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| Client Name:       SAR#:       Requested Date Range: | | | | | | |
| **Intercept**  Service Code H0036  Pre-Review | | | | | | |
| Yes | No | | | | | **Review for HUM 26**: are there immediate health/safety concerns? **If YES, consult with medical staff and document recommendations in a “physician consult” note.** |
| **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 | | | | | The PCP is present, which includes Intercept 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 service order and dated 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**   If not met, contact the provider to request and give deadline to submit. If not received, **“administratively deny”** the request. |
| Met | Not Met | | | | | The Comprehensive Crisis Plan is present. 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 is in SAR or other documentation. If not, then contact the provider to request and give deadline to submit. If not received, “**administratively deny**” the request.   * Recommended CALOCUS Level 3 – 5 * Recommended ASAM > 1.0   If necessary, review and/or request CALOCUS/ASAM worksheet; If not present, can NOT administratively deny. |
| Yes | No | | | | | Are there any current authorizations for other services? If so, consider if there are service exclusions or if EPSDT review is required.  Note the services here: |
| **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 | | | | | Is the client you’re reviewing a Medicaid client and under 21? If **yes**, review for EPSDT. |
| Yes | No | | | | | Is the Client’s Name, DOB, EHR, and MID number accurate on submitted documents? If not, contact provider for clarification. Report to appropriate HIPAA personnel if violation has occurred. |
| 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 any 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: |
| Length of stay in current service (if applicable). Note here: | | | | | | |
| Yes | No | | | | | Review current medications and assess need for referral to medical review. If review is 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 labeled as “Pharmacy 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 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 | | | Are known allergies and adverse reactions clearly documented? (Or if there are no known allergies, is this documented?) | |
| Yes | | No | | | Is the mental status sufficiently documented and does it support the diagnosis? | |
| Yes | | No | | | A review of the following dimensions is 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 | | Is there evidence of beneficiary and family and/or legally responsible person’s involvement in the assessment (if applicable)? | |
| Yes | | No | | | Is there 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? (i.e. 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 | | | Is there 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 | | | Is the CCA dated and signed by the assessor? | |
| **Intercept**  Service Code H0036  Eligibility Criteria | | | | | | |
| Intercept provider shall document written admission criteria that reflect the following requirements, which must be met for a beneficiary to be deemed eligible for Intercept services: | | | | | | |
| Met | Not Met | | | | | 1. Significant impairment is documented in at least two of the life domains related to the recipient’s diagnosis, that impede the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, medical/ health, educational/vocational, and legal.   **As evidenced by:**  AND |
| 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 Developmental Disability   **As evidenced by:**  AND |
| Met | Not Met | | | | | 1. the recipient is experiencing functional impairments in at least two of the following areas as evidenced by documentation of symptoms:   **As evidenced by:**  AND |
| 1. Is previously or imminently at risk for institutionalization, hospitalization, or placement outside the recipient’s natural living environment;  2. Is receiving or needs crisis intervention services;  3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team;  4. Is abused or neglected as substantiated by DSS, or is found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101);  5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.; or  6. Is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support | | | | | | |
| Met | Not Met | | | | | 1. Youth is at risk of out of home placement or is currently in out of home placement and 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 (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine) as available or based on established utilization review criteria established by the NC Department of Health and Human Services. |

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| **INTERCEPT**  Service Code H0036  Continued Stay 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 beneficiary’s Person Centered Plan; or the beneficiary continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains;  **As evidenced by:**  AND |
| Met | Not Met | **ONE of the following applies:**  **As evidenced by:** |
| 1. Consumer has achieved current Person Centered Plan goals and additional goals are indicated as evidenced by documented symptoms 2. Consumer is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in reaching the goals outlined in the Person Centered Plan 3. Consumer is making some progress, but the specific interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the consumer’s premorbid functioning are possible or can be achieved 4. Consumer fails to make progress or demonstrates regression in meeting goals through the strategies outlined in the Person Centered Plan. The recipients diagnosis should be reassessed to identify any unrecognized co-occurring disorders with treatment recommendations revised based on findings. | | |

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| **Intercept**  Service Code H0036  Transition or Discharge Criteria | | |
| Met | Not Met | Must meet at least **ONE** of the following:  **As evidenced by:** |
| 1. Consumer’s level of functioning has improved with respect to the goals in the Person Centered Plan, inclusive of a transition plan to step down; 2. Consumer has achieved goals and is no longer in need of TASK services; 3. Consumer is not making progress or is regressing and all reasonable clinical strategies and interventions have been exhausted, indicating a need for more intensive services 4. The consumer or family/legally responsible guardian no longer wishes to receive TASK services 5. The consumer, based on presentation and failure to show improvement despite modifications to the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g. The American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association Practice Guidelines, and that American Society of Addiction Medicine). | | |

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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 |