| UTILIZATION MANAGEMENT (UM) REQUEST **Children and Youth - OUTPATIENT TREATMENT** |
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| **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 [ ]  OtherComments 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 [ ]  Group Therapy [ ]  Individual Therapy [ ]  Collateral Services [ ]  Case Management/ICC [ ]  Rehab/IHBS[ ]  Medication Services [ ]  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 |
| **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. |