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

Service Review Criteria

Psychiatric Residential Treatment Facility Diversion and Assessment Program Clinical Coverage Policy 8D-1 State Funded MH/SA/DD Service Definitions Service Code 0911 (modifier pending); up to 30 day assessment 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 the date range requested: (*One unit per day)* 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		PCP is present, which includes the PRTF Diversion and Assessment Program, frequency and provider. If none present, then contact the provider to request and give deadline to submit. If no response, "**administratively deny**" the request.
☐ Met	☐ Not Met		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PCP/Treatment Plan contains the appropriate signatures: **For Initial review, Annual review, or when a service is added/withdrawn from the plan:** ➢ Member and/or Legally Responsible Person signature ➢ Person Responsible for Treatment Plan signature ➢ Service Order signature by the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.

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		➢ Attestation boxes checked by Approved Signatory (if using PCP) *for Medicaid members* **For PCP/Treatment Plan reviews resulting in no changes to the plan:** ➢ 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	Review for Comprehensive Crisis Plan. If none present, then contact provider and give a deadline to submit. If no response, "**administratively deny**" the request.
☐ Met	☐ Not Met	CON is present and accurate. If none present, then contact provider and give a deadline to submit. If no response, "**administratively deny**" the request. (NOTE: The CON can only be signed by an Independent physician and LCSW or Licensed Psychologist.)
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	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:
☐	☐	☐	Length of stay in current service.

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Met	Not Met	N/A	Note here:
☐ Met	☐ Not Met	☐ N/A	For concurrent request, ask for the following information: ➢ # of therapeutic leave days utilized ➢ # individual and/or family therapy sessions during previous auth. period ➢ Previously requested documentation from prior authorizations Please 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 **Create tag in Alpha**	☐ Not Met	☐ N/A	**Review for Children with Complex Needs Criteria:** 1. Medicaid eligible children ages 5 and under 21 **-AND-** 2. 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 eval (or medical evaluation as appropriate) b. Mental Health Disorders must be confirmed via Comprehensive Clinical Assessment **-AND-** 3. 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-** 4. 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: a. Is the child exhibiting <u>behaviors</u> that are a danger to self or others at this time;

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			○ Behaviors must be current (within the last 30 days) and require intervention (medical intervention, physical intervention, crisis services, or inpatient treatment) **-OR-** b. Has the child 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-** c. Has the child 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.
☐ 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:

Psychiatric Residential Treatment Facility Diversion and Assessment Program Clinical Coverage Policy 8D-1 State Funded MH/SA/DD Service Definitions Service Code 0911 (modifier pending) Specific Criteria		
Medicaid shall cover admission to Psychiatric Residential Treatment Facilities when the Member meets **all** of the following criteria:		
☐ Met	☐ Not Met	A. The member demonstrates symptomatology consistent with a DSM-5, or any subsequent editions of this reference material, diagnosis which requires and can reasonably be expected to respond to therapeutic intervention **AND** **As evidenced by:**

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☐ Met	☐ Not Met	B. The member is experiencing emotional or behavioral problems in the home, community or treatment setting and is not sufficiently stable either emotionally or behaviorally, and is in need of a comprehensive evaluation to determine if the member can be treated outside of a highly structured 24-hour therapeutic environment **AND** **As evidenced by:**
☐ Met	☐ Not Met	C. The member demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training **AND** **As evidenced by:**
☐ Met	☐ Not Met	D. The member has a history of multiple hospitalizations or other treatment episodes or recent inpatient stay with a history of poor treatment adherence or outcome or is at risk of hospitalization/incarceration and is in need of a comprehensive evaluation to determine discharge treatment and supervision options **OR** **As evidenced by:**
☐ Met	☐ Not Met	E. A comprehensive evaluation is needed to determine if less restrictive or intensive levels of treatment are appropriate to meet the member's needs **OR** **As evidenced by:**
☐ Met	☐ Not Met	F. A comprehensive evaluation is needed to determine if the family situation and functioning levels are such that the member can return to the home environment and receive community-based treatment. **As evidenced by:**

HISTORY OF SERVICES IN PAST 12 MONTHS		
Level of Treatment	**PROVIDER**	**DATES OF SERVICE**

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Service Review Criteria

Psychiatric Rehabilitation Treatment Facilities Diversion and Assessment Program

Clinical Coverage Policy 8D-1

State-Funded MH/SA/DD Service Definitions

Service Code 0911

Continuation/Utilization Service Review

All of the following criteria are necessary for continuing treatment at this level of care:		
☐ Met	☐ Not Met	A. The Beneficiary's condition continues to meet admission criteria at this level of care. **As evidenced by:**
☐ Met	☐ Not Met	B. The Beneficiary's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate. **As evidenced by:**
☐ Met	☐ Not Met	C. Treatment planning is individualized and appropriate to the Beneficiary's changing condition with realistic and specific goals and objectives stated. Treatment planning shall include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities. **As evidenced by:**
☐ Met	☐ Not Met	D. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Interventions **As evidenced by:**

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☐ Met	☐ Not Met	E. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress. **As evidenced by:**
☐ Met	☐ Not Met	F. Care is rendered in a clinically appropriate manner and focused on the Beneficiary's behavioral and functional outcomes. measures **As evidenced by:**
☐ Met	☐ Not Met	G. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. **As evidenced by:**
☐ Met	☐ Not Met	H. Beneficiary is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the Beneficiary's engagement in treatment. **As evidenced by:**
☐ Met	☐ Not Met	I. Unless contraindicated, family, guardian or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them. **As evidenced by:**
☐ Met	☐ Not Met	J. When medically necessary, appropriate psychopharmacological intervention has been prescribed or evaluated. **As evidenced by:**
☐ Met	☐ Not Met	K. There is documented active discharge planning from the beginning of treatment. **As evidenced by:**
☐ Met	☐ Not Met	L. There is documented active attempt at coordination of care with relevant outpatient providers when appropriate. **As evidenced by:**

Psychiatric Residential Treatment Facility Diversion and Assessment Program
Clinical Coverage Policy 8D-1
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Discharge Criteria		
☐ Met	☐ Not Met	The Member shall be discharged from this level of care if the following two criteria are **BOTH** met: **As evidenced by:**
a. The Member can be safely treated at an alternative level of care. b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.		
☐ Met	☐ Not Met	In addition to "a" and "b" above, **one or more** of the criteria in "c" through "g" must be met: **As evidenced by:**
c. The Member's documented treatment plan goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at an alternate level of care. d. The Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care. e. The Member, or family member, guardian, or custodian are competent but non-participatory in treatment or in following the program rules and regulations. There is non-participation to such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues. f. Consent for treatment is withdrawn, and it is determined that the member, parent, or guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care. g. The member is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care; nor is the level of care required to maintain the current level of function.		

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

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Service Review Criteria

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.

Note to Providers: Any use of restrictive interventions must be documented on an Incident Report. During their reviews, UM Care Managers will be confirming that Incident Reports were completed and submitted, when required.