



January 26, 2026

## REQUEST FOR INFORMATION TO PROVIDE TREATMENT AUTHORIZATION REVIEW SERVICES

### I NOTICE OF FUNDING OPPORTUNITY

The County of Kern, through Behavioral Health and Recovery Services (BHRS) is seeking information in the form of a proposal from one or more organizations that are qualified to provide Treatment Authorization Review (TAR) services. BHRS will review all responses received from qualified organizations and if a sufficient number of responses are received, the Department may, at its sole discretion, initiate a Request for Proposal process.

All information submitted by qualified organizations will be retained by Behavioral Health and Recovery Services (BHRS). The tentative start date for these services are **July 1, 2026**. The total available funding for this program is not intended to exceed \$250,000.

### BACKGROUND

#### II. PURPOSE

The Treatment Authorization Request (TAR) process, as outlined by the California Department of Health Care Services (DHCS), is the formal procedure through which Medi-Cal providers obtain prior approval for certain medical services before they can be delivered and reimbursed. The purpose of a Treatment Authorization Request (TAR) is to ensure that certain medical services under Medi-Cal are properly reviewed and approved before they are provided. Providers must obtain authorization prior to delivering treatments, hospital stays, or specialized procedures, and they are required to submit supporting documentation such as medical records, test results, and treatment plans to justify the request. Once submitted, DHCS consultants carefully evaluate the TAR to determine whether the service should be approved, denied, or if additional information is needed. In cases where a TAR is denied, providers have the right to appeal the decision, which helps maintain fairness and oversight in the authorization process.

#### III. IMPORTANCE

The importance of a Treatment Authorization Request (TAR) lies in its role as a safeguard within the Medi-Cal system. By requiring providers to justify the medical necessity of services, TARs help prevent unnecessary or inappropriate procedures and ensure that care is clinically appropriate. They also serve as a cost-control measure, protecting Medi-Cal resources by authorizing only those services that meet strict criteria. In addition, TARs support compliance with state and federal regulations, while improving accountability through a documented review trail of services provided. Most importantly, TARs protect patients by guaranteeing that the care they receive is evidence-based and aligned with established medical standards.

#### IV. PROCESS

##### Step 1: Initiation of TAR Review

- ❖ County Medi-Cal beneficiaries placed voluntarily or involuntarily in Fee-for-Service/Medi-Cal hospitals require a TAR for payment authorization.

##### Step 2: Initial Review by LPHA

- ❖ The TAR is first reviewed by a Licensed Practitioner of the Healing Arts (LPHA) employed by BHRS.
- ❖ The LPHA is authorized to approve payment when medical necessity is documented according to DHCS standards.
- ❖ The LPHA cannot issue a denial.

### Step 3: Escalation to Physician Review

- ❖ If questions arise regarding whether medical necessity is met, and the case could result in a denial or modification of requested bed days, the TAR is escalated to a physician reviewer.
- ❖ The physician reviewer serves as the designated component of the state inpatient documentation review process.

### Step 4: Final Determination

- ❖ The physician reviewer makes the final decision on approval, denial, or modification of the TAR request.

## V. SCOPE OF CONTRACTOR RESPONSIBILITIES

A. A Physician Reviewer who will evaluate inpatient records to determine if both acute and administrative days requested meet medical necessity guidelines as outlined by DHCS, with a response time/turnaround time of 48hrs. Physician Reviewer would need to provide in writing, a clear and concise explanation of the decision. It includes a description of the criteria or guidelines used and the clinical reasons for the decision in regard to medical necessity.

B. If the hospital appeals the 1st denial or modification of days, a different Physician Reviewer to provide a 2nd level of review of said documentation. Physician Reviewer would need to provide in writing, a clear and concise explanation of the decision. It includes a description of the criteria or guidelines used and the clinical reasons for the decision in regard to medical necessity,

C. In the event bed days are officially denied, Physician reviewer to be available same business day, for any “doc-to-doc” conversations regarding medical necessity in documentation that the inpatient facility requests. Doc-to-doc conversation can be held telephonically; however, the Physician Reviewer would need to provide in writing, a clear and concise explanation of the decision. It includes a description of the criteria or guidelines used and the clinical reasons for the decision in regard to medical necessity. This notification will be provided both to the physician at the inpatient facility with whom the conversation is held and the BHRS Authorizations Unit as the County Mental Health Plan (MHP).

D. Entity whom employs the Physician Reviewer (s) must not have any conflict of interest with any inpatient facilities contracted with Kern County MHP, and must inform Kern County MHP of any conflicts of interest with any psychiatric inpatient facilities within the state of California (Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att. 6, sec. 1(C); 42 C.F.R. § 438.210(e).)

### **Note: Expanded Coverage (Effective January 2026)**

In addition to psychiatric primary diagnoses, substance use primary diagnoses for admission to psychiatric units will also be covered under TAR Services.

## VI. PROCEDURE

A. BHRS shall provide an encrypted electronic copy of the TAR audit tool completed by a County LPHA when a County LPHA is not able to authorize reimbursement due to questionable medical necessity documentation. In the event BHRS is not able to submit an electronic copy, a hard copy of the TAR shall be submitted to Contractor.

B. All adverse decisions regarding provider requests for payment authorization based on medical necessity criteria or emergency medical condition shall be reviewed and approved by a physician, per Title IX, Section 1777(f)(1).

C. Per CCR Title IX regulations, BHRS must make all adverse decisions regarding provider requests for payment authorization based on medical necessity criteria or emergency medical conditions within fourteen (14) days of receipt of TAR from provider. BHRS shall provide TAR and audit tool to Contractor as expeditiously as possible following receipt of TAR from provider. Contractor shall review and return TAR, signed by physician, to BHRS within five (5) business days of receiving TAR from BHRS. In the event that five business days extends the review period past fourteen days of receipt of TAR, Contractor shall attempt to complete the review so the fourteen-day timeline can be met.

## VIII. DOCUMENTATION REQUIREMENTS

In determining whether a TAR shall be approved or denied, for both acute inpatient psychiatric services and administrative day services, Contractor shall consider the following:

- A. Documentation must establish an included diagnosis provided in CCR Title IX, Section 1820.205(a)(1)(A) through (R). Diagnosis must be supported by symptoms and behaviors.
- B. Documentation must establish that the hospitalized individual could not have been safely treated at a lower level of care.
- C. Documentation must establish that, as the result of a covered diagnosis, acute psychiatric hospitalization was required for one of the reasons provided in CCR Title IX, Sections 1820.205(a)(2)(B)1.a through 1820.205(a)(2)(B)1.d and 1820.205(a)(2)(B)2.a through 1820.205(a)(2)(B)2.c.
- D. Documentation for hospitalized individuals meeting the criteria for danger to self, danger to others, or danger to property must include the individual's intent or a specific plan.
- E. Documentation for hospitalized individuals meeting criteria for grave disability must indicate whether the individual is able to utilize food, clothing, and shelter that is provided.
- F. Documentation must establish that, as a direct result of a covered diagnosis, the hospitalized individual has symptoms or behaviors that present a severe risk to the individual's health.
- G. Documentation must establish that the hospitalized individual has symptoms and/or behaviors that represent a recent, significant deterioration in the individual's ability to function.
- H. Documentation must establish that additional evaluation was needed that could not have been provided at a lower level of care.
- I. Documentation must establish that the hospitalized individual required medication that could not have been provided at a lower level of care.
- J. Documentation must reflect daily symptoms and behaviors.
- K. Documentation must be legible.

## IX. TIMELINES

- A. In the event a provider disagrees with an adverse decision and submits a First Level Appeal to County, BHRS shall provide Contractor with the appeal within ninety (90) days of receipt from provider. Contractor shall review and provide a decision within sixty (60) days of receipt of appeal from BHRS. A First Level Appeal decision shall be made by a physician other than the one completing the initial Physician Advisor review.
- B. Contractor shall complete a Physician Advisor review, on average, within two (2) hours per TAR. Documentation shall be provided supporting the decision to approve or deny payment authorization for a day of service based on medical necessity criteria or emergency medical condition.
- C. Contractor shall complete First Level Appeals, on average, within one (1) hour per TAR. Documentation shall be provided supporting the decision to approve or deny the appeal.

## INFORMATION INSTRUCTIONS

The Organization's response to this Request For Information (RFI) shall be submitted with all necessary information and documentation needed to demonstrate the Organization's ability to provide Treatment Authorization Review

Services described herein, in addition to the following:

#### A. ORGANIZATION INTRODUCTION

1. The information shall include an introduction describing the Organization, the size of the Organization, the number of employees involved in providing Treatment Authorization Review Services, its organizational structure, and its subcontractors or subconsultants, if any.

2. Include the legal name, address, telephone number, and type of entity (sole proprietorship, partnership, or corporation and whether public or private).

#### B. ORGANIZATION EXPERIENCE

1. The Organization should state the firm's experience and the number of consecutive years of actual experience providing the Treatment Authorization Review Services.

2. Provide a minimum of three (3) reference letters for similar services rendered (must be within the last six (6) months on the reference company's letterhead. Each reference shall include a current point of contact and a phone number.

3. Each reference letter must have the following information: Date of the original contract; end date of the contract; services rendered; and names, addresses, and telephone numbers of contact persons within client agencies for whom the services have been provided.

#### C. CREDENTIALS/RESUMES

1. Credentials and resumes of the person(s) responsible for administering or providing the services must be provided. Include a statement of qualifications and resumes/backgrounds of key personnel assigned to the project, including the number of years these employees have been providing services, training certifications of professional and non-professional personnel.

2. Organization shall specifically provide the following information on all management, supervisory and other key employees who will be providing services:

- a. Name, address and phone number
- b. Description of education
- c. General experience
- d. Experience or education related to the RFP project

#### D. PROJECT APPROACH

Provide a detailed explanation regarding how your organization can meet our needs and handle our requirements for providing Treatment Authorization Review Services to the targeted population.

#### E. INDEMNIFICATION

Organization shall indemnify County against any claim, demands, or liability arising from damage to property, and injuries to persons, which may arise out of or because of Organization's performance of its duties under this Agreement, or failure to perform, but only in proportion to and to the extent such claim demands, damages or liability are caused by, or result from the negligent or intentional acts or omissions of Organization, its officers, agents, or employees.

#### F. INSURANCE

The Organization shall secure and maintain insurance as described below:

## 1. WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE REQUIREMENTS

In the event Organization has employees who may perform any services pursuant to this Agreement, Organization shall submit written proof that Organization is insured against liability for workers' compensation in accordance with the provisions of section 3700 of the California Labor Code.

Organization shall require any sub-contractors to provide workers' compensation for all of the subcontractors' employees, unless the sub-contractors' employees are covered by the insurance afforded by Organization. If any class of employees engaged in work or services performed under this Agreement is not covered by California Labor Code section 3700, Organization shall provide and/or require each sub-contractor to provide adequate insurance for the coverage of employees not otherwise covered.

Organization shall also maintain employer's liability insurance with limits of ONE MILLION DOLLARS (\$1,000,000) for bodily injury or disease.

## 2. COMMERCIAL GENERAL LIABILITY INSURANCE REQUIREMENTS

Organization shall maintain in full force and effect, at all times during the term of this Agreement, the following insurance:

Commercial General Liability Insurance including, but not limited to, Contractual Liability Insurance (specifically concerning the indemnity provisions of this Agreement with the County), Products-Completed Operations Hazard, Personal Injury (including bodily injury and death), and Property Damage for liability arising out of Organization's performance of work under this Agreement. The Commercial General Liability insurance shall contain no exclusions or limitations for independent contractors working on the behalf of the named insured. Organization shall maintain the Products-Completed Operations Hazard coverage for the longest period allowed by law following termination of this Agreement. The amount of said insurance coverage required by this Agreement shall be the policy limits, which shall be at least ONE MILLION DOLLARS (\$1,000,000) each occurrence and TWO MILLION DOLLARS (\$2,000,000) aggregate.

The Commercial General Liability Insurance required shall include an endorsement naming the County and County's board members, officials, officers, agents and employees as additional insureds for liability arising out of this Agreement and any operations related thereto. Said endorsement shall be provided using one of the following three options: (i) on Insurance Services Office (ISO) form Commercial General (CG) 20 10 11 85; or (ii) on ISO form CG 20 37 10 01 plus either ISO form CG 20 10 10 01 or CG 20 33 10 01; or (iii) on such other forms which provide coverage at least equal to or better than form CG 20 10 11 85.

## 3. AUTOMOBILE LIABILITY INSURANCE REQUIREMENTS

Automobile Liability Insurance against claims of Personal Injury (including bodily injury and death) and Property Damage covering any vehicle and/or all owned, leased, hired and non-owned vehicles used in the performance of services pursuant to this Agreement with coverage equal to the policy limits, which shall be at least ONE MILLION DOLLARS (\$1,000,000) each occurrence.

The Automobile liability Insurance required shall include an endorsement naming the County and County's board members, officials, officers, agents and employees as additional insureds for liability arising out of this Agreement and any operations related thereto. Said endorsement shall be provided using one of the following three options: (i) on Insurance Services Office (ISO) form Commercial General (CG) 20 10 11 85; or (ii) on ISO form CG 20 37 10 01 plus either ISO form CG 20 10 10 01 or CG 20 33 10 01; or (iii) on such other forms which provide coverage at least equal to or better than form CG 20 10 11 85.

## 4. PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS

Professional Liability (Errors and Omissions) Insurance, for liability arising out of, or in connection with, the performance of all required services under this agreement, with coverage equal to the policy limits, which shall not be

less than ONE MILLION DOLLARS (\$1,000,000) per occurrence and THREE MILLION DOLLARS (\$3,000,000) aggregate.

## 5. ADDITIONAL INSURANCE REQUIREMENTS

Any self-insured retentions in excess of TWENTY-FIVE THOUSAND DOLLARS (\$25,000) must be declared on the Certificate of Insurance or other documentation provided to County and must be approved by the County Risk Manager.

If any of the insurance coverages required under this Agreement is written on a claims-made basis, Organization, at Organization's option, shall either (i) maintain said coverage for at least three (3) years following the termination of this Agreement with coverage extending back to the effective date of this Agreement; (ii) purchase an extended reporting period of not less than three (3) years following the termination of this Agreement; or (iii) acquire a full prior acts provision on any renewal or replacement policy.

All insurance shall be issued by a company or companies listed in the current "Best's Key Rating Guide" publication with a minimum of A-, VII rating; or in special circumstances, as pre-approved by the Risk Management Division of the Office of County Counsel. The selected proposer shall file with the Contact Person, a Certificate(s) of Insurance stating the required coverages are in effect.

## SUBMITTAL INSTRUCTIONS

### A. SUBMITTAL

The proposer shall submit one (1) written copy of the Proposal and one (1) copy on thumb drive. The thumb drive (virus free) must be a standard Microsoft Windows (Word, Adobe, Excel etc.) compatible format readable by the County; using word processing software that is Windows based, preferably Microsoft Word. Proposer agrees to be fully responsible for any damage caused by any materials submitted to County. Please submit all Proposals to:

Kern County General Services Division  
REQUEST FOR INFORMATION FOR:  
**PROVIDE TREATMENT AUTHORIZATION REVIEW SERVICES**  
1115 Truxtun Ave., 3rd Floor  
Bakersfield, CA 93301  
Telephone (661) 868-3000

Proposals may be delivered in person, by courier service or by mail to the address indicated above. **ALL PROPOSALS MUST BE SEALED AND RECEIVED BEFORE 11:00 A.M. on FEBRUARY 27, 2026**, at the above office and address.

Proposals submitted after the above deadline will not be accepted. It is strongly suggested that any proposers intending to hand deliver a proposal on the last day for submission arrive at the General Services Division third floor main lobby at least ten (10) minutes prior to the proposal receipt deadline to receive a "test" time stamp to validate the official current time. The time stamp clock in the main lobby of General Services will be the official time. Any Proposal received at or after 11:00 a.m. will be returned unopened.

### B. QUESTIONS

Questions may be asked via e-mail only to Christina Frayre-Ramos, at [cfrayre-ramos@kernbhrs.org](mailto:cfrayre-ramos@kernbhrs.org), no later than 12:00 noon on February 17, 2026.