Optum

Clinical Appeals, Claims Appeals, Retrospective Reviews and Peer Reviews

May 2024

Agenda / Objectives

1. How to File a Clinical Appeal
2. Retrospective Review
3. How to File an Administrative Appeal
4. Second Level Appeals and Final Appeals
5. Peer Review Information
6. Case Examples

Meet the Optum Alaska Clinical Team

Heather Brady, LPC, Clinical Operations Director

Korey Dunn, LPC, Utilization Management Process Manager

Vanessa Green, LPC/LMHC, Clinical Appeals Care Advocate

Susan Kominik, Clinical Appeals Coordinator

Dr. Mahender Purmandla, Chief Medical Officer

How to File a Clinical Appeal

Initial Clinical Review – Workflow Process prior to Filing an Appeal

- The initial review of an authorization request submitted by a provider on behalf of a participant is completed by an Optum Care Advocate. A Care Advocate may only authorize service requests. When a Care Advocate is not able to authorize benefits based on the information provided via Optum Alaska website/Provider Express or telephonically, the Care Advocate may ask the provider for additional information.

- The timeframes for making the initial determination by Optum Alaska is one hour for an urgent request and 24 hours for a non-urgent request. Upon receipt of the additional information, the Care Advocate will authorize the services requested or suggest an alternative level of care. If the Care Advocate is not able to authorize benefits for services as requested or negotiate an alternative, the Care Advocate will refer the case to the Optum Alaska Medical Director or Physician Reviewer.

- A non-coverage determination of services results when the Optum Medical Director or Physician Reviewer reviews a service request and cannot approve the request because it does not meet the medical necessity criteria established for that level of service. The participant may request a fair hearing with the Department of Behavioral Health (DBH) for non-approved services. The provider may file an appeal with Optum.

How to Request a Clinical Appeal

A provider may request a first level clinical appeal when a request for services was denied due to lack of medical necessity or other clinical reasons. Providers may file first level appeals with Optum.

Examples of clinically reviewed appeals include:

- Appeals of denials of service that are available under the terms of the participant's Behavioral Health Medicaid plan, and that are provided for the diagnosis or treatment of a condition that is covered under the terms of the participant's Behavioral Health Medicaid Services.
- Appeals of denials of service about which there is insufficient information to make a coverage determination.

Filing for a Clinical Appeal

Follow these guidelines in order to file a clinical appeal:

- Include the Provider Appeal form and any supporting documentation considered relevant (i.e., chart notes, medical records, etc.).
- Optum will notify providers in writing of the appeal decision.

To contact the Optum Appeals Department:

call 866.245.3040 or fax 855.508.9353

Mail to: Optum Alaska Attention: Appeals Department
911 W 8th Ave #101
Anchorage, AK 99501

If the reviewer upholds the initial decision, providers have the right to file a second level appeal

Summary of Appeals

- An appeal is a request made for re-review of a determination that resulted in a 1) non-coverage determination of a service request or 2) an original claim was denied or reduced, or if payment was reduced due to a recoupment action.
- Appeal reviews are available for post-service cases; appeal reviews are not available for pre-service or concurrent cases
- Providers/facilities may appeal a non-coverage determination, whether it was based on administrative or clinical considerations. Optum does not process appeals related to Alaska Medicaid provider enrollment
- Optum Alaska provides one level of internal appeal following an initial medical necessity denial of requested services.
- A Second-Level Provider Appeal review is available with the Division of Behavioral Health (DBH)
- Providers have up to 180 days after the date of the remittance advice for the claim to file an Appeal

Retrospective Reviews

Clinical Retrospective Review

- Retrospective (retro) review is a request for a review of services that have already been delivered and a service authorization has not previously been submitted for clinical review.

- Retro reviews may be submitted if a provider was approved by the state to retrospectively cover the time of the service and/or if the participant had Medicaid eligibility retroactively approved to cover dates of service.

- If a provider has received a claims denial for lack of service authorization, the claim will be considered out-of-scope for a retro review and the provider would have to submit an appeal instead.

- Optum must receive retro review requests in writing via fax or mail. Online salesforce submissions for retrospective reviews are out-of-scope for this process.

Clinical Retrospective Review

For a request to be considered a Retrospective Review, there are certain requirements that must be met:

- **No previous approvals** can be issued for the episode of care (treatment type, treating provider, and dates of service) identified in the request.
- Provider receives a Deny due to No Authorization (DNA), and the participant is no longer receiving treatment services.
- The request must be received within **365 days after the last date of service.**
- The request must be received **after the participant has ended treatment episode or has been discharged** from the service.
- If a participant is still receiving services, submit a service authorization form, not a retrospective review request.

Required Documentation for a Retrospective Review

- Complete an Optum Alaska retro-review cover sheet. The cover sheet MUST be completed and submitted with all retro-review requests. The cover sheet is located on the provider website at: Alaska.optum.com. Please see below:

  - Once on the site select the “For Alaska Medicaid Providers” tab at the top in the gray
  - Once the drop down opens you will then click “service authorizations”
  - At the bottom of the page, under “Appeals Form” you will find the Retrospective Cover Sheet

- Please include any supporting documentation considered relevant (e.g., admission/intake assessment, biopsychosocial, treatment plan, medical necessity tool etc.)

- A review of the process as well as all required documents are listed on the Retrospective Review Information and Instruction Sheet located on the provider website at: Alaska.optum.com

Clinical Retrospective Review Cover Sheet

Optum

Optum Alaska
Attn: Retrospective Reviews
911 W. 8th Ave Ste 101
Anchorage, AK 99501
Fax# 1-855-508-9353

Retrospective Review Cover Sheet

Retrospective reviews must be received in writing and can be requested via fax or mail.

Note: Do not submit a Service Authorization form.

***Only use this cover sheet for Retrospective Review Requests**

Participant Name: _____

Participant ID: _____

Participant DOB: _____

Health Plan/Group: STATE OF ALASKA

Provider/Facility Name: _____

Provider/Facility NPI: _____

Dates of Service for retro request **ONLY**: _____
(Do not include future dates)

Procedure Code	U=Units, D=Days, S=Sessions	# Requested

Reason prior authorization was not obtained: _____

_____

_____

Please include: (If documents are not submitted, a review cannot be completed)

☐ Biopsychosocial Assessment (Include any other assessments applicable)

☐ Treatment plan for dates of service requested

☐ Medical necessity tool (i.e.: CALOCUS-CASII, LOCUS, ASAM, ECSII)

Additional documents may be requested as needed

Retrospective Review Cover Sheet

How to Submit a Retrospective Review Request to Optum

There are two options to submit a retrospective review:

You may fax the request to the following number: 855.508.9353 OR

Mail the request to the following address:

Optum Alaska Attention: Retrospective Reviews

911 W 8th Avenue, Suite 101,
Anchorage, AK 99501

Clinical Retrospective Review Determination

Optum will notify providers in writing of the retrospective review decision within 30 days of receipt of the retro-review submission.

If the reviewer upholds the initial decision, providers have the right to file a second level appeal.

Retrospective Review Important Notes

For a request to be considered a Retrospective Review, there are certain requirements that must be met:

- Retrospective Reviews **do not replace** service authorization requests.
- Retro reviews may be submitted if a provider was approved by the state to retrospectively cover the time of the service and/or if the participant had Medicaid eligibility retroactively approved to cover dates of service.
- For a request to be considered a retrospective review, there are certain requirements that must be met:
- The request must be received AFTER the participant has ENDED or has been DISCHARGED from the service (**this is different from Service Authorizations** as the participant is still actively enrolled in services).
- No previous approvals can be issued for the episode of care identified in the request

Retrospective Review Important Notes (Continued)

- Provider receives a DNA, and the participant is no longer receiving treatment services.
- The request must be **received within 365 days** after the last date of service
- Providers submit a retrospective request **using the Retrospective Review Cover Sheet** located at Alaska.optum.com, For Alaska Medicaid Providers, Service Authorizations, under Appeals.
- **No previous approvals or Non-Coverage Determinations (NCD)** can be issued for the episode of care (treatment type, treating provider, and dates of service) identified in the request.
- Do not submit a service authorization form.
- If a participant is still receiving services, submit a service authorization form, not a retrospective review request.

How to file an Administrative Appeal

First Level Administrative Appeal

Administrative Appeal: A request for a review of a non-coverage determination that is based on the benefit coverage or provider manual and that does not require any clinical decision-making.

Administrative Review: A review of plan provisions in order to make a benefit determination which is not based on review of clinical criteria or clinical policy, submitted by Appeal. Examples include:

- Provider fails to obtain pre-authorization when required
- Timely filing requirement are not met
- Provider fee schedule or coding issues

A provider may request a first level appeal if payment of an original claim was denied or reduced, or if payment was reduced due to a recoupment action. Providers may file first level appeals with Optum.

First Level Administrative Appeal

Providers must appeal for individual claim denials resulting from National Correct Coding Initiative (NCCI) edits, including:

- Procedure-to-procedure edits
- Medically unlikely edits
- Units of service edits

For additional information about NCCI regulations, refer to National Correct Coding Initiative (NCCI) National Correct Coding Initiative Edits | CMS

or visit the Centers for Medicare and Medicaid Services (CMS) website:

https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

First Level Administrative Appeal

Follow these guidelines in order to file a first level appeal:

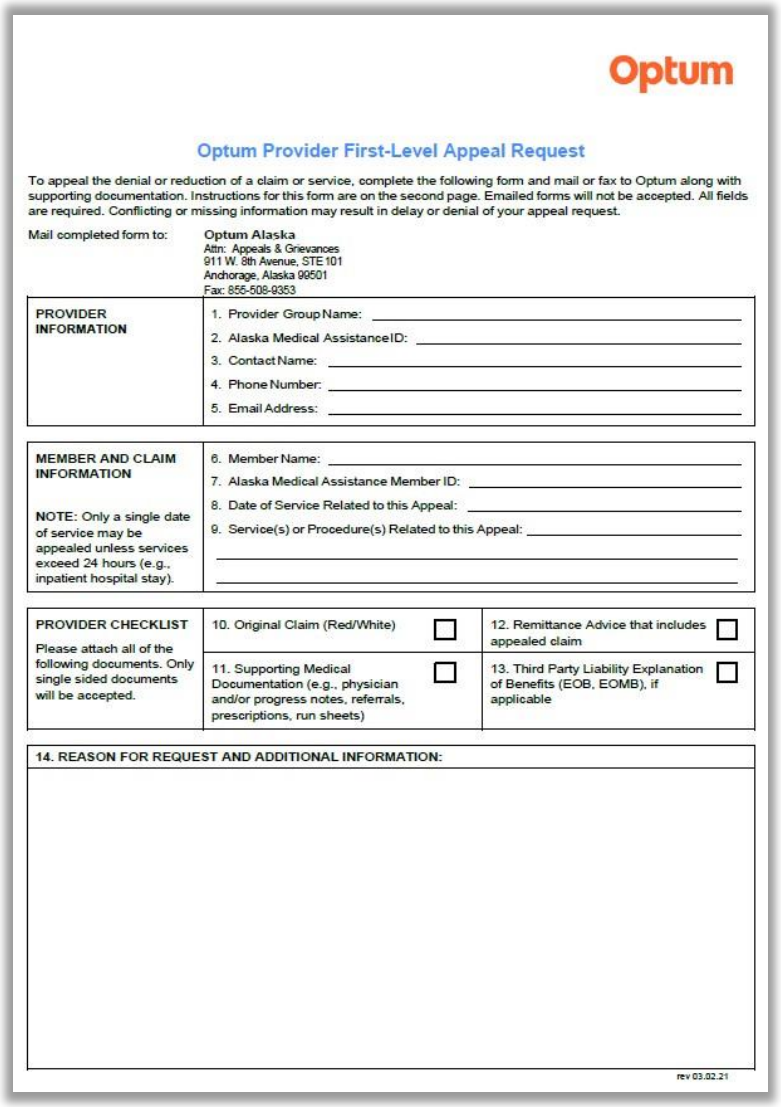
- First level appeals must be in writing and received within 180 days of the claim disposition date - the date of the remittance advice (RA). Any appeal submitted past timely will not be considered.
- Include a copy of the claim denial or payment notice from the RA, a copy of the original claim that was denied or reduced, and any supporting documentation considered relevant (e.g., chart notes, claim check audit report, etc.)
- Optum will notify providers in writing of the first level appeal decision

To contact the Optum Appeals Department, call 866.245.3040 or fax 855.508.9353 or mail to:

Optum Alaska Attention Appeals Department
911 W 8th Ave #101
Anchorage, AK 99501

If the reviewer upholds the initial decision, providers have the right to file a second level appeal.

First Level Appeals Form



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Optum Provider First-Level Appeal Request

To appeal the denial or reduction of a claim or service, complete the following form and mail or fax to Optum along with supporting documentation. Instructions for this form are on the second page. Emailed forms will not be accepted. All fields are required. Conflicting or missing information may result in delay or denial of your appeal request.

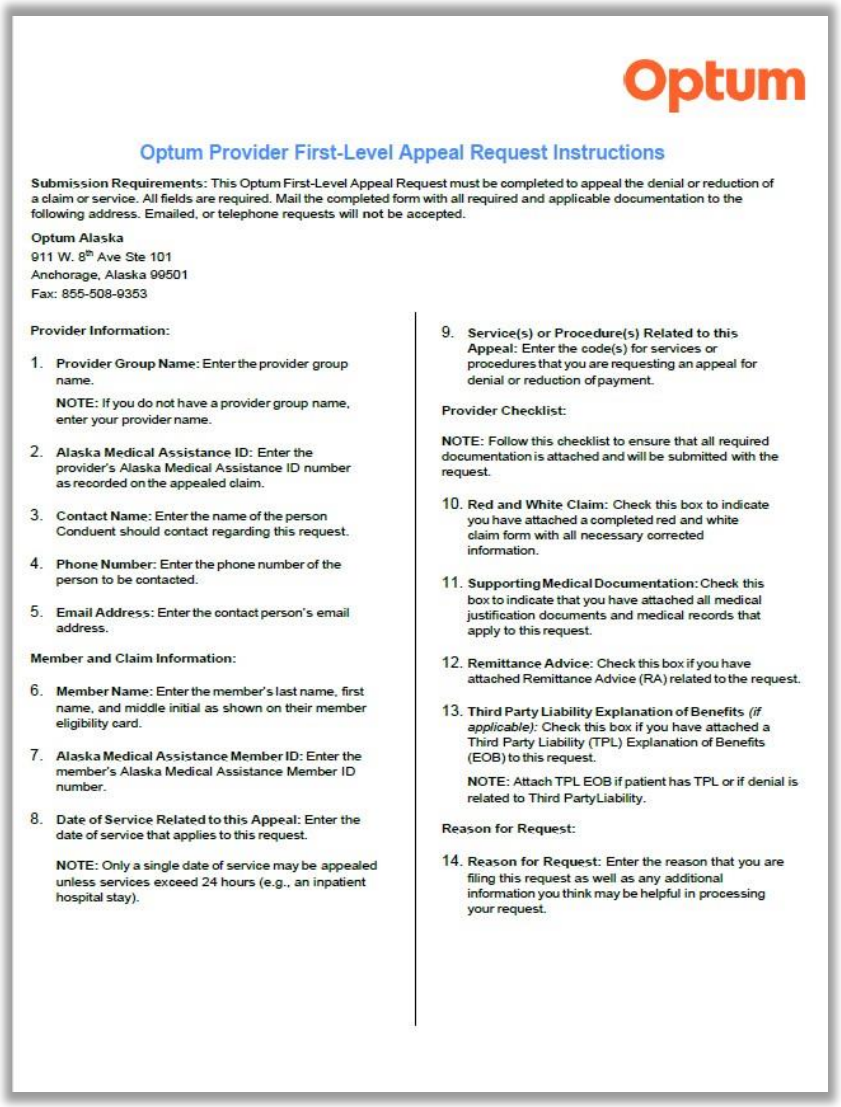
Mail completed form to: **Optum Alaska**
Attn: Appeals & Grievances
911 W. 8th Avenue, STE 101
Anchorage, Alaska 99501
Fax: 855-508-9353

PROVIDER INFORMATION	1. Provider Group Name: _____ 2. Alaska Medical Assistance ID: _____ 3. Contact Name: _____ 4. Phone Number: _____ 5. Email Address: _____
MEMBER AND CLAIM INFORMATION **NOTE:** Only a single date of service may be appealed unless services exceed 24 hours (e.g., inpatient hospital stay).	6. Member Name: _____ 7. Alaska Medical Assistance Member ID: _____ 8. Date of Service Related to this Appeal: _____ 9. Service(s) or Procedure(s) Related to this Appeal: _____ _____ _____

PROVIDER CHECKLIST Please attach all of the following documents. Only single sided documents will be accepted.	10. Original Claim (Red/White) ☐	12. Remittance Advice that includes appealed claim ☐
	11. Supporting Medical Documentation (e.g., physician and/or progress notes, referrals, prescriptions, run sheets) ☐	13. Third Party Liability Explanation of Benefits (EOB, EOMB), if applicable ☐

14. REASON FOR REQUEST AND ADDITIONAL INFORMATION:

rev 03.02.21



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Optum Provider First-Level Appeal Request Instructions

Submission Requirements: This Optum First-Level Appeal Request must be completed to appeal the denial or reduction of a claim or service. All fields are required. Mail the completed form with all required and applicable documentation to the following address. Emailed, or telephone requests will not be accepted.

Optum Alaska
911 W. 8th Ave Ste 101
Anchorage, Alaska 99501
Fax: 855-508-9353

Provider Information:

1. **Provider Group Name:** Enter the provider group name.
   NOTE: If you do not have a provider group name, enter your provider name.
2. **Alaska Medical Assistance ID:** Enter the provider's Alaska Medical Assistance ID number as recorded on the appealed claim.
3. **Contact Name:** Enter the name of the person Conduent should contact regarding this request.
4. **Phone Number:** Enter the phone number of the person to be contacted.
5. **Email Address:** Enter the contact person's email address.

Member and Claim Information:

6. **Member Name:** Enter the member's last name, first name, and middle initial as shown on their member eligibility card.
7. **Alaska Medical Assistance Member ID:** Enter the member's Alaska Medical Assistance Member ID number.
8. **Date of Service Related to this Appeal:** Enter the date of service that applies to this request.
   NOTE: Only a single date of service may be appealed unless services exceed 24 hours (e.g., an inpatient hospital stay).
9. **Service(s) or Procedure(s) Related to this Appeal:** Enter the code(s) for services or procedures that you are requesting an appeal for denial or reduction of payment.

Provider Checklist:

NOTE: Follow this checklist to ensure that all required documentation is attached and will be submitted with the request.

10. **Red and White Claim:** Check this box to indicate you have attached a completed red and white claim form with all necessary corrected information.
11. **Supporting Medical Documentation:** Check this box to indicate that you have attached all medical justification documents and medical records that apply to this request.
12. **Remittance Advice:** Check this box if you have attached Remittance Advice (RA) related to the request.
13. **Third Party Liability Explanation of Benefits** *(if applicable):* Check this box if you have attached a Third Party Liability (TPL) Explanation of Benefits (EOB) to this request.
    NOTE: Attach TPL EOB if patient has TPL or if denial is related to Third PartyLiability.

Reason for Request:

14. **Reason for Request:** Enter the reason that you are filing this request as well as any additional information you think may be helpful in processing your request.

This form is preferred but not required to file an appeal.

This form can be found on the Optum Alaska website:

[Guidelines & Policies (optum.com)]

Second Level Appeals and Final Appeals

Second Level Appeal

A provider may request a second level appeal when:

- The provider is not satisfied with the results of the first level appeal
- The provider is not satisfied with a denied enrollment or disenrollment
- The provider is not satisfied with a service authorization decision
- A second level appeal for National Correct Coding Initiative (NCCI) edits is permissible

A second level appeal must be requested in writing within 60 days of the first level appeal determination to the Division of Behavioral Health

Second Level Appeal

To submit a second level appeal, follow these guidelines:

1. Second level appeals must be in writing and postmarked within 60 days of the date of the first level appeal decision by Optum or within 60 days of the adverse enrollment or service authorization decision. NOTE: Providers may not file a second level appeal by telephone or any other oral communication.
2. Include a copy of the Optum first level appeal decision, or a copy of adverse enrollment or service authorization decision, a copy of the claim denial or payment notice, a copy of the submitted claim, and supporting documentation considered relevant.
3. Mail to:

   Division of Behavioral Health Attn: Medicaid Section
   3601 C Street, Suite 878
   Anchorage AK 99503

Providers will be notified in writing of the final decision.

Final Level Appeal

Providers may appeal a previous decision to the Commissioner of the Alaska Department of Health and Social Services (DHSS) when they are not satisfied with the results of the second level appeal only when it relates to denial of a claim for **not meeting the timely filing requirement**.

Final level appeal steps are as follows:

1. An appeal to the DHSS Commissioner must be in writing and postmarked no later than 60 days after the date of the second-level appeal decision by the Division of Behavioral Health. Include a clear description of the issue or decision being appealed and the reason for the appeal.
2. Providers should submit this appeal to:

   Commissioner, Department of Health and Social Services
   PO Box 110601
   Juneau, AK 99811-0601

Clinical Peer Reviews

What is a Peer to Peer (P2P) Review?

Clinical peer review is a scheduled phone conversation during which a requesting provider discusses the need for a service with the payor's medical director to obtain a service authorization approval, when the Care Advocates are unable to decide based on submitted clinical information. The appointment is scheduled within a certain time frame or else the case will be reviewed, and approval or denial will be decided with available information.

The discussion primarily focuses on the clinical presentation of the participant, biopsychosocial factors affecting the individual, and the medical necessity of the requested service. The review is **not** directing treatment. The discussion usually lasts 15 to 30 minutes.

Why is Optum calling me?

Service Authorization requests from the provider involve submitting documentation which includes assessments, summary of progress justifying medical necessity, completed ASAM/LOCUS/CALOCUS/ESCII clinical guidelines etc..

- If after initial review by Care advocate (CA) of the service request and documentation, Optum CA might call back for additional clinical information that is missing.
- CA's staff cases when uncertain about medical necessity with the Optum Medical Director. The service might be authorized after staffing or is scheduled for Peer 2 Peer review with the provider to further discuss medical necessity

ASAM - Clinical Guideline Tool of American Society of Addiction Medicine

LOCUS - Clinical Guideline Tool of American Association of Community Psychiatry

CALOCUS/ESCII - Clinical Guideline Tools of American Association of Child and Adolescent Psychiatry

Steps/Process/What to expect when Optum calls:

- If Live Peer Review is requested by Optum, Optum AK MD will contact the provider by phone at the scheduled appointment time considering provider's schedule
- Provider will be asked to authenticate (Participant's name, DOB, ID)
- Peer Review will be a dialogue/discussion about the participant's history/current symptoms/biopsychosocial factors
- Optum AK MD will be reviewing based on the clinical guidelines (LOCUS, CASI, ESCII, ASAM) to determine medical necessity
- If the provider does not answer at the scheduled time, then a Chart/Record Review will take place.

ASAM is American Society of Addiction Medicine

LOCUS is American Association of Community Psychiatry

CALOCUS/ESCII is American Association of Child and Adolescent Psychiatry

Situation that led to P2P

The primary reason a peer review is requested is to have a collaborative and open communication around the coordination of participants' healthcare.

Questions that may be asked in P2P:

- Update on participants' clinical progress
- Diagnostic clarification
- Clarity on medical necessity for the level of care requested
- Thoughts about continued treatment at appropriate level of care
- Care coordination with other services addressing biopsychosocial aspects
- Consideration of a personalized care plan for the participant
- Available services in the service area

Case Consultation

Case consultation compared to Peer 2 Peer review is more a collaborative dialogue between the provider and the Optum AK MD of the case, to coordinate potential assistance that Optum Alaska could facilitate with participant's care, for the optimum outcome.

Case consultation is **not** for determining service authorization request.

The appropriate care decisions are determined by the provider in consultation with the participant.

Medical Necessity

Initial Service Authorization Request

- Comprehensive Assessment by licensed Clinician
- DSM – 5 Mental Health or Substance Use Disorder diagnosis depending on service requested
- Complete Clinical Guideline Assessment – ASAM/LOCUS/CALOCUS/CASII/ESCII
- Medical Necessity Justification – Briefly explain how participant meets requested level of care

Re-Authorization Request

- Updated problem list, current clinical condition and progress in treatment, finalized by licensed clinician
- Complete Clinical Guideline Assessment – ASAM/LOCUS/CALOCUS/CASII/ESCII; if more than 60 days
- Medical Necessity Justification Note signed by licensed clinician
- Additional clinical information as requested by CA

Medical Necessity (continued)

Medical necessity reviews should be treated as an opportunity to:

- Provide education, guidance and care coordination
- Engage providers in detailed clinical discussions to assist providers in learning what information is necessary to make an accurate medical necessity determination

A determination about whether requested services are medically necessary / clinically appropriate is based on the Care Advocate's or Peer Reviewer's application of the objective Guideline Scoring Tools, which is informed by the reviewer's clinical judgment

Guideline Scoring Tools

- **LOCUS** (*American Association of Community Psychiatrists Level of Care Utilization System (LOCUS) Adult Version 20*) - Ages 19 and above for mental health treatment

- **CALOCUS - CASII** *(American Academy of Child and Adolescent Psychiatry Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII)* - Ages 6-18 years

- **ECSII** (*American Academy of Child and Adolescent Psychiatry (AACAP) Early Childhood Service Intensity Instrument (ECSII) Version 1.1*) - Ages 0-5 years

- **ASAM** (*American Society of Addiction Medicine (ASAM) Criteria*®) - all Ages - for substance use disorder treatment

Documentation

Documentation in a medical record is an essential component of recording services or care provided to the participant.

The 5 Cs of Clinical Documentation

- Clarity – Helps describe the behaviors and symptoms related to the diagnosis which justifies medical necessity
- Conciseness – Saves time for provider and reviewer
- Completeness – Avoids unnecessary delays in authorizations
- Correct – Accurate information in relating the participant's story
- Chronological Order – Assists in following participant's story

Identified barriers in Peer 2 Peer Reviews

- Lack of preparation for the review
- Assigned provider not available during review
- Individualized Care versus set program time frame: for example, 90-day program, participant no longer meets as symptoms improved but provider continues request for LOC due to the 90-day requirement
- Lack of appropriate services available in the service area

Case Examples

Case Example for Adult Mental Health Residential (AMHR)

Aryan is a 34-year-old college educated man, living alone and working as an office assistant in a medical office when he became suspicious, apprehensive, and agitated. He claimed that he did not need to be in a psychiatric clinic but has been referred by an acquaintance because he was worried.

He explained that he was upset because he thought the staff were conspiring to get him in trouble. There was no evidence of hallucinations, and his thinking was clear and logical. The office staff in fact were appreciative of his work and always complimented him on his timely completion of assignments.

However, he thought that were being overly nice to cover up for their conspiracy and thought they were disappointed by the participant's lack of success in the work world.

Case Example for Adult Mental Health Residential - AMHR (continued)

The patient's delusional thinking responded initially to antipsychotic medications, in that the agitation, preoccupation concerning the delusions diminished. However, the patient harbored the delusions for several months, despite antipsychotic drug treatment and numerous attempts by the office to present facts and reassure the patient.

The conspiracy has broadened to include therapists, employers, and neighbors of the patient. He made some threatening statements towards neighbors, "I will see to it that you stop this thing or else..." Patient also has history of high blood pressure, been inconsistent with medications and needs monitoring.

He was placed on medical leave and referred to the adult mental health rehabilitation for ongoing therapeutic environment while he gradually eased back into continuing work part-time at his job.

LOCUS for the Adult Mental Health Residential Scenario

LOCUS Evaluation - Evaluation ID: A727967 - Date of Evaluation: 04/01/2024 02:52 pm

Requested Service Intensity Level:	5 Medically Monitored Residential Services
Recommended Disposition:	5 Medically Monitored Residential Services
Clinical Decision:	5 Medically Monitored Residential Services
Variance:	No Variance: enter Rationale and Action Plan below
Clinical Rationale and Action Plan:	Level of service requested is authorized.

LOCUS RESULTS Composite Score: 24

Risk of Harm (Dimension Score): 2

•No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past

Functional Status (Dimension Score): 4

•Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors

LOCUS for the Adult Mental Health Residential Scenario (Continued)

Medical, Addictive and Psychiatric Co-Morbidity (Dimension Score): 3

•Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring

Recovery Environment - Level of Stress (Dimension Score): 3

•Recent important loss or deterioration of interpersonal or material circumstances

Recovery Environment - Level of Support (Dimension Score): 4

•Client may be on bad terms with and unwilling to use supports available in a constructive manner

Treatment and Recovery History (Dimension Score): 4

•Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure

Engagement and Recovery Status (Dimension Score): 4

•Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in daily living

Case Example for ASAM Level 2 Services

Bill, a 43-year-old divorced fisherman, was examined in the emergency observation room. He reportedly lost his job couple of years ago after an accident where he lost one of his limbs. He had been consuming about a fifth of hard liquor a day after recovering from the accident about 6 months ago. He often had blackouts from drinking and often missed his meals and spent most of his time drinking. His only income is from disability after the accident which he mainly spent on buying alcohol. He is sharing a rented room with another individual and is at risk of becoming homeless if he cannot pay rent. His family tried to encourage him multiple times to get help, but he declined and distanced himself from them. He has no other support systems in the community. He was also occasionally using pain medications he got from the streets. He was taken to the emergency room by his roommate after he shared that he was disappointed with his life and contemplating overdosing on fentanyl or drinking himself to death. He stated that he would like to stop drinking and doing drugs but every time he relapsed after just a few days of sobriety.

Participant was evaluated and managed with appropriate treatment for alcohol and opiate withdrawal. He was started on a small dose of an antidepressant that he tolerated well with no reported side effects. Participant expressed interest in considering a rehabilitation program. He was referred to ASAM Level 2 Outpatient Services.

ASAM Review Summary for Case Example Level 2 Services

InterQual® Review Summary - Created By: Purmandla, Mahender - Created Date: 04-02-2024

Criteria Subset: Level 2.5 High-Intensity Outpatient Treatment

Recommendations (indicates reviewer selection):

RECOMMENDED Evidence supports services as medically necessary.
Level 2.5: Partial Hospitalization Services with Co-occurring Capable Program
Medical Review Q & A
Review type, Choose one: Admission or transfer

The patient has been assessed for needs across the six dimensions by staff with appropriate expertise, or this will occur prior to admission.

ASAM Review Summary for Case Example Level 2 Services (Continued)

Dimension1: No acute signs or symptoms of intoxication, withdrawal or physical or mental health conditions requiring medical management, and none are anticipated. Patient's addiction medication needs (if any) can be addressed in any level of care (e.g., through referral and care coordination) and patient does not require integrated medical management of addiction.

Dimension 2: No biomedical problems

Dimension 3: History of mild to moderate mental health signs/symptoms can be addressed in any level of care directly or through referral or patient is already receiving appropriate external mental health care and does not require active co-management from the addiction treatment provider. No persistent mental health or cognitive disability.

ASAM Review Summary for Case Example Level 2 Services (Continued)

Dimension 4: Risky substance use/SUD-related behaviors likely to cause serious harm (e.g., overdose, physical or mental health crises, injury, death) or destabilizing loss (e.g., loss of home and/or family, freedom, employment). Patient will have sufficient after-hours structure to prevent risky substance use/SUD-related behaviors (either at home or in a recovery residence) but lacks sufficient skills to create a daily structure that would keep him safe during the day.

Dimension 5: Patient's living environment is sufficiently safe and supportive to help him cope with cravings and other recovery threats to use and enable participation in outpatient treatment. High likelihood of continuing to use or relapsing without close outpatient monitoring and structured therapeutic services, and a less intensive level of care is judged insufficient to stabilize the patient’s condition. Adequate support from family or significant others to safely receive outpatient care for substance use and co-occurring conditions.

Dimension 6: Continued exposure to current school, work, or living environment will render recovery unlikely, and patient lacks the resources or skills necessary to maintain an adequate level of functioning without a Level 2.5 program.

Case Example for Therapeutic Treatment Home

Tony is a 14-year-old boy who was referred for evaluation when his teacher no longer could manage him in her class. He was not only oppositional and unable to sit in his seat, but he was constantly arguing and agitated at his peers. Although his teacher thought he started most of the arguments, his mother who was a single parent felt he was disliked by his peers. At home, he was the most difficult of three brothers. His mother worked two jobs and spent hardly any time with the children. The older child who is 19 years old was into using drugs and at times abusive towards the patient. His dad was incarcerated for drug related charges. The family had no social support system in the community.

Tony was evaluated at school, was diagnosed with ADHD and oppositional-defiant disorder. He was prescribed Ritalin that was helpful in keeping his hyperactivity in control, but he still was getting in trouble with peers. His medications were disappearing at home and there was concern that they were being misused by his brother. It was difficult for mother to monitor. Patient was referred to the therapeutic treatment home for ongoing management of his behaviors.

CALOCUS for the Therapeutic Treatment Home Scenario

CALOCUS Evaluation - Evaluation ID: C728260 - Date of Evaluation: 04/01/2024 04:26 pm

Requested Service Intensity Level:	3 High Intensity Community Based Services
Recommended Disposition:	3 High Intensity Community Based Services
Clinical Decision:	3 High Intensity Community Based Services
Variance:	No Variance

Clinical Rationale and Action Plan:

Patient at this time is at risk of further decompensation and potentially having long term effects. Level of care requested is approved.

CALOCUS RESULTS Composite Score: 19

CALOCUS for the Therapeutic Treatment Home Scenario (Continued)

Risk of Harm (Dimension Score): 2

•Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others
•Some risk for victimization, abuse, or neglect

Functional Status (Dimension Score): 3

•School behavior has deteriorated to the point of the child/adolescent has faced some school disciplinary action and is at risk for placement in an alternative school program
•Recent gains and/or stabilization in functioning have been achieved while participating in treatment in a structured, protected, and/or enriched service

Co-Morbidity: Developmental, Medical, Substance Use and Psychiatric (Dimension Score): 3

•Psychiatric signs and symptoms are present that persist in the absence of stress, are moderately debilitating, and adversely affect the presenting condition

CALOCUS for the Therapeutic Treatment Home Scenario (Continued)

Recovery Environment - Environmental Stress (Dimension Score): 2

•Significant transition requiring adjustment, such as change in household members, or new school or teacher
•Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, or other factor

Recovery Environment - Environmental Support (Dimension Score): 3

•Family or primary caretakers demonstrate only partial ability to make necessary changes during treatment

Resiliency and Treatment History (Dimension Score): 3

•Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms

Q&A