CalMHSA
California Mental Health Services Authority

Policy Title: Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services	**Effective Date:** 4/15/22
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☒ **MHP** ☐ **DMC-ODS** ☐ **DMC State Plan**	**Last Revision Date:** 5/8/26

PURPOSE

This policy and procedure outlines the approach of the Mental Health Plan (MHP) for conducting concurrent reviews of psychiatric inpatient hospital and psychiatric health facility services. The MHP has delegated these responsibilities to Acentra Health, which is tasked with handling authorization and review functions for counties that enter into a participation agreement with the California Mental Health Services Authority (CalMHSA). Under a contract with CalMHSA, Acentra Health performs these services on behalf of participating counties in alignment with all Department of Health Care Services (DHCS) requirements and related Behavioral Health Information Notices (BHINs).

BACKGROUND

Pursuant to existing state and federal requirements, MHPs are required to operate a utilization management (UM) program that ensures members have appropriate access to specialty mental health services (SMHS).[1] The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures.[2] Compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for the individuals or entities to deny, limit, or discontinue medically necessary services to a member.[3] MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to members.[4] This program must include mechanisms to detect both underutilization and overutilization.[5]

Additionally, MHPs must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.[6] MHPs are responsible for certifying that claims

[1] Cal. Code Regs., tit. 9, § 1810.440(b); 42 C.F.R. § 438.210 (a)(4), (b)(1), (2)
[2] See MHP Contract, Ex. A, Att. 6 A1, Sec. 1.B.
[3] 42 C.F.R., § 438.210(e)
[4] 42 C.F.R, § 438.330(a)(1)
[5] 42 C.F.R, § 438.330(b)(3)
[6] 42 C.F.R, § 438.608(a)(1)

for all covered SMHS meet federal and state requirements.[7] MHPs provide or arrange for the provision of SMHS to Medi-Cal members that meet medical necessity and access criteria for SMHS, and approve, and authorize these services according to state requirements.[8] MHPs may place appropriate limits on a service for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for members with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports.[9] Further, MHPs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.[10]

POLICY

This policy is informed by BHINs 26-002 and 26-001 and describes how SMHS access criteria and medical necessity are applied in inpatient authorization determinations. BHIN 26-002 establishes access criteria and delivery system requirements pursuant to Welfare and Institutions Code section 14184.402, which determines whether a Medi-Cal member qualifies to receive SMHS and supports placement in the most appropriate, least restrictive setting capable of meeting the member's assessed behavioral health needs. BHIN 26-002 also establishes that the criteria to access the SMHS delivery system apply to all SMHS, including psychiatric hospital services, psychiatric inpatient hospital professional services, and psychiatric health facilities.

Once it is determined that SMHS access criteria are met per BHIN 26-002, BHINs 26-001 and 22-017 guide the application of medical necessity and concurrent review requirements for psychiatric inpatient hospital and psychiatric health facility services.

Medical Necessity Criteria for Psychiatric Inpatient Hospital Services, Psychiatric Inpatient Hospital Professional Services, and Psychiatric Health Facility Services

For Medi-Cal members who meet access criteria for the SMHS delivery system as outlined in BHIN 26-002, all covered SMHS must also be medically necessary and clinically appropriate to address the member's presenting condition in accordance with BHIN 26-001 based on the clinical judgment of a treating practitioner who is qualified under California law to make such determinations.

It is no longer required that members have one of a list of covered diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM); however, all Medi-Cal claims must include a Centers for Medicare and Medicaid Services (CMS)-approved

[7] MHP Contract, Ex. B, Sec. 5.B; 42 C.F.R, § 433.51; Cal. Code Regs., tit. 9, §1840.112
[8] See State Plan, section 3, Supplement 3 to Attachment 3.1-A, page 2c; section 3, Supplement 2 to Attachment 3.1-B, page 5
[9] 42 C.F.R., § 438.210 (a)(4)(ii)
[10] 42 C.F.R., § 438.210 (a)(3)(ii)

ICD diagnosis code.[11] Additionally, the presence of a substance use disorder or substance-related condition, whether alone or co-occurring, does not preclude a member from meeting inpatient SMHS medical necessity criteria when the requirements of BHIN 26-001 are otherwise satisfied.

For Medi-Cal coverage of inpatient SMHS, services are medically necessary if they meet the standard set forth in W&I Code section 14059.5, subdivision (a) or (b). In addition, to determine medical necessity, a treating practitioner acting within their scope of practice shall consider the following specific criteria for coverage of inpatient SMHS:

1. The member cannot be safely treated at a lower level of care, except that a member who can be safely treated with crisis residential treatment services for an acute psychiatric episode shall be considered to have met this criterion; **AND**

2. The member requires inpatient SMHS as the result of a mental disorder, or suspected mental health disorder that has not yet been diagnosed[12],[13],[14] due to

   EITHER:

   a. Having symptoms or behaviors due to a mental disorder, or suspected mental disorder that has not yet been diagnosed, that (**one of the following**):

[11] The most recent ICD 10 Tabular (October 1, 2025 – September 30, 2026) is available at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf

[12] ICD-10-CM Z codes do not represent mental or substance use disorders and, therefore, are not sufficient on their own to substantiate the medical necessity of inpatient psychiatric hospitalization. When a patient exhibits mental, cognitive, or behavioral symptoms indicative of a potential mental or substance use disorder, but a definitive diagnosis has not yet been established, an appropriate practice is to assign ICD-10-CM code F99 (mental disorder, unspecified) and/or F19.9 (substance use disorder, unspecified), as clinically indicated, to document the clinical presentation pending diagnostic clarification.

[13] A neurocognitive disorder (e.g., dementia) is not a "mental health disorder" for the purpose of determining whether a member meets criteria for access to the SMHS delivery system However, BHPs must cover SMHS for members with a neurocognitive disorder if they also have a comorbid mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described within BHIN 26-002.

[14] BHIN 26-002 removed the exclusion that prevented substance-related and addictive disorder from being considered for the purpose of determining if a member meets criteria for access to the SMHS delivery system. This is intended to allow BHPs to seek Medi-Cal reimbursement for psychiatric inpatient hospital services, psychiatric inpatient hospital professional services, psychiatric health facility services, residential treatment services, and crisis stabilization services provided to members admitted for the purpose of involuntary evaluation and treatment or intensive treatment for a severe SUD only pursuant the Lanterman-Petris Short (LPS) Act (W&I Code section 5000, et seq.). Specialty substance use disorder treatment remains available through the Drug Medi-Cal (DMC) program or DMC-ODS for Medi-Cal members who meet DMC/DMC-ODS access criteria. Nothing in this BHIN alters behavioral health delivery system obligations to provide clinically appropriate covered DMC or DMC-ODS services to members whose individualized treatment needs can be met by those services in the settings that may provide them. Providers should use their judgment to determine which service(s) are clinically appropriate for a member based on the member's individualized treatment needs.

i. Represent a current danger to self or others, or significant property destruction.
ii. Prevent the member from providing for, or utilizing, food, clothing, shelter, personal safety, or necessary medical care.
iii. Present a severe risk to the member's physical health.
iv. Represent a recent, significant deterioration in ability to function.

OR

b. Requiring admission for **one of the following:**
i. Further psychiatric evaluation.
ii. Medication treatment.
iii. Other treatment that can reasonably be provided only if the patient is hospitalized.

Continued stay services for inpatient SMHS shall only be covered when a member experiences **one of the following:**

1. Continued presence of indications that meet medical necessity, as outlined above and in BHIN 26-001.

2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization or treatment in a psychiatric health facility.

3. Presence of new indications establishing medical necessity as defined by W&I Code section 14059.5, subdivision (a) or (b) and additional criteria specified above and in BHIN 26-001.

4. Need for continued medical evaluation or treatment that can only be provided if the member remains in a hospital or psychiatric health facility.

Acentra Health meets the concurrent review authorization process requirements for authorization of inpatient SMHS outlined in BHIN 22-017 or superseding guidance.

PROCEDURE

MHPs may manage concurrent review authorizations directly or delegate these functions to an administrative entity, consistent with applicable federal and state requirements and the MHP's contract for Specialty Mental Health Services (SMHS). This policy and procedure applies to MHPs that have elected to delegate concurrent review authorization responsibilities for inpatient SMHS to Acentra Health. In such instances, Acentra Health performs these functions on behalf of the MHP. Throughout this document, Acentra Health is referenced in place of the MHP, where applicable, to reflect this delegated arrangement.

Acentra Health has established and implemented written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and other applicable BHINs.[15] Acentra Health has mechanisms in effect to ensure consistent application of review criteria for authorization decisions and consults with the requesting provider when appropriate.[16]

A. Requirements Applicable to Authorization of Inpatient SMHS

Authorization procedures and UM criteria are:

- Based on medical necessity and consistent with current evidence-based clinical practice guidelines, principles, and processes;
- Developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice;
- Evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's members and network providers.

MHPs shall comply with the following communication requirements:

- Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
- Disclose to DHCS, the MHP's providers, members and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;
- Ensure the member handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS;[17] and,
- Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization (Acentra Health will fulfill this component).

[15] 42 C.F.R., § 438.210(b)(1), MHP Contract, Ex. A, Att. 12
[16] 42 CFR, § 438.210(b)(2) (i-ii)
[17] 42 C.F.R., § 438.10(g)(2)(iv)

All Acentra Health's authorization procedures comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

For additional details regarding Acentra Health's authorization procedures please view the Acentra Health Psychiatric Inpatient Concurrent Review Manual.

B. Concurrent Review for Psychiatric Inpatient Hospital Services

This concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and psychiatric health facilities (PHFs) certified by DHCS as Medi-Cal providers of inpatient hospital services. For ease of reference, general acute care hospitals, psychiatric hospitals and PHFs are collectively referred to as "hospital or PHF" below. This authorization process applies to all inpatient admissions, whether voluntary or involuntary. To the extent there is a conflict, this section supersedes California Code of Regulations, title 9, sections 1820.215, 1820.220, 1820.225 and 1820.230.

Acentra Health, hospitals and PHFs exchange protected health information by any method compliant with the Health Insurance Portability and Accountability Act (HIPAA) and agreed upon by both parties to the exchange, which may include fax, telephone and electronic transmission. Acentra Health will consult with the member's treating provider as appropriate.[18] While reviewing an authorization request, Acentra Health may communicate with the treating provider, and the treating provider may adjust the authorization request prior to Acentra Health rending a formal decision regarding the authorization request.

I. Admission and Authorization

a. Notification of member admission and request for treatment authorization

Acentra Health maintains online portal access to receive admission notifications and initial authorization requests 24-hours a day and 7 days a week.[19] Within 24 hours of admission of a Medi-Cal member for psychiatric inpatient hospital services, the hospital or PHF must provide Acentra Health the member's admission orders,[20] initial plan of care,[21] a request to authorize the member's treatment, and a completed face sheet.

The face sheet must include the following information (if available):

[18] 42 C.F.R. § 438.210(b)(2)(ii)
[19] Welf. & Inst. Code, § 14197.1; Health & Saf. Code, §§ 1367.01(i), 1371.4(a); Managed Care boilerplate contract Exh. A, Att. 9, provision 7 C ["Contractor shall ensure that a plan or contracting physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary."]
[20] 42 CFR § 456.170
[21] 42 CFR § 456.180; 42 CFR § 441.155

- Hospital name and address
- Patient name and DOB
- Insurance coverage
- Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System
- Current address/place of residence
- Date and time of admission
- Working (provisional) diagnosis
- Date and time of admission
- Name and contact information of admitting, qualified and licensed practitioner
- Utilization review staff contact information

If, upon admission, a member is in a psychiatric emergency medical condition, as defined in Health & Safety Code section 1317.1(k), the time period for the hospital to request authorization shall begin when the member's condition is stabilized, as defined in Health & Safety Code section 1317.1(j). For emergency care, no prior authorization is required, following the reasonable person standard to determine that the presenting complaint might be an emergency.[22]

b. Review of initial authorization request

Acentra Health will decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in I.a., above. Acentra Health must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services.[23]

II. Continued Stay Authorization

a. Continued stay authorization request

When medically necessary for the member, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF must submit a continued-stay authorization request for a specified number of days to Acentra Health. Acentra Health reviews and authorizes continued stay requests in increments of up to three (3) calendar days per request. Providers must submit documentation supporting medical necessity for the continued stay

[22] Managed Care Two-Plan CCI Boilerplate exh. A, Att. 5
[23] Managed Care Two-Plan CCI Boilerplate exh. A, Att. 5

in accordance with established guidelines. Additional authorization requests must be submitted as needed for ongoing care.

b. Exchange of information between hospital or PHF and Acentra Health.

The treating provider at the hospital or PHF may request information and records from Acentra Health needed to determine the appropriate length of stay for the member. Acentra Health may request only information from the hospital and treating provider that is reasonably necessary to decide whether to grant, modify or deny the request. The exchange of information is intended to occur flexibly, with Acentra Health and hospitals exchanging relevant client and clinical information as needed to complete concurrent review procedures and for discharge planning and aftercare support.

Clinical information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- Risk assessment to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.
- Precipitating events if further identified or clarified by the treating hospital after Acentra Health admission notice.
- Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.
- Hospital information on prior episode history that is relevant to current stay.
- MHP information of relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.

- Substance use information to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.

- Known medical history to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.

- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.

- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.

- Number of continuing stay days requested.

c. Review of continued stay authorization request

Acentra Health will issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.[24]

The MHP remains responsible to cover the cost of each day of an inpatient hospital stay, at the applicable rate for acute psychiatric inpatient hospital services, until the requirements in paragraph 1 or 2 have been met:

1. The existing treatment authorization expires, and the hospital discharges the member (or the member's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by Acentra Health and the member's treating provider[25]; Or,

2. Acentra Health denies a hospital's continued stay authorization request and the hospital discharges the member (or the member's level of care in the hospital is downgraded to administrative day level while awaiting

[24] Welf. & Inst. Code 14197.1 [MCPs in practice issue a decision on a continued stay authorization request within 24 hours of receipt of the request]; See Also Health & Saf. Code, §1367.01(h)(2) specifying the timeframe for a decision begins ["after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination."]
[25] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3)

transfer), pursuant to a plan of care that is agreed upon by Acentra Health and the member's treating provider.[26]

III. Adverse Decision, Clinical Consultation, Plan of Care, and Appeal

a. While Acentra Health LMHPs/LPHAs will review authorization requests and issue approvals within their scope of practice, all Acentra Health decisions to modify or deny a treatment request will be made by a physician or psychologist who has appropriate expertise in addressing the member's behavioral health needs.[27] A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent with the psychologist's scope of practice.

b. A decision to modify an authorization request will be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and will include a clear and concise explanation of the reasons for Acentra Health's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision will also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.[28]

c. If Acentra Health modifies or denies an authorization request, Acentra Health will notify the member in writing of the adverse benefit determination via a Notice of Adverse Benefit Determination (NOABD) before the hospital discontinues inpatient psychiatric hospital services.[29] The notice to the member will meet the requirements pertaining to notices of adverse benefit determinations.[30]

d. If Acentra Health denies a hospital's authorization request, Acentra Health must work with the treating provider to develop a plan of care. Services and payment for services shall not be discontinued until the member's treating provider(s) has been notified of Acentra Health's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the member.[31] If Acentra Health and treating hospital provider do not agree on a plan of care, the provider, may,

[26] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3)
[27] 42 C.F.R. § 438.210(b)(3); Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(e)
[28] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(4)
[29] 42 C.F.R. § 438.404(c), 42 C.F.R. § 431.213(c)
[30] See generally 42 C.F.R., §§ 438.210(c), 438.404; BHIN 25-014
[31] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(3)

on behalf of the member and with the member's written consent,[32] appeal the denial to Acentra Health, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the member after receiving notice from Acentra Health.

e. Acentra Health's denial of an authorization request and a consultation between the treating provider and Acentra Health may result in one of the following outcomes:

- Acentra Health and the hospital treating provider agree that the member shall continue inpatient treatment at the acute level of care, and the denial is reversed.

- Acentra Health and the hospital treating provider agree to discharge the member from the acute level of care and a plan of care is established prior to the member transitioning services to another level of care.

- Acentra Health and the hospital treating provider agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down facility bed is not available, and the member remains in the hospital, on administrative day level of care.

- Acentra Health and treating hospital provider do not agree on a plan of care and the member, or the treating provider on behalf of the member, appeals the decision to Acentra Health.[33]

IV. Authorizing Administrative Days

a. A hospital may claim for administrative day services when a member no longer meets medical necessity for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area.[34] In order to conduct concurrent review and authorization for administrative day service claims, Acentra Health will review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the member is placed on administrative day status.

[32] 42 C.F.R., § 438.402(c)(1)(ii)

[33] 42 C.F.R., § 438.402(c)(1)(ii)

[34] Cal. Code Regs., tit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400

b. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the member is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.[35]

c. Acentra Health may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the member.[36] The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.[37]

   Examples of appropriate placement status options include, but may not be limited to, the following:

   - The member's information packet is under review;
   - An interview with the member has been scheduled for [date];
   - No bed available at the non-acute treatment facility;
   - The member has been put on a wait list;
   - The member has been accepted and will be discharged to a facility on [date of discharge];
   - The patient has been rejected from a facility due to [reason]; and/or,
   - A conservator deems the facility to be inappropriate for placement.

V. Treatment Authorization Request (TAR) Processing

After discharge, a Treatment Authorization Request (TAR) shall be submitted to Acentra Health by the treating facility within 14 calendar days of the date of discharge. Acentra Health will process and submit the TAR to the DHCS Fiscal Intermediary within 14 calendar days of receipt. In instances where the TAR is not processed by the DHCS Fiscal Intermediary (for example, "Short Doyle" or "county pay" scenarios), Acentra Health will aim to process and submit the TAR to the county of responsibility within 14 calendar days of receipt.

[35] Cal. Code Regs., tit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400
[36] Cal. Code Regs., tit. 9, § 1820.230(d)(2)(B)(1); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400
[37] Cal. Code Regs., tit. 9, § 1820.230(d)(2)(B)(2); Welf. & Inst. Code, §§ 14184.402 and 14184.102 and 14184.400

VI. Retrospective Authorization Requirements

Retrospective Treatment Authorization Requests (TARs) may be submitted to Acentra Health for payment authorization beyond the timelines specified by regulations under the following limited circumstances, subject to verification by Acentra Health:

- Retroactive Medi-Cal eligibility determinations.
- Inaccuracies in the Medi-Cal Eligibility Data System.
- Authorization of services for members with other health care coverage pending evidence of billing, including dual-eligible members.
- Member's failure to identify payer

TARs that meet retrospective criteria must be submitted by the provider to the Acentra Health within 60 calendar days of one of the following:

1. The date Medi-Cal eligibility is discovered.
2. The date a Remittance Advice (RA) showing partial payment or a Notice of Exhaustion of Benefits (EOB) is received from a third party.

Providers must bill any other insurance carrier, including Medicare, before submitting a retrospective TAR.

For retrospective reviews, providers must submit a completed TAR form along with all relevant hospital records required to determine whether to approve, modify, or deny the request, following the same guidelines as standard concurrent reviews.

Acentra Health will communicate the authorization decision to the provider within 30 calendar days of receiving all necessary information, in accordance with state requirements. Any adverse decisions will also be communicated to the individual who received the services, or their designee, within the same timeframe.

Authorization for inpatient psychiatric services will be based on clinical evaluation of the medical necessity of care, guided by the statutory and regulatory definitions of "medical necessity" and clinical judgment applied to the documentation provided by inpatient facilities.

VII. Utilization Review

Functions related to utilization review and auditing of documentation standards are distinct from UM and authorization functions. Nothing in BHIN 22-017 prohibits the MHPs from conducting utilization review and/or auditing activities in accordance with state and federal requirements. MHPs retain the right to monitor compliance with any contractual agreements between an MHP and the MHP's network providers and may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS. For example, the MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the member, or in other instances where there is evidence of fraud, waste, or abuse.

FORMS/ATTACHMENTS

Acentra Health Psychiatric Inpatient Concurrent Review Manual

REVISION HISTORY

DATE	REVISION	PAGE NUMBER(S)
4/9/2026	Legislative terminology updates ("beneficiary" to "member")	All
4/9/2026	Addition of medical necessity criteria specific to inpatient admissions and clarification of the relationship between SMHS access criteria and medical necessity in the context of inpatient authorization determinations.	2-4
3/14/25	Insertion of link to Acentra Health Psychiatric Inpatient Concurrent Review Manual	11
3/14/25	Addition of detail regarding retrospective reviews	10
3/14/25	Minor wording adjustments/changes to order of content	Various
5/7/24	Changed "Kepro" to "Acentra Health" throughout document.	Various
2/28/24	Minor wording adjustments/changes to order of content.	Various
2/28/24	Additional clarification added to "Retrospective Reviews" section.	9-10