

Beneficiary Name:

SAR#:

ID#:

Provider:

Requested Date Range: **Error! AutoText entry not defined.** Review Type: [] Initial [] Concurrent

Service Review Criteria

<u>B3 Individual Support</u> <u>Partners BHM B3 Service Definition</u>			
<u>Service Codes: Individual Support – T1019U4</u>			
<u>Pre Review</u>			
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	Review for HUM 26: immediate health/safety concerns. If MET; refer to medical staff and outreach phone call to Provider. Please note concerns here and in the Clinical Justification:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	Review for expedited criteria. If not met, notify provider and take off of expedited status.
Review for Unable to Process Criteria			
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		The requested effective start date does not precede the submission date of request. If unjustified retro request, then “unable to process” .
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		The dates of the request do not overlap with an existing authorization for the same service. If not met, make documented contact with provider to verify intended request dates. Can adjust authorized dates as requested by provider. Please note here:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		The number of units requested match calendar days requested: (15 Minute Increments) If not met, make documented contact with provider to verify intended request units/dates. Can adjust authorized dates as requested by provider. Please note here:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		The SAR is submitted no more than 30 days before requested start date. If not met, then unable to process .
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		The SAR is submitted with ICD-10 codes. If not met, then “unable to process” .
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	Review for “stacked” services. If there are current authorizations for other services, consider if there are service exclusions and if son, contact Provider for clarification. If no response, “Unable To Process” the request. Note the services here:
Review for Administrative Denial:			
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		The Treatment Plan is present, which includes Individual Support, frequency and provider. If none present, then contact the provider to request and give deadline to submit. If no response, “administratively deny” the request.
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		Initial Treatment Plan and/or Annual Treatment Plan Rewrite. In addition, the following are also present:

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		<ul style="list-style-type: none"> ➤ Beneficiary and/or Legally Responsible Person signature ➤ Person Responsible for Treatment Plan signature ➤ Attestation boxes checked by Approved Signatory (if using PCP) <p>If not met, contact the provider to request and give deadline to submit. If no response, “administratively deny” the request.</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>CALOCUS/LOCUS/ASAM level noted is 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.</p> <ul style="list-style-type: none"> ➤ Recommended LOCUS Level 1-3 ➤ Recommended ASAM Level .05- 1If necessary, review and/or request LOCUS/ASAM worksheet; If not present, can NOT administratively deny.
Other Items of Review:		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>The Beneficiary’s Name, DOB, MRN and MID number are present and accurate in necessary places (ie. PCP, CCA, Service Notes, etc.)? If not contact Provider for clarification. Report to appropriate HIPPA personnel if violation has occurred.</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>Is there evidence of active discharge planning with any concurrent requests? Consider reviewing for the following elements:</p> <ul style="list-style-type: none"> ➤ Anticipated discharge date ➤ Barriers to discharge ➤ Anticipated discharge level of care ➤ Efforts made to coordinate discharge appointment <p>If not, then make documented call to provider to request.</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>Review for past denials or partial approvals within this current episode of care. Consider implications of previous decision/recommendations and need for clinical staffing. Please note here:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>Are the requested days/units within the MCO guidelines? If not, make documented contact with provider to verify intended request dates/units. Can adjust authorized dates/units as requested by provider or educational notice to match Clinical Coverage Policy. Please note here:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>Length of stay in current service. Note here:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>If DSS/DJJ/Legal involvement, a tag has been created in AlphaMCS. Note status of involvement here:</p>

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B3 Individual Support Eligibility Criteria

Met	Not Met	
		Must meet ALL of the following criteria:
<input type="checkbox"/>	<input type="checkbox"/>	A. Adults eligible for this service must be age 18 or older
<input type="checkbox"/>	<input type="checkbox"/>	B. Must have a diagnosis of Severe and Persistent Mental Illness (SPMI)
<input type="checkbox"/>	<input type="checkbox"/>	C. Must demonstrate a deficit in at least one Instrumental Activity of Daily Living
<input type="checkbox"/>	<input type="checkbox"/>	D. A LOCUS level of II or greater is required.

B3 Individual Support Continued Service Criteria

Met	Not Met	
		Must meet the following criteria:
<input type="checkbox"/>	<input type="checkbox"/>	A. The individual continues to demonstrate need for the services as outlined in the Entrance Criteria.

B3 Individual Support Discharge Criteria

Met	Not Met	
		Discharge should occur when the individual's level of adaptive functioning has improved, as demonstrated by ONE of the following:
<input type="checkbox"/>	<input type="checkbox"/>	A. Improvement toward measurable goals outlined in the Service Plan
<input type="checkbox"/>	<input type="checkbox"/>	B. LOCUS level < II
<input type="checkbox"/>	<input type="checkbox"/>	C. When the individual has been transitioned to natural supports
<input type="checkbox"/>	<input type="checkbox"/>	D. Has developed skills to function independently.

This service is not intended for individuals living in a family residence (unless during the transition period) as it is intended to support the independent living needs of the individual. Individual Support may not be provided by an individual's family member.

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Individuals between the ages of 18 and 21 may not live in a Medicaid funded child residential treatment facility.

For individuals living in licensed residential settings this service may not exceed two months.

Individual Support may not be provided during the same authorization period as the following services:

- Partial Hospitalization
- ACTT
- Community Support Team
- SAIOP (Substance Abuse Intensive Outpatient)
- SACOP (Substance Abuse Comprehensive Outpatient)

In addition:

- The individual may not receive B3 Services if they receive services from or are enrolled in any other waiver.
- B3 Services are not an entitlement and as such, are not subject to appeal or EPSDT.
- B3 Services are only available up to the capitation amount provided to fund these services.
- B3 Services, with the exception of Psychiatric Consultation, are not available to participants of all state 1915 (c) waivers.

This service may not be provided by family members.

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Service Review Criteria

Clinical Review:

Approved Send to peer review Administrative Denial UTP

Reviewer Name, Credentials:

Date:

Clinical Justification/Reason for Peer Clinical Review:

Based on clinical review, client meets Criteria as outlined in **PBHM B3 Service Definition** as evidenced by:

Specifically,

Authorized from with the next review date being no more than 30 days prior to the renewal date. Authorization is not a guarantee of payment. Claims payment is dependent upon client funding eligibility during authorization period and contract of the service provider.