County of San Diego Mental Health Plan
UTILIZATION MANAGEMENT (UM) REQUEST
Children's Mental Health Outpatient Treatment Programs

2019

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/Program UM Committee
- COR level request must first be reviewed and approved at program level UM Committee
- COR or Designee

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 outpatient and case management services to clients.
- COR level UM requests will be submitted as an email attachment through secure email (Transport Layer Security [TLS] or encrypted) removing identifiable information (Client initials only).
- 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 must be reviewed and new client signatures need to be obtained

DOCUMENTATION STANDARDS:
- A. **Program UM Cycle:** Identify if program follows a session based (13 or 18 session model) or modified UM Cycle (time based or extended session model).
- B. **UM Level Request:** Identify if request is Program or COR level request.
- C. **Current Services:** Identify current services, admission date, diagnosis, Pathways status, current symptoms and if youth/family is requesting additional services.
- D. **Psychiatric Hospitalizations:** Provide information pertaining to recent hospitalizations; including most recent date(s) and other services client is receiving when applicable.
- E. **Child and Adolescent Needs and Strengths:** Provide completion date of CANS for current UM request. Utilize 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 summary that could be leveraged to meet treatment goals and reduce symptomology.
- F. **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.
- G. **Updated Client Plan:** Must update the client plan in CCBH prior to initiating the UM request. The updated client plan must be reviewed by Program UM Committee and presented to the youth/family for input and signatures.

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H. **Rationale for Additional Services:** Describe the symptomology that aligns with medical necessity for additional services. The rationale should support the eligibility criteria identified in Section I or J.

I. **Primary Eligibility Criteria:** First three items (Medical necessity, CANS and SED criteria) must be completed. An additional risk factor must be identified for 1) having the potential to occur due to a mental disorder **or** 2) has been displayed in past month by the client.

J. **Secondary Eligibility Criteria (COR level approval):** COR level request must have primary eligibility fulfilled and one current risk factor related to the youth's primary diagnosis to support the request for additional services.

K. **Proposed Treatment Modalities:** Select the proposed treatment modalities to mitigate current risk factors.

L. **Expected Outcome and Prognosis:** Select the projected functioning level from providing the additional services.

M. **Requested Number of Sessions or Months:** Identify the amount of sessions or time needed to achieve expected outcome.

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

O. **UM Determination/Approval:** Program UM Committee selects the approval status, indicates amount of sessions/time approved, approver's name and date **or** COR Level; program will fill in approval status based on COR determination, amount of sessions/time approved, COR Name and date approved**.**

NOTES:

o All retroactive approvals must be established through the COR. This is applicable for both program and COR level retroactive UM requests. In other words, the program must contact the COR for all retroactive UM requests.

o Utilization Management is a non-billable activity. Therefore, there is no billing for preparation of the UM form or for the UM review time spent on the case. UM is an administrative function.