Kepro

MEDICATION ASSISTED TREATMENT

Provider:		**Member ID:**	
Review Date:		**Reviewer Name:**	

1.	Does the member meet medical necessity for this service including the most appropriate level of care? **(Note: If question #1 scores 0, then all remaining questions score 0.)**	1	0
2.	Does the member have a diagnosis of Opioid and/or Alcohol Use Disorder (Moderate or Severe) that resulted from a physician assessment?	1	0
3.	Is there a current Coordination of Care agreement, including signature by all required parties (when required)?	1	0
4.	Is the agency providing the required amount of therapy (must meet service definition) per month (Phase I and/or Phase II) by appropriately credentialed staff?	1	0
5.	Is the agency providing the required amount of drug screens per month (Phase I and/or Phase II)? (*Drug screens must meet the policy minimum standard)	1	0
6.	Is the non-compliance policy enforced when the member has not been compliant with treatment or has not had successful drug screens?	1	0
7.	Is there documentation to support the frequency/intensity of services?	1	0

Total Score = _____ [Possible 7]