Member Name: [Type text]
ID#: [Type text]
Provider: [Type text]
SAR#: [Type text]
Requested Date Range: **Error! AutoText entry not defined.**Review Type: ☐ Initial ☐ Concurrent

Service Review Criteria

<table>
<tr><th colspan="4"><u>Outpatient Opioid Treatment</u>
<u>Clinical Coverage Policy 8A</u>
<u>Service Code H0020</u>
<u>Pre-Review</u></th></tr>
<tr><td>☐
Met</td><td>☐
Not Met</td><td>☐
N/A</td><td>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:</td></tr>
<tr><td>☐
Met</td><td>☐
Not Met</td><td>☐
N/A</td><td>Review for expedited criteria. If not met, notify provider and take off of expedited status.</td></tr>
<tr><td colspan="4">Review for Unable to Process Criteria</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>The requested effective start date does not precede the submission date of request. If unjustified retro request, then “unable to process”.</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>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:</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>The number of units requested match service requested. 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:</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>The SAR is submitted no more than 30 days before requested start date. If not met, then unable to process.</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>The SAR is submitted with ICD-10 codes. If not met, then “unable to process”.</td></tr>
<tr><td colspan="4">Review for Administrative Denial:</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>The Treatment Plan is present, which includes Opioid Treatment, frequency and provider. If none present, then contact the provider to request and give deadline to submit. If no response, “administratively deny” the request.</td></tr>
<tr><td>☐
Met</td><td colspan="2">☐
Not Met</td><td>The submitted PCP/Treatment Plan contains the appropriate signatures:
For Initial review, Annual review, or when a service is added/withdrawn from the plan:
➢ Member and/or Legally Responsible Person signature
➢ Person Responsible for Treatment Plan signature
➢ Service Order signature by the appropriate licensed professional as dictated by the service definition. Service Orders are valid for one year.
➢ Attestation boxes checked by Approved Signatory (if using PCP) for Medicaid members
For PCP/Treatment Plan reviews resulting in no changes to the plan:</td></tr>
</table>

Service Review Criteria

			➢ Member and/or Legally Responsible Person signature ➢ Person Responsible for Treatment Plan signature If not met, contact the provider to request and give deadline to submit. If no response, **“administratively deny”** the request.
☐ Met	☐ Not Met	☐ N/A	If the provider choses to use the PCP as the Treatment Plan, the Comprehensive Crisis Plan is present and complete. If none present, then contact provider and give a deadline to submit. If no response, “**administratively deny**” the request.
Other Items of Review:			
☐ Met	☐ Not Met		LOCUS/CALOCUS/ASAM score is noted and in SAR or other documentation. If child is age 5 or younger, CANS assessment is provided. If not, then contact the provider to request and give deadline to submit. If no response, input Quality of Care comment. ➢ *Recommended LOCUS/CALOCUS Level 3-5* ➢ *Recommended ASAM Level 1-2.5* If necessary, review and/or request LOCUS/CALOCUS/ASAM worksheet; If not present, can NOT administratively deny.
☐ Met	☐ Not Met		Check to see if a Care Coordinator has been assigned to the member. If so, indicate whether you have reviewed the most recent Care Coordination notes here:
☐ Met	☐ Not Met		The Member’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 HIPAA personnel if violation has occurred.
☐ Met	☐ Not Met	☐ 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.
☐ Met	☐ Not Met	☐ N/A	Review for 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:
☐ 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. Can adjust authorized dates/units as requested by provider or educational notice to match Clinical Coverage Policy. Please note here:
☐ Met	☐	☐ N/A	Length of stay in current service. Note here:

Member Name: [Type text]
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Service Review Criteria

	Not Met		
☐ Met	☐ Not Met	☐ N/A	Evidence of use/intended use of Evidence Based Practices. List EBP here:
☐ Met	☐ Not Met	☐ N/A	If DSS/DJJ/Legal involvement, a tag has been created in AlphaMCS. Note status of involvement here:
☐ Met	☐ Not Met	☐ N/A	**FOR STATE FUNDED**, is the State funded Benefit Plan accurate? Please add the following verification statement to the Justification Statement: "There is evidence to support the member meets the eligibility criteria of the Benefit Plan identified: (Benefit Plan)"
☐ Met	☐ Not Met	☐ N/A	Review for Service Exclusions. Check Claims for participation in & billing of other services. Check SARs for approved services. If there are Service Exclusions, contact Provider for clarification. For Child Medicaid (under age 21) EPSDT criteria may apply. For Adult Medicaid (age 21 & over) staff with supervisor for possible peer review. State Benefit Plan does not allow exclusionary services, resulting in UTP. Indicate the date you checked the claims module here, if applicable. Also, note services and provider explanation, if applicable:

<u>Outpatient Opioid Treatment</u> <u>Clinical Coverage Policy 8A</u> <u>Service Code H0020</u> <u>Entrance Criteria</u>		
The member is eligible for this service when **ALL** of the following criteria are met:		
☐ Met	☐ Not Met	A. A DSM-5 (or any subsequent editions of this reference material) diagnosis of a severe Opioid Use Disorder **As evidenced by:** AND
☐ Met	☐ Not Met	B. ASAM (American Society for Addiction Medicine) for Opioid Treatment Services (OTS) level of care is met 1. **<u>D1/Acute Intoxication and/or Withdrawal Potential</u>**: The member's current physiological dependence (in addition to a history of addiction) is confirmed by vital signs, early physical signs of narcotic withdrawal, a urine screen that is positive for opioids, the presence of old or fresh needle marks, and documented reports from medical professionals, the member or family, treatment history, or (if necessary) a positive reaction to a naloxone test.

Service Review Criteria

		2. **D2/Biomedical Conditions and Complications:** In Dimension 2, the member meets specifications in **one** of the following: a. The member meets the biomedical criteria for opioid use disorder, with or without the complications of opioid addiction, and requires outpatient medical monitoring and skilled care; **OR** b. The member has a concurrent biomedical illness or pregnancy, which can be treated on an outpatient basis with minimal daily medical monitoring; **OR** c. The member has biomedical problems that can be managed on an outpatient basis, such as liver disease or problems with potential hepatic decomposition, pancreatitis, gastrointestinal problems, cardiovascular disorders, HIV and AIDS, sexually transmitted diseases, and tuberculosis. **3. D3/Emotional, Behavioral, or Cognitive Conditions and Complications:** In Dimension 3, the member meets specifications in **one** of the following: **a.** The member's emotional, behavioral, or cognitive problems, if present, are manageable in an outpatient structured environment; **OR** **b.** The member's substance-related abuse or neglect of his or her spouse, children, or significant others requires intensive outpatient treatment to reduce the risk of further deterioration; **OR** **c.** The member has a diagnosed and stable emotional, behavioral, or cognitive problem or thought disorder (such as stable borderline personality disorder or obsessive-compulsive disorder) that requires monitoring, management, or medication because of the risk that the problem(s) will distract the member from his or her focus on treatment; **OR** **d.** The member poses a mild risk of harm to self or others, with or without a history of severe depression, suicidal or homicidal behavior, but can be managed safely in a structured outpatient environment; **OR** **e.** The member demonstrates emotional and behavioral stability but requires continued pharmacotherapy to prevent relapse to opioid use. 4. **D4/Readiness to Change:** In Dimension 4, the member meets specifications in **one** of the following: a. The member requires structured therapy, pharmacotherapy, and programmatic milieu to promote treatment progress and recovery; **OR** b. The member attributes his or her problems to persons or external events rather than to the substance-related disorder. He or she is thus

Service Review Criteria

		uninterested in making behavioral changes in the absence of clinically directed and repeated structured motivational interventions. However, the member's low interest in recovery does not render treatment ineffective. **5. <u>D5/Relapse, Continued Use, or Continued Problem Potential:</u>** In Dimension 5, the member meets specifications in **one** of the following: a. The member requires structured therapy, pharmacotherapy, and a programmatic milieu to promote treatment progress because he or she attributes continued relapse to physiologic craving or the need for opioids; **OR** b. Despite active participation in other treatment interventions without provision for opioid pharmacotherapy, the member is experiencing an intensification of addiction symptoms (such as difficulty in postponing immediate gratification and related drug-seeking behavior) or continued high-risk behaviors (such as shared needle use), and his or her level of functioning is deteriorating, despite revisions of the treatment plan; **OR** c. The member is at high risk of relapse to opioid use without opioid pharmacotherapy, close outpatient monitoring, and structured support (as indicated by his or her lack of awareness of relapse triggers, difficulty in postponing immediate gratification or ambivalence toward or low interest in treatment); **OR** d. The member is pregnant and requires continued opioid pharmacotherapy to avert repeated episodes of withdrawal by the fetus and ensure its continued health. 6. **<u>D6/Recovery Environment:</u>** In Dimension 6, the member meets specifications in **one** of the following: a. The member has a sufficiently supportive psychosocial environment to render opioid pharmacotherapy feasible. For example, significant others are supportive of recovery efforts, the member's workplace is supportive, the member is subject to legal coercion, the member has adequate transportation to the program, and the like; **OR** b. The member's family members or significant others are supportive, but require professional intervention to improve the member's likelihood of treatment success (such as assistance with limit-setting, communication skills, avoiding rescuing behaviors, education about opioid pharmacotherapy treatment and HIV-risk avoidance, and the like); **OR**

Service Review Criteria

		c. The member does not have a positive social support system to assist with immediate recovery efforts, but he or she has demonstrated motivation to obtain such a support system or to pursue (with assistance) an appropriate alternative living environment; **OR** d. The member has experienced traumatic events in his or her recovery environment (such as physical, emotional, sexual or domestic abuse) or has manifested the effects of emotional, behavioral or cognitive problems in the environment (such as criminal activity), but these are manageable on an outpatient basis. **As evidenced by:** AND
☐ Met	☐ Not Met	C. Service is a part of an aftercare planning process (time-limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service. **As evidenced by:**

Outpatient Opioid Treatment Clinical Coverage Policy 8A Service Code H0020 Continued Stay Criteria		
☐ Met	☐ Not Met	The member is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the member's service plan or the member continues to be at risk for relapse based on history or the tenuous nature of the functional gains; **As evidenced by:** **OR**
☐ Met	☐ Not Met	The member meets any of the specifications listed in the ASAM criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opioid Treatment Services. **As evidenced by:**

Outpatient Opioid Treatment Clinical Coverage Policy 8A Service Code H0020 Transition or Discharge Criteria
Member's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and **ANY** of the following apply:

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☐ Met	☐ Not Met	A. Member has achieved goals, discharge to a lower level of care is indicated. **As evidenced by:** **OR**
☐ Met	☐ Not Met	B. Member is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted. **As evidenced by:**

Outpatient Opioid Treatment Clinical Coverage Policy 8A Service Code H0020 Service Maintenance Criteria		
If the member is functioning effectively with this service and discharge would otherwise be indicated, Opioid Treatment must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision shall be based on **ANY ONE** of the following:		
☐ Met	☐ Not Met	1. History of regression in the absence of Opioid Treatment is documented in the member record. **As evidenced by:** **OR**
☐ Met	☐ Not Met	2. Presence of a DSM-5 (or any subsequent editions of this reference manual) diagnosis that would necessitate a disability management approach, in the event that there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains. **As evidenced by:**

Clinical Review:
☐Approved ☐ Send to peer review Reviewer Name, Credentials: Date: Clinical Justification/Reason for Peer Clinical Review:

Member Name: [Type text]
ID#: [Type text]
Provider: [Type text]
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Service Review Criteria

Medicaid:

Based on clinical review, member meets [Entrance/Continued Stay] Criteria for [SERVICE], outlined in Clinical Coverage Policy [CCP#], as evidenced by: [CLINICAL RATIONAL]. Authorized from [Date Range]. Authorization is not a guarantee of payment. Claims payment is dependent upon member funding eligibility during authorization period and contract of the service provider.

State:

Based on clinical review, member meets [Entrance/Continued] stay criteria as outlined in NC MHDDSAS State-Funded Enhanced Services for [SERVICE], as evidenced by [CLINICAL RATIONALE]. Authorized from [Date Range]. Authorization is not a guarantee of payment. Claims payment is dependent upon member funding eligibility during authorization period and contract of the service provider. There is evidence to support the member meets the eligibility criteria of the Benefit Plan identified: