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

Substance Abuse Halfway House State-Funded MH/SA/DD Service Definitions Service Code H2034 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 calendar days 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		Service Plan which includes Halfway House, frequency and provider. If none present, then contact the provider to request and give 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.

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☐ 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 (i.e. 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		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	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	☐ 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	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.

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			Indicate the date you checked the claims module here, if applicable. Also, note services and provider explanation, if applicable:

Substance Abuse Halfway House State-Funded MH/SA/DD Service Definitions Service Code H2034 Eligibility Criteria		
Must meet **ALL** of the following criteria:		
☐ Met	☐ Not Met	A. There is a substance use disorder diagnosis present; **As evidenced by:** AND
☐ Met	☐ Not Met	B. Meets ASAM Level 3.1 criteria. 1. The adult member who is appropriately admitted to Level 3.1 program meets specifications in **each** of the six dimensions. a. **D1/Acute Intoxication and/or Withdrawal Potential**: The member has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a Level 3.1 setting. b. **D2/Biomedical Conditions and Complications:** The member's status in Dimension 2 is characterized by **one** of the following: 1. Biomedical problems, if any, are stable and do not require medical or nurse monitoring, and the member is capable of self-administering any prescribed medications; **or** 2. A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment to recovery efforts. The problem requires medical monitoring, which can be provided by the program or through an established arrangement with another provider. c. **D3/Emotional, Behavioral or Cognitive Conditions and Complications:** The member may not have any significant problems in this dimension. However, if **any** of the Dimension 3 conditions are present, the member must be admitted to a co-occurring capable or co-occurring enhanced program (depending on his or her level of function, stability, and degree of impairment.) [Please see page 228-229 for explanation of "Co-Occurring Capable Programs/Co-Occurring Enhanced Programs"]

Service Review Criteria

		d. **<u>D4/Readiness to Change:</u>** The member's status in Dimension 4 is characterized by at least **one** of the following: 1. The member acknowledges the existence of a psychiatric condition and/or substance use problem. He or she recognizes specific negative consequences and dysfunctional behaviors and their effect on his or her desire to change. He or she is sufficiently ready to change and cooperative enough to respond to treatment in Level 3.1; **OR** 2. The member is assessed as appropriately placed at Level 1 or 2 and is receiving Level 3.1 services concurrently. The member may be at an early stage of readiness to change and thus in need of engagement and motivational strategies; **OR** 3. The member requires a 24-hour structured milieu to promote treatment progress and recovery, because motivating interventions have failed in the past and such interventions are assessed as not likely to succeed in an outpatient setting; **OR** 4. The member's perspective impairs his or her ability to make behavior changes without the support of a structured environment. For example, the member attributes his or her alcohol, other drug, or mental health problem to other persons or external events, rather than to a substance use or mental disorder. Interventions are assessed as not likely to succeed in an outpatient setting. e. **<u>D5/Relapse, Continued Use, or Continued Problem Potential</u>:** The member's status in Dimension 5 is characterized by psychiatric symptoms that pose a moderate risk of relapse to a substance use or mental disorder. Such a member demonstrates limited ability to apply relapse prevention skills, as well as deteriorating psychiatric functioning, which increases his or her risk of serious consequences and requires the types of services and 24-hour structure of a Level 3.1 co-occurring enhanced program in order to maintain an adequate level of functioning. For example, the member demonstrates deteriorating functioning during outpatient treatment or while in a halfway house that does not provide co-occurring enhanced services.

Service Review Criteria

		f. **D6/Recovery Environment:** The member's status in Dimension 6 is characterized by one of (1); **and** one of (2) **or** (3) **or** (4) **or** (5) **or** (6): 1. The member is able to cope, for limited periods of time, outside the 24-hour structure of a Level 3.1 program in order to pursue clinical, vocational, educational, and community activities; **AND** 2. The member has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the member is assessed as being unable to achieve or maintain recovery at a less intensive level of care; **OR** 3. The member lacks social contacts or has high-risk social contacts that jeopardize his or her recovery, or the member's social network is characterized by significant social isolation and withdrawal. The member's social network includes many friends who are regular users of alcohol or other drugs or regular gamblers, leading recovery goals to be assessed as unachievable outside of a 24-hour supportive setting; **OR** 4. The member's social network involves living in an environment that is so highly invested in alcohol or other drug use that the member's recovery goals are assessed as unachievable; **OR** 5. Continued exposure to the member's school, work, or living environment makes recovery unlikely, and the member has insufficient resources and skills to maintain an adequate level of functioning outside of a 24-hour supportive environment; **OR** 6. The member is in danger of victimization by another and thus requires 24-hour supervision. **As evidenced by:**

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Service Review Criteria

Continued Service Criteria		
☐ Met	☐ Not Met	The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP/Service Plan or the individual continues to be at risk for relapse based on history, or the tenuous nature of the functional gains or **any one** of the following applies: **As evidenced by:**

a. Individual has achieved initial PCP/Service Plan goals and additional goals are indicated.
b. Individual is making satisfactory progress toward meeting goals.
c. Individual is making some progress, but the PCP/Service Plan (specific interventions) need to be modified so that greater gains which are consistent with the individual's premorbid level of functioning are possible or can be achieved.
d. Individual is not making progress; the PCP/Service Plan must be modified to identify more effective interventions.
e. Individual is regressing; the PCP must be modified to identify more effective interventions.

Substance Abuse Halfway House State-Funded MH/SA/DD Service Definitions Service Code H2034 Discharge Criteria		
The individual meets the criteria for discharge if any **ONE** of the following applies:		
☐ Met	☐ Not Met	Individual's level of functioning has improved with respect to the goals outlined in the PCP/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 applies: **As evidenced by:**

A. Individual has achieved positive live outcomes that support stable and ongoing recovery.
B. Individual is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
C. Individual or family no longer wishes to receive Halfway House services.

Clinical Review:
☐Approved ☐ Send to peer review

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Service Review Criteria

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.