

Common MCE Clinical Review Questions

September 2009

Note: Depending on who is seeking the authorization for the services below (i.e., the service provider or the ICC provider), the questions could be slightly different.

Therapeutic Mentoring

1. What service is acting as the clinical Hub for purposes of coordinating care? Select only **one** of the three options below.

Note: A youth may have more than one Hub service at any one time, but only one is serving as the “clinical Hub” for purposes of coordinating care, with the most intensive service involved responsible for serving as the Hub.

- a. Intensive Care Coordination (ICC)

- i. If the youth is in ICC, what is the name of the ICC provider?
- ii. If the youth is in ICC, what was the date of the last CPT meeting that the Therapeutic Mentoring provider attended? (*Question not applicable for initial authorization*)
- iii. Has the therapeutic mentor received the most recent copy of the ICP from the ICC? What is the date of that ICP?
- iv. What was the date of the last contact with the ICC provider for purposes of coordinating care (if different from above)? *Note: Performance specifications for Therapeutic Mentoring require **weekly** contact (phone or face-to-face) between the “clinical Hub” provider and the Therapeutic Mentoring provider.*
- v. Has the ICC provider supplied a copy of the most up-to-date risk management/safety plan? What is the date of the plan?

- b. In-Home Therapy (IHT)

- i. If the youth is in IHT, what is the name of the IHT provider?
- ii. What was the date of the last contact with the IHT provider (if different from above) for purposes of coordinating care? *Note: Performance specifications for Therapeutic Mentoring require **weekly** contact (phone or face-to-face) between the “clinical Hub” provider and the Therapeutic Mentoring provider.*
- iii. Has the therapeutic mentor received a copy of the most up to date IHT treatment plan? What is the date of that plan?
- iv. Has the IHT provider supplied a copy of the most up-to-date risk management/safety plan? What is the date of the plan?

- c. Outpatient

- i. If the youth is in outpatient, what is the name of the outpatient provider?
- ii. Has the therapeutic mentor received a copy of the most up-to-date outpatient treatment plan? What is the date of that plan?
- iii. What was the date of the last contact with the outpatient provider (if different from above) for purposes of coordinating care? *Note: Performance specifications for Therapeutic Mentoring require **weekly** contact (phone or face-to-face) between the “clinical Hub” provider and the Therapeutic Mentoring provider.*

2. Are there additional behavioral health providers involved with the youth?

- a. If yes, what are they?

3. Is this youth receiving school-based behavioral health services through his/her IEP? If yes, describe the services received?
4. Does the youth have state agency involvement?
 - a. If yes, what state agency?
 - b. Is the youth receiving any services through the state agency (e.g., case management, respite, after-school, etc.)?
5. Is the youth clinically and behaviorally stable enough to manage stressors and learn new skills?
6. What are the goals that the clinical Hub provider has identified to be addressed through Therapeutic Mentoring? *(With follow-up questions to include what strategy(s) and activities they are using to address the goal(s) to be used for concurrent reviews)*

Goal(s)	Strategy (can select more than one)	Activity (can select more than one)
	<input type="checkbox"/> Provision of anticipatory guidance <input type="checkbox"/> Teaching of alternative strategies <input type="checkbox"/> Role playing <input type="checkbox"/> Behavioral rehearsal <input type="checkbox"/> Skill acquisition in the home/community <input type="checkbox"/> Practicing skills in the home/community <input type="checkbox"/> Exposure to social situations in which age-appropriate skills can be practiced <input type="checkbox"/> Enhancing conflict resolution skills <input type="checkbox"/> Developing communication skills <input type="checkbox"/> Other (describe)	<input type="checkbox"/> Social (describe) <input type="checkbox"/> Recreational (describe) <input type="checkbox"/> Athletic (describe) <input type="checkbox"/> Artistic (describe) <input type="checkbox"/> Educational (describe) <input type="checkbox"/> Activities of daily living based in the community (describe) <input type="checkbox"/> Other (describe)

7. Describe the progress on goals since the last review.
8. What is the anticipated length of time needed to reach the identified goals?
9. What is the transition/discharge plan for this youth (include any plan for a transition to a different clinical Hub provider)?
10. What is the plan for sustainability beyond transition/discharge, including plans for use of natural/community-based supports?

In-Home Behavioral Services (IHBS)

1. What service is acting as the clinical Hub for purposes of coordinating care? Select only **one** of the three options below (a, b, or c).

Note: A youth may have more than one Hub service, but only one is serving as the “clinical Hub” for purposes of coordinating care.

- a. Intensive Care Coordination *(If the ICC is serving as the clinical Hub, answer the questions below.)*
 - i. If the youth is in ICC, what is the name of the ICC provider?
 - ii. If the youth is in ICC, what was the date of the last CPT meeting that the IHBS provider attended? *(Question not applicable for initial authorization)*
 - iii. What was the date of the last contact with the ICC provider for purposes of coordinating care (if different from above)? *Note: Performance specifications for IHBS require **weekly** contact*

(phone or face-to-face) between the ICC provider and the IHBS provider.

- iv. Has the IHBS provider received the most recent copy of the ICP from the ICC? What is the date of that ICP?
- v. Has the ICC provider supplied a copy of the most up-to-date risk management/safety plan? What is the date of the plan?
- vi. Has the IHBS provider supplied a copy of the written functional behavioral assessment to the ICC provider? What is the date that the functional behavioral assessment was completed?
- vii. Has the IHBS provider supplied a copy of the IHBS behavioral management plan to the ICC provider? What is the date of the plan?
- b. In-Home Therapy (*If the IHT is serving as the clinical Hub, answer the questions below.*)
 - i. If the youth is in IHT, what is the name of the IHT provider?
 - ii. What was the date of the last contact with the IHT provider (if different from above) for purposes of coordinating care? *Note: Performance specifications for IHBS require **regular** contact (phone or face-to-face) between the “clinical Hub” provider and IHBS provider.*
 - iii. Has the IHBS provider received a copy of the most up-to-date IHT treatment plan? What is the date of that plan?
 - iv. Has the IHT provider supplied a copy of the most up-to-date risk management/safety plan? What is the date of the plan?
 - v. Has the IHBS provider supplied a copy of the written functional behavioral assessment to the IHT provider? What is the date that the functional behavioral assessment was completed?
 - vi. Has the IHBS provider supplied a copy of the IHBS behavioral management plan to the IHT provider? What is the date of the plan?
- c. Outpatient (*If outpatient is serving as the clinical Hub, answer the questions below.*)
 - i. If the youth is in outpatient, what is the name of the outpatient provider?
 - ii. What was the date of the last contact with the outpatient provider (if different from above) for purposes of coordinating care? *Note: Performance specifications for IHBS require **regular** contact (phone or face-to-face) between the “clinical Hub” provider and the IHBS provider.*
 - iii. Has the IHBS received a copy of the most up-to-date outpatient treatment plan? What is the date of that plan?
 - iv. Has the IHBS provider supplied a copy of the written functional behavioral assessment to the outpatient provider? What is the date that the functional behavioral assessment was completed?
 - v. Has the IHBS provider supplied a copy of the IHBS behavioral management plan to the outpatient provider? What is the date of the plan?
- 2. Are there additional behavioral health providers currently involved with the youth?
 - a. If yes, what are they?
- 3. Is this youth receiving school-based behavioral health services through his/her IEP? If yes, describe the services received?
- 4. Does the youth have state agency involvement?
 - a. If yes, what state agency?
 - b. Is the youth receiving any services through the state agency (e.g., case management, respite, after-school, etc.)?

5. Describe the severity, frequency, and duration of the identified behavior(s) that are to be addressed through IHBS (*initial review*).
6. What are the settings in which the target behavior(s) typically occur? (Check all that apply.)
 - a. *Home*
 - b. *School*
 - c. *Work*
 - d. *Community*
7. What are the goals that the clinical Hub provider has identified to be addressed through IHBS?
8. What are the goals identified by the IHBS provider on the IHBS behavior plan?
9. Has the use of a behavior management monitor been identified as necessary to work with the youth and family to implement the IHBS behavior plan?
10. What has been the progress on goals since the last review? Include data on the severity, frequency, and duration of the identified behavior(s) that prompted the initial referral to IHBS.
11. What is the anticipated length of time needed to reach the identified goals?
12. What is the transition/discharge plan for this youth (include any plan for a transition to a different clinical Hub provider)?
13. What is the plan for sustainability beyond transition/discharge, including plans for use of natural/community-based supports?

Family Support and Training (FS&T)

Note: These questions are to be used when FS&T is requested as a stand-alone service independent of ICC.

1. What service is acting as the clinical Hub for purposes of coordinating care? Select only **one** of the **two** options below.

Note: A youth may have more than one Hub service at any one time, but only one is serving as the “clinical Hub” for purposes of coordinating care, with the most intensive service involved responsible for serving as the Hub.

- a. In-Home Therapy
 - i. If the youth is in IHT, what is the name of the IHT provider?
 - ii. What was the date of the last contact with the IHT provider (if different from above) for purposes of coordinating care? *Note: Performance specifications for FS&T **weekly** contact (phone or face-to-face) between the “clinical Hub” provider and the Therapeutic Mentoring provider.*
 - iii. Has the FS&T provider received a copy of the most up-to-date IHT treatment plan? What is the date of that plan?
 - iv. Has the IHT provider supplied a copy of the most up-to-date risk management/safety plan? What is the date of the plan?
- b. Outpatient
 - i. If the youth is in outpatient, what is the name of the outpatient provider?
 - ii. What was the date of the last contact with the outpatient provider (if different from above) for purposes of coordinating care? *Note: Performance specifications for Therapeutic Mentoring require **weekly** contact (phone or face-to-face) between the “clinical Hub”*

provider and the Therapeutic Mentoring provider.

- iii. Has the FS&T provider received a copy of the most up-to-date outpatient treatment plan?
What is the date of that plan?
2. Are there additional behavioral health providers involved with the youth?
 - a. If yes, what are they?
3. Does the youth have state agency involvement?
 - a. If yes, what state agency?
 - b. Is the youth/family receiving any services through the state agency (e.g., case management, respite, after-school, parent aide, etc.)?
4. What are the behavioral/emotional needs of the youth that require the assistance of a Family Partner to help the parent/caregiver manage?
5. What are the goals that the clinical Hub provider has identified to be addressed through FS&T? *(With follow-up questions to include what strategy(s) and activities they are using to address the goal(s) to be used for concurrent reviews)*
6. Describe the progress on goals since the last review.
7. What is the anticipated length of time needed to reach the identified goals?
8. What is the transition/discharge plan (include any plan for a transition to a different clinical Hub provider)?
9. What is the plan for sustainability beyond transition/discharge, including plans for use of natural/community-based supports?

In Home Therapy (IHT)

1. Who referred the Member for IHT?
 - Mobile Crisis Intervention (list provider name and contact info)
 - Intensive Care Coordination (list provider name and contact info)
 - Outpatient therapist (list provider name and contact info)
 - State agency (with contact info)
 - DCF
 - DMH
 - DDS
 - DYS
 - Other (name)
 - School personnel (contact info)
 - IP/CBAT/EATS/TCU provider as step-down (list provider name and contact info – and indicate if IHT provider attended the discharge planning meeting at the IP, CBAT, etc., facility)
 - Primary care (contact info)
 - Family/self
 - Other (describe)

2. What prompted the referral for IHT? (Describe the precipitants.)
3. What is the diagnosis?
4. Is the youth in ICC?
 - a. If the youth is in ICC, what was the date of the last CPT meeting that the IHT provider attended? (*Question not applicable for initial authorization*)
 - b. Has the IHT received the most recent copy of the ICP from the ICC? What is the date of that ICP?
 - c. What was the date of the last contact with the ICC provider for purposes of coordinating care (if different from above)?
 - d. Has the ICC provider supplied a copy of the most up-to-date risk management/safety plan? What is the date of the plan?
 - e. What are the goals that the Care Planning Team has identified to be addressed by IHT?
5. If the youth is not in ICC, is IHT currently serving as the clinical Hub for Therapeutic Mentoring, IHBS, or FS&T services? If yes, what are the goals that the IHT provider has identified to be addressed by those services? (*Please be specific to each service if more than one service is involved.*) Also indicate date(s) of last contact with these providers for purposes of coordinating care.
6. Are there additional behavioral health providers involved with the youth (e.g., outpatient, psychiatry, etc.)?
 - a. If yes, what are they?
 - b. If the youth is seeing a psychiatrist, what medications are currently prescribed?
7. Is this youth receiving school-based behavioral health services through his/her IEP? If yes, describe the services received.
8. Does the youth have state agency involvement?
 - a. If yes, what state agency?
 - b. Is the youth receiving any services through the state agency (e.g., case management, respite, after-school, etc.)?
9. If the parent/caregiver(s) are having difficulty accessing their own medical and/or psychiatric services, or other community services, was CSP offered to them?
10. What are the IHT treatment goals identified on the IHT treatment plan and the anticipated length of time needed to reach the identified goals?
11. Describe the specific clinical strategies, tasks, and interventions that the IHT master's-level clinician is utilizing to reach the treatment goals described above.
12. Is the Therapeutic Training and Support paraprofessional also working with the Member? If yes, describe the specific tasks he/she is working on with the Member and his/her family.
13. Describe the progress on goals since the last review (for CCR only).
14. What is the transition/discharge plan for this youth?
15. What is the plan for sustainability beyond transition/discharge, including plans for use of natural/community-based supports?