UTILIZATION MANAGEMENT (UM) REQUEST
CYF - Outpatient Treatment

FOR COR SUBMISSION THE CLIENT NAME AND NUMBER MUST BE REDACTED (utilize initials vs. full client name)

A. Program UM Cycle:

☐ Program follows a **STANDARD session based UM Cycle** (13 or 18 initial treatment session, followed by Program UM for up to an additional 13 or 18 treatment session, and requiring COR UM review and approval for any additional treatment sessions).

☐ Program follows a **MODIFIED UM Cycle** (time based or extended sessions) approved by COR *(written exception on file)*.
The UM time based cycle is months.
The UM is a session cycle.

B. UM Level Request:

☐ This is a Program Level UM request
☐ This is a COR Level UM request - number of treatment sessions received to date:
☐ Initial COR Level UM request
☐ Prior COR Level UM requests – attach prior correspondence and approval

C. CURRENT SERVICES:

☐ Therapy ☐ CM/ICC ☐ Rehab/IHBS ☐ Meds

Youth/family requesting additional services?

☐ YES ☐ NO ☐ Other

Explain:

ADMISSION DATE:

DIAGNOSIS:

☐ Pathway Enhanced (Subclass)

DESCRIPTION OF SYMPTOMS:

D. Psychiatric Hospitalizations: ☐ YES ☐ NO

Provide most recent dates of hospitalization and relevant history when applicable:

Other Behavioral Health Services Client is Receiving *when applicable*:

E. Child and Adolescent Needs and Strengths (CANS)

Date of most current CANS (*Required at UM Cycle)*:

Number of CANS 'High Need' Items (*from current Assessment Summary)*:

Number of CANS 'Help is Needed' Items (*from current Assessment Summary)*:

List the CANS 'Strengths to Leverage' Items (*from current Assessment Summary)*:

☐ *CANS Assessment Summary is available for UM reviewer*

F. Pediatric Symptom Checklist (PSC)

Date of most current Parent PSC (*Required at UM Cycle)*:
Total Scale Score (0-70 scale, with 28 or higher indicating impairment):
☐ Parent did not complete

Date of most current Youth PSC (*Required at UM Cycle)*:
Total Scale Score (0-70 scale, with 30 or higher indicating impairment):
☐ Not applicable, child is 10 years old or younger
☐ Youth did not complete

☐ *PSC Assessment Summary is available for UM reviewer*

G. ☐ **Updated Client Plan completed prior to UM request** (reviewed by Program UM Committee)

H. RATIONALE FOR ADDITIONAL SERVICES:

I. PRIMARY ELIGIBILITY CRITERIA:

☐ Client continues to meet **Medical Necessity** and demonstrates benefit from services

☐ **CANS** indicate at least one actionable need (rated 2 or 3) on the 'Child Behavioral and Emotional Needs', 'Risk Behaviors' OR 'Life Functioning'

☐ Client meets the criteria for **Serious Emotional Disturbance** 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 (within the last month)
- ☐ imminent or recent high risk for suicide (within the last month)
- ☐ imminent or recent high risk of violence to others due to a mental disorder (within the last month)

J. SECONDARY ELIGIBILITY CRITERIA – Required for COR Level Approval:

☐ **Client has met the above criteria as indicated AND meets a minimum of one of the following Current Risk Factor related to child's primary diagnosis:**

- ☐ Child has been a danger to self or other in the last month
- ☐ Child experienced severe physical or sexual abuse or has been exposed to extreme violence in the last month
- ☐ Child's behaviors are so substantial and persistent that current living situation is in jeopardy
- ☐ Child exhibited bizarre behaviors in the last month
- ☐ Child has experienced traumatic event within the last month
- ☐ Current PSC Youth or Parent indicates overall impairment (28 or higher for parent / 30 or higher for youth)
- ☐ Other

K. Proposed Treatment Modalities:

☐ Family Therapy	☐ Group Therapy
☐ Individual Therapy	☐ Collateral Services
☐ Case Management/ICC	☐ Rehab/IHBS
☐ Medication Services	☐ Other

L. 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

M. REQUESTED NUMBER OF SESSIONS:

REQUESTED NUMBER OF MONTHS:
(for programs under written COR approval)

N. Requestor's Name, Credential: Date:

O. UM DETERMINATION / APPROVAL

Program UM Committee (always required)

☐ UM Approved ☐ Modified UM Request ☐ UM Not Approved **Sessions/Time Approved**: **OR**

☐ Supports COR Level UM Request ☐ Does not supports COR Level UM Request ☐ Other:

Approver's Name, Credential: Date:

Comments:

COR Level (when applicable) ☐ Applicable ☐ Not Applicable

☐ UM Approved ☐ Modified UM Request ☐ UM Not Approved ☐ Retro UM Approval

Sessions/Time Approved: Date:

Program transcribes COR determination onto form and attaches COR determination correspondence