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| Client Name:       SAR#:       Requested Date Range: | | | | | | |
| **Psychiatric Residential Treatment Facilities (PRTF)**  Clinical Coverage Policy 8D-1  Service Code 911  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”.** |
| Met | Not Met | | | | | The # of units requested match calendar days requested. 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 PRTF 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 6 * Recommended ASAM Level > 1   If necessary, review and/or request CALOCUS/ASAM worksheet; If not present, can NOT administratively deny. |
| Met | Not Met | | | N/A | | For initial requests, the CON is present and accurate. If none present, then contact provider and give a deadline to submit. If not received, “**administratively deny**” the request. **(NOTE: The CON can only be signed by an Independent physician and LCSW or Licensed Psychologist.)** |
| **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 | | | | | Are services “stacked”? 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 requested days/units are within the MCO guidelines. If over the benefit plan, review for EPSDT. |
| Yes | No | | | | | Is the Client’s Name, DOB, 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 | | | N/A | | 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.  Note here: |
| Yes | No | | | | | Is there a Care Coordinator in place? If not, make documented call to Care Coordinator Manager (or email) of county that consumer originally resides and request that a Care Coordinator be assigned. Note here: |
| Yes | No | | | | | Has there been a PRTF staffing?  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 Pharmicist, 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? | |

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| **Psychiatric Residential Treatment Facilities (PRTF)**  Clinical Coverage Policy 8D-1  Service Code 911  Eligibility Criteria | | | |
| Medicaid shall cover admission to Psychiatric Rehabilitation Treatment Facilities when the beneficiary meets **all** of the following criteria: | | | |
| Met | Not Met | 1. The beneficiary demonstrates symptomatology consistent with a DSM-5, or any subsequent editions of this reference material, diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.   **As evidenced by:** | |
| Met | Not Met | 1. The beneficiary is experiencing emotional or behavioral problems in the home, community or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.   **As evidenced by:** | |
| Met | Not Met | 1. The beneficiary demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.   **As evidenced by:** | |
| Met | Not Met | 1. The beneficiary has a history of multiple hospitalizations or other treatment episodes or recent inpatient stay with a history of poor treatment adherence or outcome.   **As evidenced by:** | |
| Met | Not Met | 1. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the client’s needs.   **As evidenced by:** | |
| **Psychiatric Residential Treatment Facilities (PRTF)**  Clinical Coverage Policy 8D-1  Service Code 911  Continued Stay Criteria | | |
| **All** of the following criteria are necessary for continuing treatment at this level of care: | | | |
| Met | Not Met | A.The beneficiary's condition **continues to meet admission criteria** at this level of care.  **As evidenced by:** | |
| Met | Not Met | B. The beneficiary’s treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.  **As evidenced by:** | |
| Met | Not Met | C. Treatment planning is individualized and appropriate to the beneficiary’s changing condition with realistic and specific goals and objectives stated. Treatment planning shall include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities.  **As evidenced by:** | |
| Met | Not Met | D. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.  **As evidenced by:** | |
| Met | Not Met | F. If treatment progress is not evident, there is documentation of treatment plan adjustments to address such lack of progress.  **As evidenced by:** | |
| Met | Not Met | G. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.  **As evidenced by:** | |
| Met | Not Met | H. Beneficiary is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the beneficiary’s engagement in treatment.  **As evidenced by:** | |
| Met | Not Met | I. Unless contraindicated, family, guardian, or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.  **As evidenced by:** | |
| Met | Not Met | J. When medically necessary, appropriate psychopharmacological intervention has been prescribed or evaluated.  **As evidenced by:** | |
| Met | Not Met | K. There is documented active discharge planning from the beginning of treatment.  **As evidenced by:** | |
| Met | Not Met | L. There is a documented active attempt at coordination of care with relevant outpatient providers when appropriate.  **As evidenced by:** | |

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| **Psychiatric Residential Treatment Facilities (PRTF)**  Clinical Coverage Policy 8D-1  Service Code 911  Discharge Criteria | | |
| Met | Not Met | The beneficiary shall be discharged from this level of care if the following two criteria are both met:  **As evidenced by:** |
| 1. The client can be safely treated at an alternative level of care. 2. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place. | | |
| Met | Not Met | In addition to “a” and “b” above, **one or more** of the criteria in “c” through “g” must be met:  **As evidenced by:** |
| C. The beneficiary’s documented treatment plan goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at an alternate level of care.  D. The beneficiary no longer meets admission criteria, or meets criteria for a less or more intensive level of care.  E. The beneficiary, or family member, guardian, or custodian is competent but non-participatory in treatment or in following the program rules and regulations. There is non-participation to such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.  F. Consent for treatment is withdrawn, and it is determined that the beneficiary, parent, or guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.  G. The beneficiary is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care; nor is the level of care required to maintain the current level of function. | | |

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| **Clinical Review:** |
| Unable to Process  Administrative Denial  Approved  Send to peer review (see below for notes on this process)  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** * **If initial review, make documented call to provider 2 weeks post admission and request discharge plan be uploaded.** |
| **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 |