FAX TO: **Optum Public Sector San Diego**
Fax: (866) 220 – 4495
Phone: (800) 798-2254, Option 3, then Option 4

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

Intensive Home-Based Services (IHBS), billable as Service Code 83, are mental health rehabilitative services that are available to Katie A subclass members as well as beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and meet medical necessity criteria and are receiving Intensive Care Coordination. A Child and Family Team must be identified in order to provide IHBS. IHBS are individualized, strength-based interventions that assist the client in building skills necessary for successful functioning in the home and community. IHBS is offered to clients with significant and complex functional impairment. These services are primarily delivered in the home, school or community and outside an office setting.

IHBS Criteria: (All 5 items are required for authorization of IHBS)

1. ☐ **Client is under the age of 21**
2. ☐ **Intensive Care Coordination (ICC) is a documented intervention on the Client Plan dated: _____**
   (Not eligible for IHBS unless receiving ICC)
3. ☐ **Client meets medical necessity criteria for Specialty Mental Health Services as documented in the Behavioral Health Assessment (BHA) dated: _____**
   DSM/ICD Mental Health diagnosis: _____
4. **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: _____**
5. **Duration Requested:** (Select one)
   - ☐ **Up to 12 months of IHBS intervention**

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed BHA, 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; 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

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO