District of Columbia Medicaid Collaborative Care Model (CoCM) Continued Services Review Assessment

Created August 2025

Please complete all sections of this form.

PATIENT NAME: (First)_____ (Last)_____

MEDICAID ID number:_____

DATE OF BIRTH (mm/dd/yyyy) _____

TREATING PROVIDER NAME: (First)_____ (Last)_____

TREATING PROVIDER NPI #: _____

FACILITY NAME: _____ FACILITY NPI #: _____

REQUEST START DATE (should **not** overlap with current approval dates): _____

1. **I have verified that the beneficiary is DC Medicaid eligible for the Collaborative Care Model (CoCM) services being requested.**

   ☐ **Yes.** Note: Per the DC Medicaid Provider Billing manual, section 9.3; Eligibility Identification: It is the responsibility of the provider to always verify that the patient is eligible for Medicaid before rendering services.

   ☐ **No.** Note: This review will go to a Clinical Reviewer for a comprehensive review.

2. **Beneficiary remains engaged and has not had a gap in services for more than six (6) months.**

   ☐ **Yes.**

   ☐ **No.** Note: A gap in services for more than six (6) months is considered a new occurrence of care which does not require prior authorization. Please submit a new request after the initial six-month period if continued services are needed.

3. **Beneficiary has documentation of a mental, behavioral health, serious emotional disturbance, or psychotic condition diagnosis, which necessitates a CoCM intervention.**

   ☐ **Yes.**

   ☐ **No.** Note: This review will go to a Clinical Reviewer for a comprehensive review.

4. **Beneficiary has made progress towards CoCM outcome goals as outlined in the Plan of Care.**

   ☐ **Yes.** Note: By selecting yes, the provider is attesting that continued progress is anticipated and CoCM outcome goals have not yet been met. **Skip to Question 5.**

   ☐ **No. Please answer question 4.a. below.**

4.a. If you answered "No" above, have interventions been implemented, and/or treatment adjustments been made in the plan of care?

☐ **Yes.**

☐ **No.** Note: This review will go to a Clinical Reviewer for a comprehensive review.

5. Beneficiaries' progress has been tracked and documented utilizing a validated clinical rating scale.

☐ **Yes. Please answer Question 5.a. below.**

☐ **No. Skip to affirmations.** Note: This review will go to a Clinical Reviewer for a comprehensive review.

5.a. Please indicate what clinical rating scale was utilized to document baseline measure and re-evaluation scores:

☐ **PHQ 9**

☐ **GAD7**

☐ **Other (Please enter)** ☐

AFFIRMATION - Please affirm and acknowledge below:

☐ I AFFIRM that the submitted clinical documentation supports the requested CoCM service and are medically necessary and consistent with CMS and/or DHCF requirements.

☐ I ACKNOWLEDGE the services are subject to post payment review of medical necessity and completeness of documentation according to Medicaid program rules and that the DHCF may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules.

☐ I ACKNOWLEDGE that approval of this authorization request does not guarantee payment. Payment is based on eligibility at the time of services.

TREATING PROVIDER SIGNATURE: _____