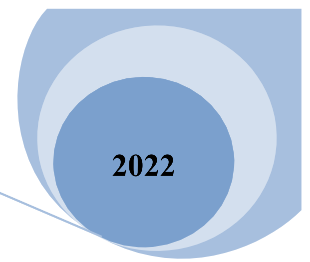

County of San Diego Mental Health Plan

Utilization Management Request (UM)

Short-Term Residential Therapeutic Programs

REQUEST COMPLETED BY:

- Licensed/Waivered Psychologist
- Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
- Licensed/Registered Professional Clinical Counselor
- Physician (MD or DO)
- Nurse Practitioner

APPROVAL COMPLETED BY:

- Program Manager or Designated Program UM Committee – UM Committee must consist of at least 1 licensed member and may not include the requesting clinician
- If the STRTP does not have a licensed member other than the requesting clinician to serve as UM Committee, the BHS COR or designee shall review and approve the UM

COMPLIANCE REQUIREMENTS:

- Clinicians are expected to clearly explain the short-term treatment model and UM process for additional services based on need to client/families upon intake.
- Prior to expiration of the current UM Cycle, programs are expected to complete a UM Request to receive approval for providing additional services to clients.
- UM Request Form must have all required elements (listed below) completed within the form.
- In addition to completing the UM form, the following tasks are required prior to submitting the request:
    - Updated CANS is entered in CYF mHOMS
    - Updated PSC and Y-PSC (when applicable) are entered in CYF mHOMS
    - Client Plan and/ or Problem List must be reviewed and updated as clinically indicated

DOCUMENTATION STANDARDS REQUIREMENTS:

A. **Admission Date**: Identify admission date, diagnosis, current services, description of symptoms, and Qualified Individual Assessment status.

B. **Psychiatric Hospitalizations:** Provide information pertaining to recent hospitalizations; including mostrecent date(s) and other services client is receiving when applicable.

C. **Child and Adolescent Needs and Strengths:** Provide completion date of CANS for current UM request. information from CYF-mHOMS CANS Assessment Summary to identify the number of needs rated at a '2' (Help is Needed) and '3' (High Need). List the Strengths from the assessment summarythat could be leveraged to meet treatment goals and reduce symptomology.

D. **Pediatric Symptom Checklist:** Provide completion date of PSC and PSC-Y (when applicable) for current UM request. Utilize information from the CYF mHOMS PSC Assessment Summary to identify the subscale scores and total scale score for both the Parent PSC and Youth PSC. If the Parent PSC or Youth PSC was not completed for the current UM request, indicate on form.

E. **Client Plan and/or Problem List:** Review the client plan and/or Problem List and update as needed in CCBH prior to initiating the UM request.

F. **Eligibility Criteria:** Outline how Medical Necessity is met and describe how services will be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR 438.210).

G. **Interagency Placement Committee (IPC) Considerations :** Indicate if Child Welfare Services or Juvenile Probation IPC has determined that the youth meets criteria for placement in a STRTP per All County Letter No. 17-122. If answered "no" provide explanation.

H. **Clinical Review Report:** Required by the Interim STRTP Regulations Version 2; Section 14 titled "Clinical Reviews, Collaboration, and Transition Determination"

1. Describe the type and frequency of services provided during the previous 90-day authorization period
2. Describe the impact of services toward the achievement of Client Plan Goals and include goals of transitioning to lower level of care
3. Provide the date of the most recent mental health program staff meeting, which must include Head of Service, or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed (must occur at least every 90 days and be completed prior to submittal of the STRTP UM Request)
4. Provide the date of the most recent CFT meeting (must occur at least every 90 days and be completed prior to submittal of the STRTP UM Request)
   - Indicate if the CFT/treatment team agrees that the STRTP continues to meet the specific therapeutic needs of the youth (answer yes, no or other - if other explain)
   - Indicate if the "CFT Meeting Summary and Action Plan" form is available based on UM reviewer request (answer yes or no). "CFT Meeting Summary and Action Plan" only required to be submitted if requested by the UM reviewer
5. Provide a Clinical Review Recommendation for either: Continued Treatment in the STRTP, Transition from the STRTP, or Other
   - If Transition is selected, describe the recommendation for transition
   - If Other is selected, describe the treatment recommendation

❖ Recommendation for transition or continued treatment must be supported in the client record and CFT documentation

I. **Proposed Treatment Modalities:** Select the proposed treatment modalities to mitigate current riskfactors.

J. **Requested Number of Days**: Input number of requested days (up to 90).

K. **Requestor Name and Credential:** Type in requestor's name and date.

L. **UM Determination/Approval:** Program UM Committee selects the approval status, indicates time approved, UM Committee Member's names and date reviewed.

NOTES:

- All retroactive approvals must be documented by the UM Committee in Section K in the comments section under UM Determination/ Approval.
- UM is a non-billable activity. Therefore, there is no billing for preparation of theUM form or for the UM review time spent on the case. UM is an administrative function.
- UM request that is denied or authorized for a reduced/modified amount, duration, or scope other than requested will require issuing a Notice of Adverse Benefit Determination (NOABD) to beneficiary/family/clinician within stipulated timelines.