UM Child Checklist

Member: _____ Date Checklist Initially Completed: _____

Assessments/Attachments

Done	Not Done	N/A	
☐	☐	☐	For IPRS services, the member is eligible based on benefit plan, sliding scale criteria, and the service is available in the catchment the member resides; requires service plan or PCP, CCA (completed Annually at a minimum)
☐	☐	☐	CALOCUS/LOCUS completed and supports level of care or explanation listed
☐	☐	☐	ASAM Completed (to include narrative supporting level of care)
☐	☐	☐	Psychological/Neuropsych (Required for TBI/MR services/PRTF)
☐	☐	☐	Comprehensive Clinical Assessment (must be within last 30 days for Level III + Level IV, also required for IIHS)
☐	☐	☐	IEP/504 plan or other school documents (Required for Day Treatment – documentation needs to support that the school has attempted to implement interventions that have been unsuccessful)
☐	☐	☐	Court Order (when plan states service is court ordered)
☐	☐	☐	CON (Required for PRTF)
☐	☐	☐	ICPC Form (Required for Out of State Treatment)
☐	☐	☐	Informed Consent Form (Required for Out of State Treatment)
☐	☐	☐	Denials from all In-state facilities (Required for Out of State treatment unless PRTF provides specialty program that does not exist with current contracted providers)
☐	☐	☐	Documentation for coverage of Medical expenses, Transportation expenses and school payment (for out of state treatment)
☐	☐	☐	Tracking sheet of denials from all in-network providers, or explanation as to why they were not considered (for client specific contract requests)
☐	☐	☐	TICCA (TF-CBT recommended treatment)

Clinical Justification for Initial Services

Done	Not Done	N/A	
☐	☐	☐	Diagnosis completed and accurate, if any, deferred diagnosis explanation for this
☐	☐	☐	Clear clinical justification for services and frequency being requested
☐	☐	☐	Explanation as to why lower levels of care are not clinically appropriate— including previous services tried, when these were tried and outcomes
☐	☐	☐	Documentation of prior hospitalizations (Dates and Reasons)
☐	☐	☐	Documentation of current behaviors and symptoms and frequency of these
☐	☐	☐	For any member with a sexual abuse history, or current sexualized behaviors, please describe this in detail (when did it occur, was DSS involved, any charges, who was the perpetrator, etc.)
☐	☐	☐	Current medication, frequency, dosage and compliance
☐	☐	☐	Natural supports identified and included in PCP planning or reasons for not including documented

☐	☐	☐	Areas of need in school addressed (suspensions, expulsions, EC services)
☐	☐	☐	Strengths of the member and family
☐	☐	☐	Goals support the need for the requested service (even for initial plans, there must be at least one goal with a clinical focus)
☐	☐	☐	Measurable, realistic, step-down, transition plan included
☐	☐	☐	Service frequency listed is consistent throughout the PCP and associated TAR
☐	☐	☐	DSS, Court, Probation/Parole requirements are addressed in plan
☐	☐	☐	EPSDT justification included when requesting services outside standard guidelines (Medicaid Only)

Signature Requirements

Done	Not Done	N/A	
☐	☐	☐	Signature page completed: ☐ Legally Responsible Person ☐ QP/LP ☐ Minor signature for SUD Services ☐ Member/Guardian ☐ Service Order
☐	☐	☐	Dates for all signatures (license number on service order when applicable)

Health and Safety

Done	Not Done	N/A	
☐	☐	☐	Services in the PCP reflect assessed risk factors
☐	☐	☐	Comprehensive Crisis Plan completed
☐	☐	☐	Relapse Prevention Plan
☐	☐	☐	Inclusion Natural/Community Supports
☐	☐	☐	Restrictive Intervention Plan, if applicable
☐	☐	☐	Explanation of clinical need for Residential Treatment (why are in home services not realistic)

If a change to a service, including a frequency change, a new service is added, or goals are changed/modified this should be done using a PCP update form. All active goals should be copied over to the PCP update form. The where am I now section should provide the clinical details to support why the change is being made. If there is only a change in frequency or modified goals, this requires only the member/guardian and QP signature. If a new service is added, this requires a new service order.

For Reauthorization Requests

Done	Not Done	N/A	
☐	☐	☐	Documentation of progress or lack of progress towards goals
☐	☐	☐	If lack of progress, documentation of changes to strategies and interventions
☐	☐	☐	Clear description of behaviors, including frequency and intensity
☐	☐	☐	Individualized, measurable, realistic, discharge plan – based on progress that would indicate readiness to transition to a less restrictive service
☐	☐	☐	During the last authorization period, were there any restrictive interventions? If so, list dates, what occurred and length of the intervention.

☐	☐	☐	Evidence of coordination with primary care physician, including any medical conditions, and if seeing any specialty providers who these are
☐	☐	☐	For residential services, list dates of all therapy services and credentials of clinician providing. (As a reminder for Level III and PRTF facilities this is a part of the service requirements and should occur within the facility at the minimum frequency required or explanation as to why this did not occur)
☐	☐	☐	For members in residential – dates of home/day visits and summary of how these went
☐	☐	☐	For Residential Level III, prior to any requests that would exceed 180 days a psychiatric or psychological assessment clinical supporting continuation and why less restrictive services would not be appropriate is required
☐	☐	☐	For Residential Level II, prior to any requests that would exceed 270 days where transition to Level I is not occurring, a comprehensive clinical assessment with clinical justification as to why needs cannot be met with Level I or less restrictive services and a plan update outlining changes being made to strategies and interventions to increase effectiveness
☐	☐	☐	For IIHS, if requesting beyond the 6 month authorization of 56 units, clear justification for this as service is intended to be titrated and provided on a short term basis
☐	☐	☐	Date of last medication management visit, and who prescribes (NP, psychiatrist, primary care, etc.)
☐	☐	☐	Documentation of coordination with school, DSS, DJJ, natural support or anyone else involved in the child's treatment
☐	☐	☐	Evidence of coordination with primary care physician, including any medical conditions, and if seeing any specialty providers who these are
☐	☐	☐	If there were any crisis episodes during the last authorization period, please describe and include reference to behaviors plans, safety plans, etc.
☐	☐	☐	Documentation of any changes in diagnosis, such as clarification of rule out or deferred diagnoses and any changes in medications.

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Additional References

- A comprehensive list of (b)(3) services can be found here. Accompanying service definitions can be found in Cardinal Innovations' resource library by searching (b)(3)
- Behavioral Health Clinical Coverage Policies Here
- State funded Clinical Coverage Policies Here
- For more information related to Unable to Process requests and why a Treatment Authorization Request may be marked as Unable to Process, please refer to the Unable to Process Training.
- For information related to Person Centered Plan development:
    - Common PCP Errors
    - PCP Development Hierarchy
    - PCP Service & Frequency Tool