☑OK To Use

AUDIT NAME
2024 Standard VI Coverage and Authorization of Services

PASSING %
100

☐Consumer linked to this audit

☐ Staff Audit

SECTIONS

Section

NUMBERTITLE
1 VI. Service Authorization & Utilization Management

SECTION QUESTIONS

Questions			
1	6.1 Written Program Description: A utilization management program is in operation. The written utilization management program description includes:	Met/Partially Met/Not Met	N/A
2	6.1a The CMHSP has a written utilization program description that the criteria used in making decisions	Met/Partially Met/Not Met	N/A
3	6.1b. Procedures to evaluate clinical necessity, and the process used to review and approve the provision of clinical services.	Met/Partially Met/Not Met	N/A
5	6.1c Mechanisms to identify and correct under-utilization as well as over utilization.	Met/Partially Met/Not Met	N/A
6	6.1d Reauthorization, concurrent and retrospective procedures.	Met/Partially Met/Not Met	N/A
7	6.2 Arbitrary denial or reduction of the amount, duration or scope of a required service solely because of a consumer's diagnosis, type of illness or condition is prohibited.	Met/Partially Met/Not Met	N/A
8	6.3 Any service limits imposed are appropriate and restricted to criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	Met/Partially Met/Not Met	N/A
9	6.4 Mechanisms are in effect to ensure consistent application of review criteria for authorization decisions	Met/Partially Met/Not Met	N/A
10	6.5 Review decisions are supervised by qualified medical professionals.	Met/Partially Met/Not Met	N/A
11	6.6 Procedures: Prospective (pre-authorization, concurrent, and retrospective procedures are established and include:	Met/Partially Met/Not Met	N/A

12	6.7 Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.	Met/Partially Met/Not Met	N/A
13	6.8 Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.	Met/Partially Met/Not Met	N/A
14	6.9 The reason for decisions is clearly documented.	Met/Partially Met/Not Met	N/A
15	6.10 The reason for decisions are available to the beneficiary.	Met/Partially Met/Not Met	N/A
16	6.11 There are well-publicized and readily available appeals mechanisms for providers.	Met/Partially Met/Not Met	N/A
17	6.12 There are well publicized and readily available appeal mechanisms for beneficiaries.	Met/Partially Met/Not Met	N/A
18	6.13 Notification of the denial is sent to the beneficiary.	Met/Partially Met/Not Met	N/A
19	6.14 Notification of denial is sent to the provider.	Met/Partially Met/Not Met	N/A
20	6.15 Notification of a denial includes a description of how to file an appeal.	Met/Partially Met/Not Met	N/A
21	6.16 UM decisions are made in a timely manner as required by the exigencies of the situation.	Met/Partially Met/Not Met	N/A
22	6.17 There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.	Met/Partially Met/Not Met	N/A
23	6.18 The involved provider is informed verbally or in writing of the action if a service authorization request was denied or services were authorized in an amount, duration or scope that was less than requested.	Met/Partially Met/Not Met	N/A

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