

UTILIZATION MANAGEMENT (UM) REQUEST
CYF – Short-Term Residential Therapeutic Programs (STRTP) Outpatient
 (STRTP Offering Day Services Complete Prior Authorization Day Services Request Form)

UM Reviews occur within the program level Utilization Management Committee at 90-day interval

A. ADMISSION DATE:

DIAGNOSIS

- Experience of Trauma
- History of Trauma Per Screener
- CWS Involved
- Justice Involved
- Homeless

CURRENT SERVICES:

- Therapy CM/ICC Rehab/IHBS Meds

DESCRIPTION OF SYMPTOMS:

QUALIFIED INDIVIDUAL (QI) ASSESSMENT

- QI assessment completed and STRTP level of care was recommended, **OR**
- QI assessment completed and Home-Based level of care was recommended; however, assessment by STRTP indicates STRTP level of care
- Other:

B. Psychiatric Hospitalizations: YES NO

Provide most recent dates of hospitalization and relevant history when applicable:

Other Behavioral Health Services Client is Receiving *when applicable:*

C. Child and Adolescent Needs and Strengths (CANS)

Date of most current CANS *(Required at UM Cycle):*

Number of CANS ‘High Need’ (items rated a ‘3’) *(from current Assessment Summary):*

Number of CANS ‘Help is Needed’ (items rated a ‘2’) *(from current Assessment Summary):*

List the CANS ‘Strengths to Leverage’ items *(from current Assessment Summary):*

CANS Assessment Summary is available for UM reviewer

D. Pediatric Symptom Checklist (PSC): *(Required at UM Cycle)*

Date of most current Parent PSC:

- Parent did not complete

Date of most current Youth PSC:

- Not applicable, child is 10 years old or younger
- Youth did not complete

	<u>Parent PSC Score</u>	<u>Youth PSC Score</u>	<u>Clinical Cutoff Score</u>
Attention Problems Subscale (0-10)			At-Risk if score is 7 or higher
Internalizing Problems Subscale (0-10)			At-Risk if score is 5 or higher
Externalizing Problems Subscale (0-14)			At-Risk if score is 7 or higher
*Total Scale Score			

***Parent:** *Total score of 28 or higher for ages 6-18 or scale score of 24 or higher for ages 3-5 indicates impairment*

***Youth:** *Score of 30 or higher for ages 11-18 indicates impairment*

PSC Assessment Summary is available for UM reviewer

E. Client Plan and Problem List reviewed and updated as needed prior to UM request *(reviewed by Program UM Committee)*

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F. ELIGIBILITY CRITERIA:

Child meets Medical Necessity ([BHIN No. 21-073](#) or any superseding BHIN) in the following manner:

Specify 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

Per [All County Letter No. 17-122](#) Child Welfare Services or Juvenile Probation IPC has determined that the youth meets criteria for placement in a STRTP

Yes No - Explanation

H. CLINICAL REVIEW REPORT (Fulfills [STRTP Interim Regulations Version 2](#) Requirement):

1. Describe the type and frequency of services provided by the STRTP during previous 90-day review period:

2. Describe the impact of these services toward the achievement of Client Plan Goals (Include progress toward goals of transitioning to a lower level of care)

3. Date of most recent mental health program staff meeting, which must include Head of Service or Licensed Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed (must occur at least every 90 days and prior to submittal of STRTP UM Request):

4. Date of most recent CFT meeting where Clinical Review Recommendation was discussed (must occur at least every 90 days and prior to submittal of STRTP UM Request):

The CFT/Treatment Team determined that the STRTP continues to meet the specific therapeutic needs of the youth:

Yes No Other

The CFT Meeting Summary and Action Plan is available based on UM reviewer request: Yes No

5. Clinical Review Recommendation:

Continued Treatment in STRTP; rationale for continued treatment:

Transition from the STRTP, include transition recommendation:

Other:

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

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I. Proposed Treatment Modalities:

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Group Therapy | <input type="checkbox"/> Case Management/ICC | <input type="checkbox"/> Rehab/IHBS |
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Collateral Services | <input type="checkbox"/> Medication Services | <input type="checkbox"/> Other |

J. REQUESTED NUMBER OF DAYS:

Up to 90 days per UM cycle

K. Requestor's Name, Credential:

Date:

L. UM DETERMINATION / APPROVAL

- UM Approved Modified UM Request UM Not Approved **Date Approved:**

UM Committee (The UM Committee must consist of at least 1 licensed member and may not include the requesting clinician. UM shall be reviewed by the BHS COR or designee if qualified UM Committee is not available at the program level):

Member's Name, Credential: _____ Date: _____

Member's Name, Credential: _____ Date: _____

Member's Name, Credential: _____ Date: _____

Member's Name, Credential: _____ Date: _____

Comments when applicable:

Note: 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 Medi-Cal beneficiary/family/clinician within stipulated timelines.