FAX TO: **Optum Public Sector San Diego**
Fax: (866) 220 – 4495
Phone: (800) 798-2254, Option 3, then Option 4
IHBS Prior Authorization Request web based electronic form: IHBS Prior Authorization Request- Web Based

County of San Diego Mental Health Plan
Intensive Home-Based Services (IHBS) Prior Authorization Request

☐ Prior Authorization Request (Prior to provision of IHBS)

☐ Continuing Request (After initial authorization of up to 12 months)

Client Information

Client Name: _____	Date of Birth: _____	Client ID: _____

Program Information

Legal Entity: _____		Program Name: _____
Phone: _____		Fax: _____
Unit #: _____	Subunit #: _____	Program Manager Name: _____

SCOPE OF SERVICE

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided in alignment with the care plan for the client, and as referenced in the Integrated Core Practice Model (ICPM), informed by the Child and Family Team (CFT). IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet access criteria.

IHBS Criteria: (All 6 items are required for authorization of IHBS)

1. ☐ **Client is under the age of 21**
2. ☐ **Intensive Home-Based Services (IHBS) has been identified as a beneficial component for the clinical care of the youth**
3. ☐ **Intensive Care Coordination (ICC): Client is eligible for and receiving ICC services.**
   (Not eligible for IHBS unless receiving ICC)
4. ☐ **Client meets medical necessity criteria for Specialty Mental Health Services BHIN 21-073 as documented in**
   (select all that apply)
   - ☐ **Behavioral Health Assessment (BHA) dated: _____**
   - ☐ **DSM/ICD Mental Health diagnosis: _____**
   - ☐ **Progress/CFT Note dated: _____**
   - ☐ **Other: _____**
5. **Amount Requested:** (Select one)
   - ☐ **Up to 15 hours of IHBS intervention per week;**
   - ☐ **16-25 hours of IHBS intervention per week; must provide rationale for not referring to TBS and attach written COR support: _____**
6. **Duration Requested:** (Select one)

☐ **Up to 12 months of IHBS intervention**

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed Identified document(s) in section 4**

☐ **IHBS scope, amount and duration authorized as requested: START DATE: _____ END DATE: _____**

☐ **IHBS request is ☐ denied; ☐ modified; ☐ reduced; ☐ terminated; or ☐ suspended**

Reason: _____

NOABD was issued to the Medi-Cal beneficiary and provider on the following date: _____

Optum Clinician Signature/Date/Licensure:

Within five business days of Optum receipt, authorization will be forwarded to the requesting provider