Name: ID#: SAR #: SAR Submit Date:
DOB:

Adaptive Behavioral Treatment (ABT)

Administrative Review

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 staff with I/DD UM Supervisor for permission to **"unable to process"**.
☐ Met	☐ 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 (phone call and pend request) to verify intended request dates. If provider indicates that the dates were entered in error, then pend for replacements SAR(s). Please note here:______
☐ Met	☐ Not Met	The SAR is submitted no more than 30 days before requested start date. (UTP process)
☐ Met	☐ Not Met	The SAR is submitted with ICD-10 codes. (UTP process)
☐ Met	☐ Not Met	The person is eligible for Medicaid as verified in Alpha or NCTRACKS. (UTP process)
☐ Met	☐ Not Met	Service/ Procedure Code on the SAR matches the plan. (UTP process)
☐ Met	☐ Not Met	The Service Provider on the SAR matches the provider identified in the plan. (UTP process)
☐ Met	☐ Not Met	Requested end date on the SAR does not extend beyond the end date of the valid plan. (UTP process)
☐ Met	☐ Not Met	Requested units in the plan match the SAR. (UTP process)
☐ Met	☐ Not Met	Requested Start date and End date are identified in the plan and match the SAR (UTP process).

Review for Administrative Denial:			
☐ Met	☐ Not Met	☐ NA for 0359	Valid Treatment Plan is present and signed/dated/Credentials by licensed person and family and covers dates of service requested. If none present, then contact the provider to request and give deadline to submit. (Admin Denial process),
☐ Met	☐ Not Met	☐ NA for 0359	The Annual Treatment Plan with all elements is present with all pages (Admin Denial process), OR Updated Treatment Plan Revision with indication that goals have been reviewed is present or progress summary (Admin Denial process).
☐ Met	☐ Not Met	☐ NA for 0359	Signed service order is present and signed/dated by an Approved Signatory (signed by PsyD, PHD, MD, DO,). • Service Order statement needs to cover the amount of time provider wants their plan to be valid for. Plan/service order can be valid for up to one year if indicated. For all others, contact the provider to request and give deadline to submit. (Admin Denial process),
☐ Met	☐ Not Met		Valid Psychological Eval is present and supports request (to include DSM 5 diagnosis of Autism. ONLY for 0359T/LP can be provisional Autism diagnosis). • Must be completed within 3 years, ○ *Note date of evaluation or signature date here:* ______

			• Psychological Evaluation Must be signed (by LPA, PhD, or PsyD) and dated: **OR**
			  ○ ***Note name and credentials of signatory here:*** ______
			  ○ For Psychological Evaluation only: Must contain Autism specific testing, cognitive testing and adaptive assessment
			• Developmental Pediatrician Evaluation with Autism specific testing/interpretation and diagnosis is acceptable within 3 years
			  ○ ***Note name and credentials of signatory here:*** ______
			• **Provisional Autism Diagnosis is acceptable for 0359T/LP assessment code:** A provisional diagnosis of ASD is a diagnosis made by a licensed professional as provisional or rule-out based on significant concern for ASD (e.g., physician screening results, parent report, early intervention documentation of concern, or observation of symptoms) when a comprehensive evaluation has not yet been completed. Provisional diagnosis maybe made by licensed psychologist, physician, or clinicians with a Master's degree for whom this service is within their scope of practice (e.g., licensed Psychological Associate, Licensed Clinical Social Worker)
			  ○ ***Note name and credentials of signatory here:*** ______
			• Must be a definitive diagnosis of Autism for all other codes. **For all codes, the psychological evaluation must be present in alpha (may have been submitted with previous requests—make sure to check patient module).** If not included or in alpha, then document call to provider and pend in alpha. Please note here:______
			(Admin Denial process),

Other Items of Review:		
☐ Met	☐ Not Met	Are the requested days/units within the MCO guidelines? If not, make documented contact with provider to verify intended request dates/units. • If provider indicates that the dates/units were entered in error, then pend for replacements SAR(s). (Can **NEVER** Admin Deny or UTP)

		Review for Children with Complex Needs Criteria:
		☐ Medicaid eligible children ages 5 and under 21; -**AND**-
		☐ Who have been diagnosed with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder;
		  a. Developmental Disabilities must be confirmed via psychological evaluation (or medical evaluation as appropriate)
		  b. Mental Health Disorders must be confirmed via Comprehensive Clinical Assessment; -**AND**-
		☐ Who are at risk of not being able to return to or maintain placement in a community setting;
		  a. Based on the needs of the child, the current caregiver cannot maintain the child's health and safety -**AND**-
		☐ Has a history of mental health and intellectual and/or developmental disabilities diagnoses or treatment AND 1 or more of the following risk factors will include the following:
		  ☐ Exhibiting behaviors that are a danger to self or others at this time;
		    ☐ Behaviors must be current (within the last 30 days) and require intervention (medical intervention, physical intervention, crisis services, or inpatient treatment)
		  -OR-

<table>
<tr><td></td><td>☐ Been expelled or is at risk of expulsion from school due to disruptive or dangerous behaviors;
☐ Child is unable to participate in any structured educational setting based on current behaviors
-OR-
☐ Experienced incidents for crisis such as frequent ED visits, out of home placements, involvement with criminal justice system, or involuntary commitments.
☐ Frequent ED visits is defined as 3 or more visits in the past 12 months
☐ Incidents of out of home placement, involvement with criminal justice system, or involuntary commitment has occurred within the last 12 months.
<u>If Yes, Create tag in Alpha</u> **Not included in Initial Review Criteria for Approval</td></tr>
<tr><td></td><td>Has High Priority Diagnosis tag present in Alpha?
☐ YES ☐ NO – create tag in alpha</td></tr>
<tr><td></td><td>MH/SU services: Beneficiary is receiving an MH/SU service other than Medication Management or Inpatient.
☐ YES- <u>Review with Clinical Reviewer</u> ☐ NO

For IDD Utilization Reviewers only: Beneficiary has a MH diagnosis other than Autism?
☐ YES- <u>Review with Clinical Reviewer</u> ☐ NO ☐ N/A (MH Utilization Reviewer)</td></tr>
</table>

Outcome of Administrative Review:
☐ Proceed to Medical Necessity Review ☐ Unable to Process ☐ Administrative Denial Notes: ______ Reviewer Name: ______ Date:______
<u>Supervisory Review</u> *(ONLY completed when proceeding with Administrative Denial or UTP):* ☐ Administrative Denial ☐ Unable to Process ☐ Proceed to Medical Necessity Review Comments: Supervisor Name, Credentials: Date:

Name: ID#: SAR #: SAR Submit Date:
DOB:

EPSDT REVIEW

MET	NOT MET	N/A	Criteria to Approve Service
☐	☐	☐	The recipient is under 21 years old.
☐	☐	☐	The request was submitted on or before the effective date of the service.
☐	☐	☐	The request shows how the service will correct or ameliorate a defect, physical or mental illness, or medical condition. This includes: 1. Documentation showing that medical necessity and policy criteria are met; • Must be medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified by screening.” • “Ameliorate” means to: Improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. • Must be generally recognized as an accepted method of medical practice or treatment. • Must not be experimental, investigational. • Must be safe. • Must be effective. 2. Documentation to support that all EPSDT criteria are met: and 3. Evidence-based literature to support the request, if available. If this information not provided, the provider will be contacted.
☐	☐	☐	This request is not for a habilitative service, respite or home modifications.
☐	☐	☐	If requested service exceeds policy limits (hrs., visits, frequency, etc.) documentation submitted addresses why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
☐	☐	☐	Request includes current information from the recipient’s physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, the provider will be contacted.
☐	☐	☐	There is a Service Order for the requested service.
☐	☐	☐	The service will be provided within NC or out of state if there is not a similarly efficacious service available in NC.
☐	☐	☐	The service meets waiver service definitions or Medicaid service standards and has been considered under both.
☐	☐	☐	Service is within definition limits or exceeds hard limits if the service is coverable under EPSDT
☐	☐	☐	Total cost of beneficiary’s care does not exceed the waiver cost limit with the addition of EPSDT services. (i.e. $135,000)
☐	☐	☐	Request is not for any of the following: • Pediatric mobility systems & aug comm (send to HP Enterprise) • Oral nutrition that appears on the DMA fee schedule (send to HP Enterprise)

			• Formula that does not appear on the DMA fee schedule (send to HP Enterprise)

Initial Review:
List Current Service Codes/Units Requested:

Care Manager Note:

All Criteria Met: ☐ YES—APPROVE ☐ NO (send to Second Level Supervisory Review/Clinical Review)

Care Manager Name, Credentials: Date:

Supervisory Review/Clinical Review:

☐ Approved ☐ Send to Peer Review

Comments:

Supervisor Name, Credentials: Date: