must be pre-authorized, which means that any claim using the base procedure code H2015HK, H2019HE, or S5145HE must utilize an M-Auth.

5. Although the client has an episode in Provider Connect, I don't have the ability to create a new request. Per DMH HEAT ticket response, *"the client needs to be associated with the agency via Web Services."* Can you explain what that means? ***(Added 2/25/21)***
   This DMH HEAT response means that before you can access the client in Provider Connect for requesting an authorization, the client should have an admission episode under your LE in IBHIS, created directly from your EHR system.

6. We have staff with Provider Connect for DR/DTI authorizations. Do they need to do anything further to submit for IHBS authorizations? ***(Added 2/25/21)***
   No, the process is the same but you will have to select the appropriate funding source, benefit plan and CPT code for IHBS/TBS.

7. Can we delete an incorrect uploaded document in Provider Connect? ***(Added 2/25/21)***
   No, unfortunately you cannot at this time. You can create a HEAT ticket to have the document(s) removed by DMH.

8. Will we have to upload each document separately in Provider Connect? ***(Added 2/25/21)***

Yes. Currently, you do need to submit each document separately. Please refer to QA Bulletin 20-05R for the updated list of documents that must be submitted. The CANS and ICC Eligibility form are no longer required.

9. Why is the authorization period shorter than 6 months? It is approved until 6/30/21 when it should be until 7/20/21. ***(Added 2/25/21)***
   The end of the fiscal year requires the generation of new M-authorization and P-authorizations. This will appear as the authorization having an end date for the end of the fiscal year (6/30/21). However, the remainder of the authorized period will be included on an automatically generated new authorization with a start date of 7/1/21. Therefore, the total authorized period is not shorter than 6 months. Claims submitted with a date of service on or after 7/1/21 should be submitted using the new M-authorization.

Requesting Pre-Authorization

1. Does a client have to be opened in IBHIS, have an LE episode, prior to sending an authorization request?
   Yes, new clients should be admitted and assessed first to establish medical necessity and an LE episode opened prior to submitting an authorization request.

2. How far in advance can we submit the pre-authorization request for re-authorization? ***(Updated 2/25/21)***
   You can submit it up to 10 business days in advance of the requested start date. All submitted documents should be current/recently completed. If you want to align the authorization period with the due dates for the Client Treatment Plan or other documents, you can submit the re-authorization request at any time so long as the requested start date of the authorization is not more than 10 business days from the submission date.

3. What documents do we need to submit for the 6 month extension of TBS, IHBS, TFC services? ***(Updated 2/25/21)***
   For renewals of pre-authorization requests, providers must submit the request with the following documents:
    1. Supplemental assessment form indicating the clinical need for the service and signed by an Authorized Mental Health Discipline (refer to Clinical Forms Bulletin 20-04)
    2. Initial Full Assessment and any more recent assessments (if not previously submitted) and any recent assessments since the original authorization request submission
    3. Current Client Treatment Plan, which must include any new/updated proposed interventions for IBHS/TBS/TFC

   Please refer to QA Bulletin 20-05R for the updated list of documents that must be submitted.

4. For those clients for whom the 6 month marker is not between Oct and Jan 1, will the IHBS authorization be extended or less in order to ensure that the IHBS authorization falls in line with the 6 month reviews?
   The authorization can never extend beyond six months. The provider is able to select a timeframe shorter than six months if they would prefer that authorization documentation coincide with treatment plans and/or CANS.

5. If the IHBS goals need to be updated, do you need to re-submit a pre-authorization? Or are we able to wait until the 6 months expire?
   Updating the CPT does not require another authorization as long as the client is in need of IHBS services.

6. We heard at the Intensive Specialized Foster Care (ISFC) roundtable that IHBS services for ISFC clients could start prior to receiving authorization. Is that correct? ***(Updated 2/25/21)***
   No. IHBS cannot be provided until pre-authorization is approved. However, there is a grace period between 10/1/20 and 3/1/21 to allow providers to begin submitting authorization requests. During the grace period, claims will not be denied. We suggest providers submit their authorizations requests as soon as possible.

7. For Short-Term Residential Therapeutic Program (STRTP) providers, if we provide both TBS and IHBS to clients, do we need to submit all documents TWICE (one set for IHBS, and one set for TBS), or can we submit all required documents and both supplemental forms in one submission?
   Providers must submit separate pre-authorization requests along with all of the required documents for both requests.

8. Do services under our Therapeutic Foster Care funded program require pre-authorization?
   The requirement for pre-authorization is based on the specific service provided, not the funded program. If you do not provide Therapeutic Foster Care services (i.e. services provided by a foster parent), IHBS or TBS, there is no pre-authorization requirement.

9. Do providers still complete 30-day reviews with the TBS team throughout the 6-month authorization?
   If you are referring to the monthly TBS team meetings, yes, continue with these as usual.

10. How do we handle authorizations with existing clients who have been receiving services that now require authorization?
    An Authorization Request will need to be submitted as soon as possible, and that Authorization would be valid from the date of Authorization for 6 months.

11. Do existing clients that are in a transition phase need to be (re)authorized if discharging prior to the end of the grace period (claims will be denied without pre-authorization beginning March 1)? ***(Updated 2/25/21)***
    It is a good idea to submit the preauthorization request if there is any chance the client will still be receiving services after March 1 to prevent any lapses in services and denials of claims.

12. What would be reasons to have an authorization denied? ***(Updated 2/25/21)***
    The reasons for denial may include, but not be limited to, the lack of information supporting the client's eligibility for the services (medical necessity) which could be due to missing documents, no response from the requestor to the reviewer's questions for over 10 business days, incomplete or outdated forms, and required forms that do not include required elements.

13. If a provider has missing documentation when requesting authorization, how long do they have to provide the proper documentation before closing out the request? ***(Updated 2/25/21)***
    Providers have up to 10 business days from the date of submission. However, we strongly encourage providers to submit all documentation at the time of the initial request to avoid denials.

14. Regarding assessment addenda, do we only need the most recent addendum that would support the current treatment plan, or do we include all addenda since the initial full assessment? ***(Added 2/25/21)***

    Only the most recent/current addendum is needed if it addresses the client's needs for the services being requested and the treatment plan objectives.

15. If the CTP will expire in two weeks, can we submit for authorization prior to doing a new plan? ***(Added 2/25/21)***

    We would encourage updating the CTP prior to submitting for authorization. This way, the review period for the CTP will coincide with the authorization period.

16. Is there a disenrollment process for IHBS if the client discontinues services prior to the authorization expiring? ***(Added 2/25/21)***

    Providers do not have to report disenrollment to the DMH authorization unit. However, you would update the client's treatment plan accordingly (e.g. adding Rehab or any other services).

17. Who do we contact when we haven't received approval after the 5th business day? ***(Added 2/25/21)***
    For Legal Entities: Please submit a HEAT ticket
    For Directly-Operated: Please send an email to ChildWelfareAuth@dmh.lacounty.gov

18. If a client's funding source changes during treatment (e.g. FSP to Outpatient Care Services), should we re-submit a new Authorization? ***(Added 2/25/21)***
    If the client's funding source changes during treatment, then you will have to submit a new authorization request. Refer to Question 3 in the Provider Connect and M-Auths section above.

Training

1. Are providers required to complete ICC training i.e. CFT and ICPM training prior to providing ICC services?
   No, it is not a requirement, but we highly recommend the online training module via the following link: https://dmh.lacounty.gov/qa/qa-training/

2. Where can I find the Provider Connect Training?
   For the Provider Connect Training, refer to this link: https://dmh.lacounty.gov/pc/cp/provider-connect/

Span Fiscal Year Member Authorization for IHBS and TBS

1. What is Span Fiscal Year (FY) Member Authorization (M-Auth)? ***(Added 5/13/21)***
   Span FY M-Auth is an authorization with a begin date and an end date that extends from the current fiscal year to the next fiscal year.

For example, a client with an original authorization end date of 7/20/2021 will appear as an authorization having an end date for the end of the current fiscal year (6/30/21). Subsequently, the remainder of the authorized period will be included on an automatically generated new M-Auth with a start date of 7/1/2021 and original end date of 7/20/2021. Claims submitted with a date of service on/after July 1st must be submitted using the newly generated M-Auth.

2. What should legal entities do with Span FY M-Auth claims? ***(Added 5/13/21)***
   Legal entities must submit all claims with **date of service prior to July 1st by July 5th** . Claims submitted with a **date of service on or after July 1st** must be submitted using the new M-Auth.

   Please note that during the period of May 1st through June 30th, IHBS and TBS claims will be accepted with a P-Auth, as long as there is an authorization in place. However, beginning July 1st, the claim will be denied if a valid M-Auth is not used on the claim.

3. Why must legal entities submit claims by June 30th for Span FY M-Auth? ***(Added 5/13/21)***

   In order for CIOB to shift any remaining units from the current FY to the next FY for Span FY M-Auth, legal entities must submit all claims with date of service prior to July 1st by June 30th.

4. Why do legal entities need to hold claims for a two-week period (July 1st through July 15th) for clients that have Span FY M-Auth? ***(Added 5/13/21)***

   The end of the fiscal year requires the generation of new authorizations. During this two-week period, CIOB will create new authorization for clients that previously had Span FY M-Auth.

5. When will the new authorizations be ready for legal entities to use for submitting claims for clients with Span FY M-Auth? ***(Added 5/13/21)***

   New authorizations for Span FY M-Auth will be ready by July 16th. Child Welfare Division will notify legal entities of the new authorizations for the Span FY M-Auth.

6. Can legal entities still submit claims using the old authorizations with date of service beginning July 1st? ***(Added 5/13/21)***

   No. All legal entities will need to use the new M-Auth to submit claims with the date of service beginning July 1st; otherwise, claims submitted with the original authorization will be denied as the original authorization has the end date of June 30th.

7. What should legal entities do with clients whose authorization end dates do not cross into the new FY? ***(Added 5/13/21)***

   Legal Entities must use the **P-Auth** for all services that do not require pre-authorization (e.g., Medication Support, Mental Health Services) and the **M-Auth** for services that do require pre-authorization (e.g., IHBS, TBS). To prevent any lapses in services and denials of claims, legal entities should submit an authorization request if there is any chance that the client will continue to receive services after June 30th.

8. Will LEs find the Span FY authorizations created by CIOB in ProviderConnect once they are ready? ***(Added 5/13/21)***

   Yes, LEs should follow the normal search for authorizations in ProviderConnect to find the Span FY authorizations.

9. Can LEs submit new Member Authorization (M-Auth) requests with the begin and end date that DO NOT cross FY during the 2 week-period from July 1 – July 15, 2021 while CIOB is working on the Span FY authorizations? ***(Added 5/13/21)***

   Yes, LEs can submit new M-Auth requests if the LEs' Budget Tracking Account for the FY 21-22 is in place, which is expected to be ready by July 1, 2021.

10. How do LEs know when their budget tracking account for the FY 21-22 is ready? ***(Added 5/13/21)***

    LEs can look at their LE Data Extract to get the most updated authorization information. The information is refreshed weekly.