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| Client Name:       SAR#:       Requested Date Range: | | | | | | | | | |
| **Intensive In-Home Services**  Medicaid Clinical Coverage Policy 8A  Service Code H2022  Pre-Review | | | | | | | | | |
| Yes | | | No | | | | **Review for HUM 26:** immediate health/safety concerns. **If MET,** **refer to medical staff**  **and Outreach phone call to Provider.** | | |
| **Review for Unable to Process Criteria** | | | | | | | | | |
| Met | | Not Met | | | | | The requested effective start date does not precede the submission date of request. If unjustified retro request, then “**unable to process**”. | | |
| Met | | Not Met | | | | | The dates of the request do not overlap with an existing authorization for the same service. If overlap is 5 days or less, then make documented contact with provider to verify intended request dates. Can adjust authorized dates as requested by provider. If more than 5 days overlap, then **unable to process**. | | |
| Met | | Not Met | | | | | The SAR is submitted no more than 30 days before requested start date. If not met, then “**unable to process”.** | | |
| **Review for Administrative Denial:**  *If anything is not met, please submit for QOC tracking* | | | | | | | | | |
| Met | | Not Met | | | | | | PCP is present, which includes IIH, frequency and provider. If none present, then contact the provider to request and give deadline to submit. If not received, “**administratively deny**” the request. | |
| Met | | Not Met | | | | | | Initial PCP and/or Annual PCP Rewrite have signed and dated service order by Approved Signatory. In addition, the following are also present:   * Client and/or Legally Responsible Person signature * Person Responsible for PCP signature * DJJ and/or CFT attestation, if applicable * **Attestation boxes checked by Approved Signatory—if not checked, Administratively Deny**   For all others, contact the provider to request and give deadline to submit. If not received, “**administratively deny**” the request. | |
| Met | | Not Met | | | | | | Review for Comprehensive Crisis Plan. If none present, then contact provider and give a deadline to submit. If not received, “**administratively deny**” the request. | |
| Met | | Not Met | | | | N/A | | The Comprehensive Clinical Assessment and/or Addendum is present and supports request (to include DSM 5 diagnosis). If not present, then document call to provider. If not provided by deadline, “**administratively deny”**. | |
| Met | | Not Met | | | | | | CALOCUS/ASAM level noted in SAR or other documentation. If not, then contact the provider to request and give deadline to submit. If no response, “**administratively deny**” the request.   * Recommended CALOCUS Level 3 - 5 * Recommended ASAM Level > 1   If necessary, review and/or request CALOCUS/ASAM worksheet; If not present, can NOT administratively deny. | |
| **Process notes:**   * **When documenting call outs to provider, please document in a “patient note” in Alpha the day the call out is made. Notes should be coded as “Care Management”.** * **The following is the process for notifying Clinical Support Team of an Administrative Denial:**  1. **Please complete the Request Template and note Administrative Denial.** 2. **Send to Clinical Support Team.** 3. **Note that, if within 24 hours of submitting the Request Template to Clinical Support, a new SAR is received from the provider that contains the needed documentation, notify Clinical Support Team so that they may halt the process for generating and mailing the Administrative Denial Letter.** 4. **When a new SAR is received as described above, please document in a “patient note” a description of why an administrative denial letter was not generated for the initial SAR.** | | | | | | | | | |
| **Other Items of Review:** | | | | | | | | | |
| Yes | No | | | | | | | Review for “stacked” services. If there are current authorizations for other services, consider if there are service exclusions and if so, review under EPSDT. Requires clinical denial if EPSDT criteria not met.  Note the services here: | |
| Yes | No | | | | | | | The Client’s Name, DOB, MRN and MID number are present and accurate in necessary places (i.e. PCP, CCA, Service Notes, etc)? If not contact Provider for clarification. Report to appropriate HIPAA personnel if violation has occurred. | |
| Yes | No | | | | | | | The requested days/units are within the MCO guidelines? If over the benefit plan, review for EPSDT. | |
| Yes | No | | | N/A | | | | Is there evidence of active discharge planning with any concurrent requests?  Consider reviewing for the following elements:   * anticipated discharge date * barriers to discharge * anticipated discharge level of care * efforts made to coordinate discharge appointment   If not, then make documented call to provider to request. | |
| Yes | No | | | | | | | Are there past denials or partial approvals within this current episode of care? Consider implications of previous decisions/recommendations and need for clinical staffing.  Please note here: | |
| Yes | No | | | N/A | | | | For concurrent request, is there evidence of titration in units? If not, consider if needs to go to peer review and please note here: | | |
| Length of stay in current service. Note here: | | | | | | | | | |
| Yes | No | | | | | | | Review current medications and assess need for referral to medical review. If review needed,(yes) complete Medication Review Consultation Form ([http://mysp.smokymountaincenter.com/dept.clop/cm/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fdept%2Eclop%2Fcm%2FShared%20Documents%2FMHSA%20UM%20FORMS%20AND%20REVIEW%20TOOLS&FolderCTID=0x012000B4D86B6A1F01BA459A100B130004E563&View={AD74E0AD-01EF-4476-9101-2266E0F75027}](http://mysp.smokymountaincenter.com/dept.clop/cm/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fdept%2Eclop%2Fcm%2FShared%20Documents%2FMHSA%20UM%20FORMS%20AND%20REVIEW%20TOOLS&FolderCTID=0x012000B4D86B6A1F01BA459A100B130004E563&View=%7bAD74E0AD-01EF-4476-9101-2266E0F75027%7d) ), email to Pharmacist, and document all of the above in a “patient note”. This note should be coded as “pharmacist consult” | |
| Yes | No | | | N/A | | | | Have the consumer’s concurrent medical needs been appropriately assessed or reassessed? If not, make documented contact with provider to make recommendations regarding this and refer to QOC. | |
| **Review for QOC Concerns specific to CCA. First, complete this section. If any boxes are selected “no” in this section, send for QOC tracking with “inadequate CCA” as the concern.**  **Assess for Diagnostic Clarity:**  **N/A - If concurrent review, check the box and proceed to continued stay review.** | | | | | | | | | |
| Yes | No | | | | | | | | Is there a description of the presenting problems including:  source of distress  precipitating events and  associated problems or symptoms, and  recent progressions  (all above should be selected to choose “Yes”) |
| Yes | No | | | | | N/A | | | If there are “rule-out” diagnoses, were these resolved within the first 6 months? If not, contact provider and request documentation to support resolution of “rule-out” diagnoses and document in patient note with “Care Management” label. |
| Yes | No | | | | | | | | Was the course of illness was clearly documented regarding  onset,  triggers,  intensity,  frequency,  duration of symptoms, and  course of illness?  (all above should be selected to choose “Yes”) |
| Yes | No | | | | | | | | Is the diagnosis clear? (i.e. there aren’t multiple, incompatible or frequently changing diagnoses.) |
| Yes | No | | | | | | | | Was there adequate assessment of co-occurring behavioral health/substance abuse/IDD conditions? |
| Yes | No | | | | | N/A | | | Are current medications included for both:  physical and  psychiatric treatment  (all above should be selected to choose “Yes”) |
| Yes | No | | | | | | | | Mental status is sufficiently documented and supports the diagnosis. |
| Yes | No | | | | | | | | A review of the following dimensions in included:  biological (include strengths, weaknesses, risks, and protective factors)  psychological (include strengths, weaknesses, risks, and protective factors)  familial (include strengths, weaknesses, risks, and protective factors)  social (include strengths, weaknesses, risks, and protective factors)  developmental (include strengths, weaknesses, risks, and protective factors)  environmental (include strengths, weaknesses, risks, and protective factors)  (all above should be selected to choose “Yes”) |
| Yes | No | | | | | | | | Environment and psychosocial factors potentially contributing to functional status are identified and considered:  housing,  legal,  financial,  educational or vocational, and  nutrition or sleep.  (all above should be selected to choose “Yes”) |
| Yes | No | | | | | | | | Is the treatment history adequate; information went beyond prior dates of service to include:  levels of care,  types of interventions, and  responsiveness to/engagement with prior treatment?  (all above should be selected to choose “Yes”) |
| Yes | No | | | | N/A | | | | evidence of beneficiary and family and/or legally responsible person’s involvement in the assessment (if applicable) |
| Yes | No | | | | | | | | Evidence of provider discussion of results with beneficiary and family and/or legally responsible person |
| Yes | No | | | | | | | | Is there analysis and interpretation of the assessment information with an appropriate case formulation; (does this assessment support the diagnosis?) |
| Yes | No | | | | | | | | Are there recommendations for additional assessments, services, support, or  treatment including specific evidence-based practices based on the results of the CCA? |
| Yes | No | | | | | | | | A strengths/protective factors/problem summary which addresses  risk of harm,  functional status,  co-morbidity, (behavioral and medical)  recovery environment, and  treatment and recovery history  (all above should be selected to choose “Yes”) |
| Yes | No | | | | | | | | Are known allergies and adverse reactions clearly documented? (Or if there are no known allergies, is this documented?) |
| Yes | No | | | | | | | | Is the CCA dated and signed by the assessor? |

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| **Intensive In-Home Services**  Medicaid Clinical Coverage Policy 8A  Service Code H2022  Medical Necessity Review | | |
| **A beneficiary is eligible for this service when all of the following criteria are met:** | | |
| Met | Not Met | 1. There is an MH/SA diagnosis (as defined by the DSM-5 or its successors), other than a sole diagnosis of intellectual and developmental disability.   **As evidenced by:** |
| Met | Not Met | 1. Based on the current comprehensive clinical assessment, this service was indicated and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective.   **As evidenced by:** |
| Met | Not Met | 1. The youth has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal/homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use).   **As evidenced by:** |
| Met | Not Met | 1. The youth’s symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of his or her mental health or substance abuse condition, requiring intensive, coordinated clinical interventions.   **As evidenced by:** |
| Met | Not Met | 1. The youth is at imminent risk of out-of-home placement based on the child or adolescent’s current mental health or substance abuse clinical symptomatology, or is currently in an out of-home placement and a return home is imminent.   **As evidenced by:** |
| Met | Not Met | 1. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).   **As evidenced by:** |

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| **Intensive In-Home Services**  Medicaid Clinical coverage Policy 8A  Service Code H2022  Continued Service Criteria | | |
| Met | Not Met | The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the client’s PCP; or the client continues to be at risk for out-of-home placement based on current clinical assessment, history, or the tenuous nature of the functional gains;  **AND** |
| Met | Not Met | **One** of the following applies:  **As evidenced by:** |
| 1. The client has achieved current PCP goals and additional goals are indicated as evidenced by documented symptoms; 2. The client is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP; 3. The client is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the client’s premorbid are possible; or 4. The client fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. The client’s diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services. | | |

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| **Intensive In-Home Services**  Medicaid Clinical Coverage Policy 8A  Service Code H2022  Discharge Criteria | | |
| Met | Not Met | Any **one** of the following applies:  **As evidenced by:** |
| 1. The client has achieved goals and is no longer in need of IIH services; 2. The client’s level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care; 3. The client is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; 4. The client or legally responsible person no longer wishes to receive IIH services; or 5. The client, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association.) | | |

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| **Clinical Review:** |
| Approved  Send to peer review (see below for notes on this process)  UTP  Administratively Deny  Reviewer Name, Credentials:       Date:  Clinical Justification: |
| **Process Notes:**   * **If Approval is granted under EPSDT, please include the following in Clinical Justification: An individualized statement about why this service is needed that provides explanation of how EPSDT criteria are met. A checklist that notes generalized EPSDT criteria is not sufficient to document the need for an EPSDT service.** * **Document consideration/exploration of less restrictive/less costly community-based alternatives and include rationale for appropriate rejection of such alternatives** * **If continued stay review, document progress/lack of progress or changing needs since last review and sufficiently document needs that support the continued stay determination** |
| **Sending to Peer Review:** |
| Complete the initial peer review referral form  Ensure that the contact information provided to the Peer Reviewer is correct by calling the number yourself and verifying that a clinician can be contacted. If the number provided is not correct, please note on the QOC spreadsheet.  Complete the email template for the Clinical Support Team and attach the necessary documents  Ensure that the SAR is designated as being in “peer review” status in Alpha |