

Member Name: [Type text]

ID#: [Type text]

SAR#: [Type text]

Provider: [Type text]

Requested Date Range: **Error! AutoText entry not defined.**

Review Type: [] Initial [] Concurrent

Service Review Criteria

<u>Psychiatric Residential Treatment Facilities</u> <u>Clinical Coverage Policy 8D-1</u> <u>State Funded MH/SA/DD Service Definitions</u> <u>Service Code 0911 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: (<i>One unit per day</i>) 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” .
Review for Administrative Denial:			
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met		PCP is present, which includes PRTF, 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		The submitted PCP/Treatment Plan contains the appropriate signatures: For Initial review, Annual review, or when a service is added/withdrawn from the plan: <ul style="list-style-type: none">➤ 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) <i>for Medicaid members</i>

PRTF

Updated 5/31/2019

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		<p>For PCP/Treatment Plan reviews resulting in no changes to the plan:</p> <ul style="list-style-type: none"> ➤ Member and/or Legally Responsible Person signature ➤ Person Responsible for Treatment Plan signature <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	Review for Comprehensive Crisis Plan. If none present, then contact provider and give a deadline to submit. If no response, “administratively deny” the request.
<input type="checkbox"/> Met	<input type="checkbox"/> 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. (<u>NOTE</u> : The CON can only be signed by an Independent physician, LPA, LCSW or Licensed Psychologist.)
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	Comprehensive Clinical Assessment and/or Addendum is present and supports request (to include DSM 5 diagnosis). If not included, then document call to provider. If not provided by deadline, administratively deny .
Other Items of Review:		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>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.</p> <ul style="list-style-type: none"> ➤ <i>Recommended LOCUS/CALOCUS Level 3-5</i> ➤ <i>Recommended ASAM Level 1-2.5</i> <p>If necessary, review and/or request LOCUS/CALOCUS/ASAM worksheet; If not present, can NOT administratively deny.</p>
<input type="checkbox"/> Met	<input type="checkbox"/> 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:
<input type="checkbox"/> Met	<input type="checkbox"/> 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.
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>Is there evidence of active discharge planning with any concurrent requests?</p> <p>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	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:
<input type="checkbox"/> Met	<input type="checkbox"/> 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.

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			Please note here:
<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	Length of stay in current service. Note here: he has been in the PRTF for 30 days following more than 30 days in the PRTF divergent program.
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	For concurrent request, ask for the following information: <ul style="list-style-type: none"> ➤ # of therapeutic leave days utilized ➤ # individual and/or family therapy sessions during previous auth. period ➤ Previously requested documentation from prior authorizations Please note here:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	Evidence of use/intended use of Evidence Based Practices. List EBP here:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	If DSS/DJJ/Legal involvement, a tag has been created in AlphaMCS. Note status of involvement here:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> 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)"
<input type="checkbox"/> Met Create tag in Alpha	<input type="checkbox"/> Not Met	<input type="checkbox"/> 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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			<ul style="list-style-type: none"> ○ Behaviors must be current (within the last 30 days) and require intervention (medical intervention, physical intervention, crisis services, or inpatient treatment) <p>-OR-</p> <ul style="list-style-type: none"> b. Has the child been expelled or is at risk of expulsion from school due to disruptive or dangerous behaviors <ul style="list-style-type: none"> ○ Child is unable to participate in any structured educational setting based on current behaviors <p>-OR-</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> ○ 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.
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A	<p>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:</p>

Psychiatric Residential Treatment Facilities

Clinical Coverage Policy 8D-1

State MH/SA/DD Service Definitions

Service Code 0911

Entrance Criteria

Medicaid shall cover admission to Psychiatric Residential Treatment Facilities when the Member meets **all** of the following criteria:

<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>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.</p> <p>As evidenced by:</p>
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Service Review Criteria

<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>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, to be treated outside of a highly structured 24-hour therapeutic environment.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>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.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>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.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>E. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the Member's needs.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>F. The family situation and functioning levels are such that the Member cannot currently remain in the home environment and receive community-based treatment.</p> <p>As evidenced by:</p>

CURRENT AND HISTORY OF SERVICES		
Level of Treatment	PROVIDER	DATES OF SERVICE

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Service Review Criteria

<u>Psychiatric Residential Treatment Facilities</u> <u>Clinical Coverage Policy 8D-1</u> <u>State-Funded MH/SA/DD Service Definitions</u> <u>Service Code 0911</u> <u>Continuation/Utilization Service Review</u>		
All of the following criteria are necessary for continuing treatment at this level of care:		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	A. The Member’s condition continues to meet admission criteria at this level of care. As evidenced by:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	B. The Member’s treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate. As evidenced by:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	C. Treatment planning is individualized and appropriate to the Member’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:
<input type="checkbox"/> Met	<input type="checkbox"/> 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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<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>E. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>F. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes. measures</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>G. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>H. Member 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 Member's engagement in treatment.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>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.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>J. When medically necessary, appropriate psychopharmacological intervention has been prescribed or evaluated.</p> <p>As evidenced by:</p>
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>K. There is documented active discharge planning from the beginning of treatment.</p> <p>As evidenced by:</p>

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<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>L. There is documented active attempt at coordination of care with relevant outpatient providers when appropriate.</p> <p>As evidenced by:</p>
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<u>Psychiatric Residential Treatment Facilities</u> <u>Clinical Coverage Policy 8D-1</u> <u>State MH/SA/DD Service Definitions</u> <u>Service Code 0911</u> <u>Discharge Criteria</u>		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>The Member shall be discharged from this level of care if the following two criteria are both met:</p> <p>As evidenced by:</p>
<p>a. The Member can be safely treated at an alternative level of care.</p> <p>b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.</p>		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>In addition to "a" and "b" above, one or more of the criteria in "c" through "g" must be met:</p> <p>As evidenced by:</p>
<p>c. 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.</p> <p>d. The Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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Service Review Criteria

Clinical Review:

Approved Send to peer review

Reviewer Name, Credentials: Date:

Clinical Justification/Reason for Peer Clinical Review:

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.](#)

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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.