

**INTENSIVE SERVICES**  
**H0004 IS, H0004 HO IS, H0004 HQ IS, H0004 HO HQ IS**

<b>Provider:</b>		<b>Member ID:</b>	
<b>Review Date:</b>		<b>Reviewer Name:</b>	

1.	Does the documentation demonstrate that the member met medical necessity criteria including level of care (program description), for the authorization period under review? <b>(Note: If question #1 scores 0, then all remaining questions score 0.)</b>	1	0		
2.	Is there a current Service Plan for IS that demonstrates participation by Physician/Psychologist/Approved Licensed Professional* and member including all required signatures, credentials, each with dates, start and stop times? <b>(Note: If Question #2 scores zero, all remaining questions will score zero.)</b>	3	1.5	0	
3.	Does the plan demonstrate participation by all required team members, including members from other agencies involved in behavioral health care of the member (dates, start and stop times) including all required signatures and credentials?	3	1.5	0	
4.	Does the Service Plan demonstrate that services will be provided according to the program description and service definition? <b>(If this question scores zero, question 2 and all remaining questions score zero).</b>	3	1.5	0	
*5.	Does the Service Plan address all the dynamics of the identified problems/deficits as per the program description?	3	2	1	0
*6.	Do the service plan objectives reflect measurable steps the member would take toward achieving service plan goals? <b>(Must meet service definition).</b>	3	2	1	0
7.	Are goals and objectives commensurate with time spent in services?	3	0		
8.	Is the member's clinical presentation/status reviewed in accordance with continuing stay criteria and length of program as per the program description?	3	1.5	0	
9.	Does the service plan include individualized and measurable components of discharge criteria as per the program description?	3	1.5	0	
10.	Do the service notes include: <ul style="list-style-type: none"> <li>• Signature with appropriate Practitioner Credentials</li> <li>• Service start and stop times</li> <li>• Location of service</li> <li>• Date</li> <li>• Service code and/or descriptor?</li> </ul> <b>(Note: If there is no signature by an approved clinician Questions 10-14 will score zero for those notes).</b>	3	2	1	0
*11.	Do the service notes clearly identify the interventions utilized by the clinician and relate to the member's identified behavioral	3	2	1	0

	health condition? <b>(Note: If question #11 scores zero, questions 12,13, and 14 score 0.)</b>				
*12.	Do the service notes relate back to the appropriate objectives and assessed need?	3	2	1	0
*13.	Does the documentation demonstrate the member's individualized response to the psychotherapeutic/supportive counseling interventions?	3	2	1	0
*14.	Is pertinent interval history documented including changes in symptoms and functioning and addressing appropriate high-risk factors?	3	2	1	0
15.	Is there documentation that demonstrates that all the program requirements and expectations were explained to the member prior to starting the IS program?	3	0		
16.	Does a comprehensive review of the current clinical status substantiate that medical necessity is met for continued stay at this level of care?	3	0		

**Total Score = \_\_\_\_\_ [Possible 46]**

\* Refer to Provider Manual for licensing requirements

\* The scoring for these questions is as follows:

- 3 – 100% of the documentation meets this standard
- 2 – 99% to 75% of the documentation meets this standard
- 1 – 74% to 50% of the documentation meets this standard
- 0 – Under 50% of the documentation meets this standard