| UTILIZATION MANAGEMENT (UM) REQUEST **CYF - 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  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’)** (*from current Assessment Summary)***:**  **Number of CANS ‘Help is Needed’ (items rated a ‘2’)** (*from current Assessment Summary)***:**  **List the CANS ‘Strengths to Leverage’ items** (*from current Assessment Summary)***:**  *CANS Assessment Summary is available for UM reviewer* | | | | | |
| **D.** **Pediatric Symptom Checklist (PSC):** (*Required at UM Cycle)* | | | | | |
| **Date of most current Parent PSC:**  Parent did not complete | | | **Date of most current Youth PSC:**  Not applicable, child is 10 years old or younger  Youth did not complete | | |
|  | **Parent PSC Score** | | | **Youth 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*  **\*Youth:** *Score of 30 or higher for ages 11-18 indicates impairment* | | | | | |
| *PSC Assessment Summary is available for UM reviewer* | | | | | |
| **E.**  **Updated Client 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 (The 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 beneficiary/family/clinician within stipulated timelines. | | | | | |