

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.

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ASSESSMENT (Make one selection for each dimension.)	
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DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	
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	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	
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	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	
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	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	
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	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

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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.

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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/HSP

Name (print):

Signature of physician/HSP:

Date:

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