Member Name:
ID#:
SAR #:
Provider:
Requested Date Range:
Review Type: ☐Initial ☐Concurrent

Service Review Criteria

Outpatient Behavioral Health Service Medicaid Clinical Coverage Policy 8C **Outpatient Individual Therapy Codes (CPT & H):** 90832; 90832GT; 90834; 90834GT; 90837; 90845; 90839 crisis; Add on for Crisis first 30 minutes and additional 30 minutes- 90840; 90833; 90833GT; 90836; 90838; add on for E&M codes **Family Therapy Codes (CPT &H):** 90846; 90847 **Group Therapy Codes (CPT & H):** 90849; 90853; 90857 Pre Review			
☐ Met	☐ Not Met	☐ 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:
☐ Met	☐ Not Met	☐ N/A	Review for expedited criteria. If not met, notify provider and take off of expedited status.

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 not met, make documented contact with provider to verify intended request dates. Can adjust authorized dates as requested by provider. Please note here:
☐ Met	☐ Not Met	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:
☐ 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 SAR is submitted with ICD-10 codes. If not met, then **"unable to process"**.

Review for Administrative Denial:		
☐ Met	☐ Not Met	The Treatment Plan is present, which includes Outpatient 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.

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Service Review Criteria

☐ Met	☐ Not Met	Initial Treatment Plan and/or Annual Treatment Plan Rewrite have signed service order and written date by Approved Signatory*. In addition, the following are also present: ➢ Member and/or Legally Responsible Person signature ➢ Person Responsible for Treatment Plan signature ➢ **Attestation boxes checked by Approved Signatory (if using PCP)** If not met, contact the provider to request and give deadline to submit. If no response, **"administratively deny"** the request. ***Fully licensed clinicians can sign service orders for Outpatient Therapy. Associate-level clinicians require service orders signed by an MD, PhD, NP, or PA.***

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 HIPPA 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 decision/recommendations and need for clinical staffing. Please note here: none noted

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☐ 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	☐ Not Met	☐ N/A	Length of stay in current service. Note here:
☐ 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:

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Family Therapy Codes (CPT &H): 90846; 90847

Group Therapy Codes (CPT & H): 90849; 90853; 90857

Entrance Criteria

All of following criteria are necessary for admission of a member to outpatient treatment services:

Member Name:
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Review Type: ☐Initial ☐Concurrent

Service Review Criteria

☐ Met	☐ Not Met	**A.** A Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5), or any subsequent editions of this reference material, diagnosis. **AND** **As evidenced by:**
☐ Met	☐ Not Met	**B.** The member presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the (DSM-5) or any subsequent editions of this reference material, diagnosis. **AND** **As evidenced by:**
☐ Met	☐ Not Met	**C.** The member does not require a higher level of care **AND** **As evidenced by:**
☐ Met	☐ Not Met	**D.** Member is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions. **AND** **As evidenced by: AND**
☐ Met	☐ Not Met	E. There is no evidence to support that alternative interventions would be more effective, based on North Carolina community practice standards (e.g. Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Board of Addiction Medicine.)

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Family Therapy Codes (CPT &H): 90846; 90847

Group Therapy Codes (CPT & H): 90849; 90853; 90857

Continued Stay Criteria

The criteria for continued service include **both A and B below:**

☐ Met	☐ Not Met	A. **ANY** of the following criteria **As evidenced by:**
☐ Met	☐ Not Met	1. The desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the member's treatment plan, **OR**
☐ Met	☐ Not Met	2. The member continues to be at risk for relapse/regression based on current clinical assessment, and history, **OR**
☐ Met	☐ Not Met	3. Tenuous nature of the functional gains

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Service Review Criteria

☐ Met	☐ Not Met	B. ANY of the following criteria (in addition to 'A') **As evidenced by:**
☐ Met	☐ Not Met	1. The member has achieved current treatment plan goals, and additional goals are indicated as evidenced by documented symptoms, **OR**
☐ Met	☐ Not Met	2. The member is making satisfactory progress towards meeting goals and there is documentation that supports that continuation of this service is expected to be effective in addressing goals outlined in the treatment plan.

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Family Therapy Codes (CPT &H): 90846; 90847

Group Therapy Codes (CPT & H): 90849; 90853; 90857

Discharge Criteria

ANY of the following criteria must be met:

☐ Met	☐ Not Met	A. The member's level of functioning has improved with respect to the goals outlined in the treatment plan, **OR** **As evidenced by:**
☐ Met	☐ Not Met	B. The member or legally responsible person no longer wishes to receive these services, **OR** **As evidenced by:**
☐ Met	☐ Not Met	C. The member, based on presentation and failure to show improvement, despite modifications in the treatment plan, requires a more appropriate best practice or evidence-based treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association.) **As evidenced by:**

Clinical Review:

☐ Approved ☐Send to peer review

Reviewer Name, Credentials: Date:

Clinical Justification/Reason for Peer Clinical Review:

Member Name:
ID#:
SAR #:
Provider:
Requested Date Range:
Review Type: ☐Initial ☐Concurrent

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: Click or tap here to enter text.