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| Client Name:       SAR#:       Requested Date Range: | | | | | | |
| **Level III Residential**  Clinical Coverage Policy 8D-2  Service Code H0019UQ (<4 beds) and H0019US (5+ beds)  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 Level III 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 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 | | | | | 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, 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? | |

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| **Level III Residential**  Clinical Coverage Policy 8D-2  Service Code H0019UQ (<4 beds) and H0019US (5+ beds)  Eligibility Criteria | | | | | |
| A beneficiary is eligible for this service when all of the following criteria are met: | | | | | |
| Met | Not Met | | Medically stable but may need some intervention to comply with medical treatment AND  The beneficiary’s needs cannot be met with Family/Program Residential Treatment services  **As evidenced by:**  AND | |
| Met | Not Met | | The beneficiary is experiencing **any one** of the following (may be related to the presence of moderate to severe affective, cognitive or behavioral problems or intellectual/developmental delays/disabilities):  **As evidenced by:** | |
| 1. Severe difficulty maintaining in the naturally available family setting or lower level treatment setting as evidenced by but not limited to: 2. Frequent and severe conflict in the setting, 3. Frequent and severely limited acceptance of behavioral expectations and other structure, 4. Frequent and severely limited involvement in support or impaired ability for forming trusting relationships with caretakers 5. A pervasive and severe inability to form trusting relationships with caretakers or family members 6. An inability to consider the effect of inappropriate personal conduct on others. 7. Frequent physical aggression including severe property damage or moderate to severe aggression toward self or others. 8. Severe functional problems in school or vocational setting or other community setting as evidenced by: 9. Failure in school or vocational setting because of frequent and severely disruptive behavioral problems 10. Frequent and severely disruptive difficulty in maintaining appropriate conduct in community settings OR 11. Severe and pervasive inability to accept age appropriate direction and supervision from caretakers or family members, coupled with involvement in potentially life-threatening, high-risk behaviors. 12. Medication administration and monitoring have alleviated some symptoms, but other treatment interventions are needed to control severe symptoms. 13. Significant limitations in ability to independently access or participate in other human services and requires intensive active support and supervision to stay involved in other services 14. Significant deficits in ability to manage personal health, welfare and safety without intense support and supervision. 15. For beneficiaries identified with or at risk for inappropriate sexual behavior: 16. The parent/caretaker is unable to provide the supervision of the sex offender required for community safety 17. Moderate to high-risk for re-offending 18. Moderate to high-risk for sexually victimizing others 19. Deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems   e. A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria and a Checklist for Risk Assessment of Adolescent Offenders. | | | | |
| **Level III Residential**  Clinical Coverage Policy 8D-2  Service Code H0019UQ (<4 beds) and H0019US (5+ beds)  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 PCP; or the beneficiary continues to be at risk for relapse based on 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. Beneficiary has achieved initial PCP goals and additional goals are indicated. 2. Beneficiary is making satisfactory progress toward meeting goals. 3. Beneficiary is making progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the client’s pre-morbid level of functioning, are possible or can be achieved. 4. Beneficiary is not making progress; the PCP must be modified to identify more effective interventions. 5. Beneficiary is regressing; the PCP must be modified to identify more effective interventions.   **As evidenced by:**  AND | | | | | |

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| **Level III Residential**  Clinical Coverage Policy 8D-2  Service Code H0019UQ (<4 beds) and H0019US (5+ beds)  Transition/Discharge Criteria | | | | |
| Met | Not Met | | The beneficiary shall be discharged from this level of care if any **one** of the following is true:  **As evidenced by:** | |
| 1. The level of functioning has improved with respect to the goals outlined in the PCP and the client can reasonably be expected to maintain these gains at a lower level of treatment. 2. The client no longer benefits from service as evidenced by absence of progress toward PCP goals and more appropriate service(s) is available. 3. Discharge or step-down services can be considered when in a less restrictive environment, the safety of the client around sexual behavior, and the safety of the community can reasonable be assured. | | | | |
| **Level III Residential**  Clinical Coverage Policy 8D-2  Service Code H0019UQ (<4 beds) and H0019US (5+ beds)  Service Maintenance Criteria | | | | |
| Met | | Not Met | | If the beneficiary is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service shall be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least **one** of the following:  **As evidenced by:** |
| 1. There is a past history of regression in the absence of residential treatment or a lower level of residential treatment. 2. There are current indications that the client requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment. 3. In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains, the presence of a DSM-5 or any subsequent editions of this reference material, diagnosis would necessitate a disability management approach. | | | | |

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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** |
| **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 |