

UM (b)(3) Checklist

Note: This checklist is to be used as a supplement to Cardinal Innovations' Authorization Guidelines

Member: _____ Date Checklist _____
Initially Completed: _____

Assessments/Attachments

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CALOCUS/LOCUS – supports level of care or explanation listed (if MH diagnosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ASAM completed (if applicable/for SUD requests) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Comprehensive Clinical Assessment (required for Mental Health (MH) services, should be within last 30 days or have an addendum completed within that time) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychological/Neuropsychological (Required for IDD/TBI Services). Psychological must include cognitive and adaptive testing with scores (for additional information, please reference the Clinical Practice Guidelines for Psychological Testing) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Unified plan (if member is receiving more than one service) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recovery Assessment Scale ((b)(3)Peer Support Services) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Transition Plan (Individual Support Services) |

Clinical Justification for Initial Services

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diagnosis completed and accurate, if any, deferred diagnosis explanation for this |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clear clinical justification for services and frequency being requested |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Natural supports identified and included in PCP planning or reasons for not including documented |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DSS, Court, Probation/Parole requirements are addressed in plan (if applicable) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of current behaviors and symptoms and frequency of these |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current medication, frequency, dosage and compliance details |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Service frequency listed is consistent throughout the PCP and associated TAR |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strengths of the member and family |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Goals support the need for the requested service (even for initial plans, there must be at least one goal with a clinical focus) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Measurable, realistic, step-down, transition plan included |

Signature Requirements

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signature page completed: |
| | | | <input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> QP/LP <input type="checkbox"/> Minor signature for SUD Services |
| | | | <input type="checkbox"/> Member/Guardian <input type="checkbox"/> Service Order |
| | | | <u>Note:</u> Signature dates cannot be prior to the completed on date of the plan.
Please refer to Unable to Process Training and Common PCP Errors documents |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dates for all signatures (license number on service order when applicable) |

Health and Safety

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Services in the PCP reflect assessed risk factors |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Comprehensive Crisis Plan (3 pages) completed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Information related to a relapse prevention plan for SUD services |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inclusion Natural/Community Supports |

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, accompanying a PCP update. If a new service is added, this requires a new service order.

For Reauthorization Requests

This information should be submitted within the body of the TAR or included with supporting clinical documentation

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of progress or lack of progress towards goals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If lack of progress, documentation of changes to strategies and interventions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clear description of behaviors, including frequency and intensity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Individualized, measurable, realistic, discharge plan –
based on progress that would indicate readiness to transition to a less restrictive service |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of last medication management visit, and who prescribes (NP, psychiatrist, primary care, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of coordination with school, DSS, DJJ,
natural support or anyone else involved in the child's treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Evidence of coordination with primary care physician, including any
medical conditions, and if seeing any specialty providers who these are |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If there were any crisis episodes during the last authorization period,
please describe and include reference to behaviors plans, safety plans, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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)
- 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:
 - o [Common PCP Errors](#)
 - o [PCP Development Hierarchy](#)
 - o [PCP Service & Frequency Tool](#)
- For information related to Psychological testing, please refer to the [Clinical Practice Guidelines for Psychological Testing](#)