# UTILIZATION MANAGEMENT (UM) REQUEST
## Children and Youth - OUTPATIENT TREATMENT

**UM Reviews occur within the program level Utilization Management Committee at a 6-month 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

**Youth/family requesting additional services?**

☐ YES ☐ NO ☐ Other

Comments as applicable: _____

**DESCRIPTION OF SYMPTOMS:** _____

**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'):** _____

**Number of CANS 'Help is Needed' (items rated a '2'):** _____

**List the CANS 'Strengths to Leverage' items:** _____

*CANS is available for UM reviewer*

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

**Date of most current Parent PSC:** _____

☐ Parent did not complete

| | Parent PSC Score | Clinical Cutoff Score |
|---|---|---|
| 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*

*PSC is available for UM reviewer*

**E.** ☐ **Updated Care Plan and/ or Problem List completed prior to UM request** (reviewed by Program UM Committee)

**F. ELIGIBILITY CRITERIA:**

**Child meets Medical Necessity (BHIN No. 21-073) 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. Proposed Treatment Modalities:**

- ☐ Family Therapy
- ☐ Individual Therapy
- ☐ Case Management/ICC
- ☐ Medication Services
- ☐ Group Therapy
- ☐ Collateral Services
- ☐ Rehab/IHBS
- ☐ Other

**H. Expected Outcome and Prognosis:**

- ☐ Return to full functioning
- ☐ Expect improvement but less than full functioning
- ☐ Relieve acute symptoms, return to baseline functioning
- ☐ Maintain current status/prevent deterioration

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**I. REQUESTED NUMBER OF MONTHS:** _____
Up to 6 months per UM cycle

**J. Requestor's Name, Credential**: _____ Date: _____

**K. UM DETERMINATION / APPROVAL**

☐ UM Approved ☐ Modified UM Request ☐ UM Not Approved **Time Approved**: _____

**UM Committee Members (UM Committee must consist of at least 1 licensed member and may not include the requesting clinician):**

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 member/family/clinician within stipulated timelines.