

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>Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)</u>		
<u>Clinical Coverage Policy 8A</u>		
<u>State-Funded MH/SA/DD Service Definitions</u>		
<u>Service Code H2035</u>		
<u>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 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	The PCP is present, which includes SACOT, 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PCP/Treatment Plan contains the appropriate signatures: For Initial review, Annual review, or when a service is added/withdrawn from the plan: 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> For PCP/Treatment Plan reviews resulting in no changes to the plan: <ul style="list-style-type: none"> ➤ 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.

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<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	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:		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	If Medicaid member and under 21, review for EPSDT. 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. <ul style="list-style-type: none"> ➤ <i>Recommended LOCUS/CALOCUS Level 3-5</i> ➤ <i>Recommended ASAM Level 1-2.5</i> If necessary, review and/or request LOCUS/CALOCUS/ASAM worksheet; If not present, can NOT administratively deny.
<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 (i.e. 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	Is there evidence of active discharge planning with any concurrent requests? Consider reviewing for the following elements: <ul style="list-style-type: none"> ➤ 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.
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A
<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. Please note here:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> N/A
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	Length of stay in current service. Note here:

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<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 individual counseling sessions conducted during previous auth ➤ # of family counseling sessions conducted during previous auth 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	<input type="checkbox"/> Not Met	<input type="checkbox"/> 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>Substance Abuse Comprehensive Outpatient Treatment (SACOT)</u> <u>Clinical Coverage Policy 8A</u> <u>State-Funded MH/SA/DD Service Definitions</u> <u>Service Code H2035</u> <u>Entrance Criteria</u>		
The member is eligible for this service when all of the following criteria are met:		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	A. There is a substance use disorder diagnosis present; As evidenced by:
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	B. The member meets ASAM Level 2.5 criteria. 1. <i>Direct admission</i> to a Level 2.5 program is advisable for the member who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) and in Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist), as well as in at least one of Dimensions 4, 5, or 6.

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		<p>2. <i>Transfer</i> to a Level 2.5 program is advisable for the member who</p> <ol style="list-style-type: none">has met essential treatment objectives at a more intensive level of care ANDrequires the intensity of services provided at Level 2.5 in a least one dimension. (A member also may be transferred to Level 2.5 from a Level 1 or Level 2.1 program when the services provided at the less intensive level of have proved insufficient to address the member s needs, or when those services have consisted of motivational interventions to prepare the member for participation in a more intensive level of service, for which he or she now meets the admission criteria. <p>3. <u>D1/Acute Intoxication and/or Withdrawal Potential:</u> The member has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a Level 2.5 setting. See separate withdrawal management chapter for how to approach “unbundled” withdrawal management for adults.</p> <p>4. <u>D2/Biomedical Conditions and Complications:</u> In Dimension 2, the member’s biomedical conditions and problems, if any, are not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts. Examples include unstable hypertension or asthma requiring medication adjustment or chronic back pain that distracts from recovery efforts. Such problems require medical monitoring and/or medical management, which can be provided by a Level 2.5 program either directly or through an arrangement with another treatment provider.</p> <p>5. <u>D3/Emotional, Behavioral or Cognitive Conditions and Complications:</u> Problems in Dimension 3 are not necessary for admission to a Level 2.5 program. However, if any of the Dimension 3 conditions are present, the member must be admitted to either a co-occurring capable or co-occurring enhanced program, depending on the member’s level of function, stability, and degree of impairment in this dimension. The severity of the member’s problems in Dimension 3 may require partial hospitalization or a similar supportive living environment in conjunction with a Level 3.1 program. On the other hand, if the member receives adequate support from his or her family or significant other(s), a Level 2.5 program may suffice. [Please see page 213-214 for explanation of</p>
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		<p>“Co-Occurring Capable Programs/Co-Occurring Enhanced Programs”]</p> <p>6. D4/Readiness to Change: The member’s status in Dimension 4 is characterized by at (a) or (b):</p> <ul style="list-style-type: none">a. The member requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program; ORb. The member’s perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. (For example, the member has unrealistic expectations that his or her alcohol, other drug, or mental health problem will resolve quickly, with little or no effort, or the member experiences frequent impulses to harm himself or herself. He or she is willing to reach out but lacks ability to ask for help.) Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the member’s willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest that treatment at Level 2.5 can be effective. <p>7. D5/Relapse, Continued Use, or Continued Problem Potential: The member’s status in Dimension 5 is characterized by at (a) or (b):</p> <ul style="list-style-type: none">a. Although the member has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms of the substance-related disorder (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his or her level of functioning is deteriorating despite modification of the treatment plan; ORb. There is high likelihood that the member will continue to use or relapse to use of substances or gambling without close outpatient monitoring and structured therapeutic services, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping or postponing immediate gratification, or ambivalence toward treatment. The
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		<p>member has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is adjudged insufficient to stabilize the member's condition so that direct admission to Level 2.5 is indicated.</p> <p>8. D6/Recovery Environment: The member's status in Dimension 6 is characterized by (a) or (b):</p> <ul style="list-style-type: none"> a. Continued exposure to the member's current school, work, or living environment will render recovery unlikely. The member lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.5 program; OR b. Family members and/or significant other(s) who live with the member are not supportive of his or her recovery goals, or are passively opposed to his or her treatment. The member requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is no active opposition to, or sabotaging of, his or her recovery efforts. <p>As evidenced by:</p>
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Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)
Clinical Coverage Policy 8A
State-Funded MH/SA/DD Service Definitions
Service Code H2035
Continued Service Criteria

<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<p>The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's PCP or the member 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:</p> <p>As evidenced by:</p>
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- A. Member has achieved PCP goals and continued services are needed in order to meet additional goals;
- B. Member is making satisfactory progress toward meeting goals;
- C. Member is making some progress, but the PCP (specific interventions) need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible or can be achieved;

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- D. Member is not making progress; the PCP must be modified to identify more effective interventions; or
- E. Member is regressing; the PCP must be modified to identify more effective interventions.

Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)
 Clinical Coverage Policy 8A
 State-Funded MH/SA/DD Service Definitions
 Service Code H2035
 Discharge Criteria

The member meets the criteria for discharge if **any one** of the following applies:

<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	Member's level of functioning has improved with respect to the goals outlined in the PCP, 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: As evidenced by:
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- A. Member has achieved positive life outcomes that support stable and ongoing recovery.
- B. Member is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; or
- C. Member or family no longer wishes to receive SACOT services.

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:

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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.](#)