IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201906 FEBRUARY 12, 2019

IHCP establishes PA request and assessment forms for residential and inpatient SUD treatment

Effective March 15, 2019, the Indiana Health Coverage Programs (IHCP) will require providers to use three new forms when requesting prior authorization (PA) for inpatient and residential treatment for substance use disorder (SUD). This requirement will apply to services rendered under both the fee-for-service (FFS) and the managed care delivery systems. The three new forms required are as follows:

- *Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form* – This form must be used to request PA for inpatient and residential SUD treatment services, rather than using the standard universal PA request form.
- *Initial Assessment Form for Substance Use Disorder Treatment Admission* – This assessment form must be completed and submitted as an attachment to the SUD residential and inpatient treatment PA request form for initial admissions.
- *Reassessment Form for Continued Substance Use Disorder Treatment* – This assessment form must be completed and submitted for requests to extend authorization for residential and inpatient SUD treatment.

The three new forms are attached to this bulletin for reference and are also accessible from the *Forms* page of the provider website at in.gov/medicaid/providers. Providers can begin to use these forms immediately. Use of these forms will be *required* for residential and inpatient SUD treatment PA requests submitted on or after March 15, 2019.

The IHCP will update the Provider Healthcare Portal (Portal) in the near future to allow electronic submission of these PA requests for FFS members. Until these enhancements are made, all requests and assessments for residential or inpatient SUD treatment must be submitted on paper via **fax**. PA requests for FFS members should be directed to Cooperative Managed Care Services (CMCS). PA requests for managed care members should be directed to the managed care entity (MCE) with which the member is enrolled. Watch future IHCP publications to learn when Portal updates have been made.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

TO PRINT

A printer-friendly version of this publication, in black and white and without photos, is available for your convenience.

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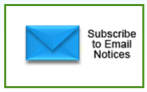

Indiana Health Coverage Programs
Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form

Please use this form and its associated attachment if you have a 3.1 or 3.5 American Society of Addiction Medicine (ASAM) residential designation or are an inpatient psychiatric facility/hospital.

Check the radio button of the entity that must authorize the service based on the member's enrollment/ benefits.

Fee-for-Service	○ **Cooperative Managed Care Services (CMCS)**	**P: 1-800-269-5720**	**F: 1-800-689-2759**
Hoosier Healthwise	○ **Anthem Hoosier Healthwise**	**P: 1-866-408-6132**	**F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229**
	○ **Anthem Hoosier Healthwise – SFHN**	**P: 1-800-291-4140**	**F: 1-800-747-3693**
	○ **CareSource Hoosier Healthwise**	**P: 1-844-607-2831**	**F: 1-844-432-8924**
	○ **MDwise Hoosier Healthwise**	**P: 1-888-961-3100**	**F: 1-888-465-5581**
	○ **MHS Hoosier Healthwise**	**P: 1-877-647-4848**	**F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649**
Healthy Indiana Plan (HIP)	○ **Anthem HIP**	**P: 1-844-533-1995**	**F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229**
	○ **CareSource HIP**	**P: 1-844-607-2831**	**F: 1-844-432-8924**
	○ **MDwise HIP**	**P: 1-888-961-3100**	**F: 1-866-613-1642**
	○ **MHS HIP**	**P: 1-877-647-4848**	**F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649**
Hoosier Care Connect	○ **Anthem Hoosier Care Connect**	**P: 1-844-284-1798**	**F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229**
	○ **MHS Hoosier Care Connect**	**P: 1-877-647-4848**	**F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649**

Please complete all appropriate fields.

Patient Information
IHCP Member ID (RID):
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:
Ordering, Prescribing, or Referring (OPR) Provider Information
OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		**Dx2**		**Dx3**	

Requesting Provider Information
Requesting Provider NPI:
Taxonomy:
Tax ID:
Provider Name:
Rendering Provider Information
Rendering Provider NPI:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:
Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:

☐ Inpatient ☐ Residential

Dates of Service Start	**Stop**	**Procedure/ Service Codes**	**Modifiers**		**Service Description**	**Taxonomy**	**Place of Service (POS)**	**Units**	**Dollars**

Notes:

Mandatory Additional Documentation Checklist

☐ *Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission*	☐ Intake assessment	☐ Clinical assessment	☐ Psychosocial assessment	☐ Treatment goals and plans

Signature of Qualified Practitioner _____ Date: _____

Indiana Health Coverage Programs

Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission

PLEASE TYPE INFORMATION INTO THIS FORM.
Fax form to the appropriate entity along with the Residential/Inpatient SUD PA Request Form.
Supporting clinical information must also be submitted. See checklist for mandatory additional documentation.

MEMBER INFORMATION	
Member Name:	
IHCP Member ID:	Date of Birth:

ESTIMATED TREATMENT DURATION	
SERVICE START DATE:	
ESTIMATED LENGTH OF STAY:	

ICD-10 DIAGNOSIS CODE(S) (Enter the ICD-10 diagnosis code for the primary diagnosis in slot 1; then enter any applicable co-occurring diagnosis codes.)		
1.	3.	5.
2.	4.	6.

SUBSTANCE USE DISORDER TREATMENT HISTORY
(Attach additional documentation as needed.)

Prior Treatment	Duration	Approximate Dates	Outcome

SUBSTANCES OF CHOICE
(Complete the fields below. If substances are unknown, select **Unable to Obtain.**)

Unable to Obtain ☐

Substance	Age at First Use	Date of Last Use	Frequency of Use	Amount

Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission

REQUESTED TREATMENT LEVEL				
	Treatment Level Description	**ASAM Level**	**Codes**	**Units (One Unit = One Day)**
○	Clinically Managed Low-Intensity Residential Services (Adult)	3.1	H2034 U1	
○	Clinically Managed Low-Intensity Residential Services (Adolescent)	3.1	H2034 U2	
○	Clinically Managed High Intensity Residential Services (Adult)	3.5	H0010 U1	
○	Clinically Managed Medium Intensity (Adolescent)	3.5	H0010 U2	
○	Medically Managed Inpatient Services (Adult)	4.0	Inpatient Billing	
○	Medically Managed Inpatient Services (Adolescent)	4.0	Inpatient Billing	

For inpatient psychiatric facilities/hospitals, please provide your prior authorization revenue code below.

ASSESSMENT (Make one selection for each dimension.)	
DIMENSION 1 | Acute Intoxication and/or Withdrawal Potential	
○	No withdrawal
○	Minimal risk of severe withdrawal
○	Moderate risk of severe withdrawal
○	No withdrawal risk, or minimal or stable withdrawal
○	At minimal risk of severe withdrawal
○	Patient has the potential for life threatening withdrawal
○	Patient has life threatening withdrawal symptoms, possible or experiencing seizures or delirium tremens (DTs) or other adverse reactions are imminent

DIMENSION 2 | Biomedical Conditions/Complications	
○	None or not sufficient to distract from treatment
○	None/stable or receiving concurrent treatment – moderate stability
○	Require 24-hour medical monitoring, but not intensive treatment
○	Severe instability requires 24-hour medical care in licensed medical facility. May be the result of life threatening withdrawal or other co-morbidity

DIMENSION 3 | Emotional/Behavioral/Cognitive Conditions	
○	None or very stable
○	Mild severity, with potential to distract from recovery; needs monitoring
○	Mild to moderate severity; with potential to distract from recovery; needs to stabilize
○	None or minimal; not distracting to recovery
○	Mild to moderate severity; needs structure to focus on recovery
○	Demonstrates repeated inability to control impulses, or unstable with symptoms requiring stabilization
○	Moderate severity needs 24-hour structured setting
○	Severely unstable requires 24-hour psychiatric care

Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission

	DIMENSION 4 | Readiness to Change
○	Readiness for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment almost daily to promote change
○	Open to recovery but requires structured environment
○	Has little awareness of need for change due to cognitive limitations and addiction and requires interventions to engage to stay in treatment
○	Has marked difficulty with treatment or opposition due to functional issues or ongoing dangerous consequences
○	Poor impulse control, continues to use substances despite severe negative consequences (medical, physical or situational) and requires a 24-hour structured setting

	DIMENSION 5 | Relapse, Continued Use, or Continued Problem Potential
○	Minimal support required to control use, needs support to change behaviors
○	High likelihood of relapse/continued use or addictive behaviors, requires services several times per week
○	Intensification of addiction and/or mental health issues and has not responded to active treatment provided in a lower levels of care. High likelihood of relapse, requires treatment almost daily to promote change
○	Understands relapse but needs structure
○	Has little awareness of need for change due to cognitive limitations and addiction and requires interventions to engage to stay in treatment
○	Does not recognize the severity of treatment issues, has cognitive and functional deficits
○	Unable to control use, requires 24-hour supervision, imminent dangerous consequences

	DIMENSION 6 | Recovery/Living Environment
○	Supportive recovery environment and patient has skills to cope with stressors
○	Not a fully supportive environment but patient has some skills to cope
○	Not a supportive environment but can find outside supportive environment
○	Environment is dangerous, patient needs 24-hour structure to learn to cope
○	Environment is imminently dangerous, patient lacks skills to cope outside of a highly structured environment

SIGNATURE OF PHYSICIAN/HSPP	
Name (print):	
Signature of Physician/HSPP:	**Date:**

Mandatory Additional Documentation Checklist

☐ Intake assessment	☐ Clinical assessment	☐ Psychosocial assessment	☐ Treatment plan/goals

PLEASE FAX FORM and the mandatory additional documentation with the Residential/Inpatient SUD Prior Authorization Request Form TO THE APPROPRIATE ENTITY.

Indiana Health Coverage Programs

Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

PLEASE TYPE INFORMATION INTO THIS FORM.
Fax form to the appropriate entity.
Supporting clinical information must also be submitted.

MEMBER INFORMATION	
Member Name:	
IHCP Member ID:	Date of Birth:

CONTINUED TREATMENT DURATION	
Existing Service Authorization Number (PA Number):	
Requested End Date of Extension:	

ICD-10 DIAGNOSIS CODE(S) (Enter the ICD-10 diagnosis code for the primary diagnosis in slot 1; then enter any applicable co-occurring diagnosis codes.)		
1.	3.	5.
2.	4.	6.

MEDICATION

Please list ALL medications prescribed by the SUD treatment provider, such as a buprenorphine product. Include type, dosage, frequency, start date, patient's response, and prescriber below (**OR ATTACH MEDICATION LIST**).

N/A ☐ Medication List Attached ☐

Name of Medication	Type/Dosage/Frequency	Start Date	Patient's Response	Prescriber

REQUESTED TREATMENT LEVEL

	Treatment Level Description	ASAM Level	Codes	Units (One Unit = One Day)
○	Clinically Managed Low-Intensity Residential Services (Adult)	3.1	H2034 U1	
○	Clinically Managed Low-Intensity Residential Services (Adolescent)	3.1	H2034 U2	
○	Clinically Managed High Intensity Residential Services (Adult)	3.5	H0010 U1	
○	Clinically Managed Medium Intensity (Adolescent)	3.5	H0010 U2	
○	Medically Managed Inpatient Services (Adult)	4.0	Inpatient Billing	
○	Medically Managed Inpatient Services (Adolescent)	4.0	Inpatient Billing	

For inpatient psychiatric facilities/hospitals, please provide your prior authorization revenue code below.

Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

ASSESSMENT (Make one selection for each dimension.)	
DIMENSION 1 | Acute Intoxication and/or Withdrawal Potential	
○	No withdrawal
○	Minimal risk of severe withdrawal
○	Moderate risk of severe withdrawal
○	No withdrawal risk, or minimal or stable withdrawal
○	At minimal risk of severe withdrawal
○	Patient has the potential for life threatening withdrawal
○	Patient has life threatening withdrawal symptoms, possible or experiencing seizures or delirium tremens (DTs) or other adverse reactions are imminent

DIMENSION 2 | Biomedical Conditions/Complications	
○	None or not sufficient to distract from treatment
○	None/stable or receiving concurrent treatment – moderate stability
○	Require 24-hour medical monitoring, but not intensive treatment
○	Severe instability requires 24-hour medical care in licensed medical facility. May be the result of life threatening withdrawal or other co-morbidity

DIMENSION 3 | Emotional/Behavioral/Cognitive Conditions	
○	None or very stable
○	Mild severity, with potential to distract from recovery; needs monitoring
○	Mild to moderate severity with potential to distract from recovery; needs to stabilize
○	None or minimal; not distracting to recovery
○	Mild to moderate severity; needs structure to focus on recovery
○	Demonstrates repeated inability to control impulses, or unstable with symptoms requiring stabilization
○	Moderate severity needs 24-hour structured setting
○	Severely unstable requires 24-hour psychiatric care

DIMENSION 4 | Readiness to Change	
○	Readiness for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment almost daily to promote change
○	Open to recovery but requires structured environment
○	Has little awareness of need for change due to cognitive limitations and addiction and requires interventions to engage to stay in treatment
○	Has marked difficulty with treatment or opposition due to functional issues or ongoing dangerous consequences
○	Poor impulse control, continues to use substances despite severe negative consequences (medical, physical or situational) and requires a 24-hour structured setting

Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

**DIMENSION 5	** Relapse, Continued Use or Continued Problem Potential	
○	Minimal support required to control use, needs support to change behaviors
○	High likelihood of relapse/continued use or addictive behaviors, requires services several times per week
○	Intensification of addiction and/or mental health issues and has not responded to active treatment provided in a lower levels of care. High likelihood of relapse, requires treatment almost daily to promote change
○	Understands relapse but needs structure
○	Has little awareness of need for change due to cognitive limitations and addiction and requires interventions to engage to stay in treatment
○	Does not recognize the severity of treatment issues, has cognitive and functional deficits
○	Unable to control use, requires 24-hour supervision, imminent dangerous consequences

**DIMENSION 6	** Recovery/Living Environment	
○	Supportive recovery environment and patient has skills to cope with stressors
○	Not a fully supportive environment but patient has some skills to cope
○	Not a supportive environment but can find outside supportive environment
○	Environment is dangerous, patient needs 24-hour structure to learn to cope
○	Environment is imminently dangerous, patient lacks skills to cope outside of a highly structured environment

DOCUMENT THE FOLLOWING IN THE BOXES BELOW OR ATTACH A SUMMARY PAGE. SUPPORTING CLINIAL INFORMATION MAY BE ATTACHED TO THIS FORM.

1. Describe how the member is progressing under the current treatment plan, including the member's engagement in treatment.

2. Document the revised treatment plan and goals.

Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

3. Document the discharge plan/disposition. Include discharge level of treatment, agency name, and any coordination that has been done with the transition provider. A full, comprehensive discharge plan is required to complete this service request. For members with an opioid use disorder, please describe the discharge plan for medication assisted treatment (MAT), including scheduling appointments with outpatient MAT providers.

SIGNATURE OF SIGNATURE OF PHYSICIAN/HSPP	
Name (print):	
Signature of physician/HSPP:	**Date:**

PLEASE FAX FORM and any supporting documentation TO THE APPROPRIATE ENTITY.