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| UTILIZATION MANAGEMENT (UM) REQUEST AND AUTHORIZATION **CYF - Outpatient Treatment** | | | |
| Client Name: | Client #: | | Program: |
| **ADMISSION DATE:**  **CURRENT SERVICES & FREQUENCY:**  MHS MHS-R CM Meds     sessions per month  **Does youth/family request additional services?**  YES NO Explain: | **DIAGNOSIS:**  **ICD-10 CODE(S):**    **DESCRIPTION:** | | |
| **Psychiatric Hospitalizations:** YES  NO(*Provide relevant history)*:  **Other Services Client Receiving:**  **See CFARS dated:**       **at** **Admission**  **or** **UM Cycle** **CURRENT CFARS Reviewed:** YES NO | | | |
| **RATIONALE FOR ADDITIONAL SERVICES:**  **COR approved UM Exception. For**       **session cycle OR**       **months cycle** *(written exception on file).*  **New Client Plan was completed prior to UM request and reviewed by UM Committee** *(client/family input/signatures may be pending UM Approval)* | | | |
| **ELIGIBILITY CRITERIA:** UM POST INITIAL 13 SESSIONS  **Client continues to meet Medical Necessity and demonstrates benefit from services**   * Consistent participation: YES NO * CFARS – Impairment Rating guideline of 5: YES NO * Client meets criteria for Pathways to Well-Being Enhanced Services: YES NO   **Client meets the criteria for SED based upon the following:**  As a result of a mental disorder the child has **substantial** and **persistent** impairment in at least two of the following areas:  Self-care and self- regulation  Family relationships  Ability to function in the community  School functioning  **AND One of the following occurs**:  Child at risk for removal from home due to a mental disorder  Child has been removed from home due to a mental disorder  Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.  **OR** **The child displays:**  acute psychotic features,  imminent risk for suicide  imminent risk of violence to others due to a mental disorder    **ELIGIBILITY CRITERIA –** UM POST 26 SESSIONS(*Requires COR approval)*  **Client has met the above criteria as indicated AND Meets a minimum of one continuing current Risk Factor related to child’s primary diagnosis:**  Child has been a danger to self or other in the last two weeks  Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks  Child’s behaviors are so substantial and persistent that current living situation is in jeopardy  Child exhibited bizarre behaviors in the last two weeks  Child has experienced trauma within the last two weeks | | | |
| **Proposed Treatment Modalities: Planned Frequency:**  Family Therapy       per month  Group Therapy       per month  Individual Therapy       per month  Collateral Services       per month  Case Management/Brokerage       per month  Individual Rehab       per month  Group Rehab       per month  Medication Services       per month  **Pathways to Well-Being (Katie A. Subclass Only)**  Intensive Care Coordination       per month  Intensive Home Based Services       per month | | **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 | |
| **REQUESTED NUMBER OF SESSIONS:** | | **REQUESTED NUMBER OF MONTHS:**  (for programs under written COR approval) | |
| **PROGRAM REVIEW: ADDITIONAL UM CYCLE**  Requestor’s Name, Credential & Signature: Date:       **Request:** Approved Reduced Denied Sessions/Time Approved:  Approver’s Name, Credential & Signature: Date:  Comments: | | | |
| **COR REVIEW: UM POST 26 SESSIONS**  **Request:**  Approved Reduced Denied Retroactive Authorization Sessions/Time Approved:  COR Name and Credentials:       Date Approved:  Comments:  (attach written COR approval; NOA-B may be required for Medi-Cal Clients) | | | |