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 Form Webpage Link

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

☐ 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:
SmartCare Program ID:	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 according to an individualized treatment plan developed in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan. They may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to members 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)

RETIRED

1. ☐ **Client is under the age of 21**
2. ☐ **Intensive Home-Based Services (IHBS) is a documented intervention on the Client Plan dated**
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 as documented in the**
   Mental Health Assessment (BHA) dated: ☐
   Diagnostic and Statistical Manual (DSM)/International Classification of Diseases (ICD)
   Mental Health diagnosis: ☐
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 Therapeutic Behavioral Services (TBS) and attach written Contracting Officer's Representative (COR) support:
6. **Duration Requested:** (Select one)
   ☐ Up to 12 months of IHBS intervention

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed MHA, Client Plan and/or Progress Notes**

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

IHBS request is: ☐ **Denied** ☐ **Modified** ☐ **Reduced** ☐ **Terminated** ☐ **Suspended**

Reason: ☐

Notice of Adverse Benefit Determination (NOABD) was issued to the Medi-Cal beneficiary and provider on the following date: ☐

Optum Clinician Signature/Licensure: ☐

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