

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

<i>Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission</i>	Intake assessment	Clinical assessment	Psychosocial assessment	Treatment goals and plans
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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
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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	
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Medically Managed Inpatient Services (Adult)	4.0	Inpatient Billing	
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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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	No withdrawal
	Minimal risk of severe withdrawal
	Moderate risk of severe withdrawal
	No withdrawal risk, or minimal or stable withdrawal
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DIMENSION 2 Biomedical Conditions/Complications	
	None or not sufficient to distract from treatment
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	Require 24-hour medical monitoring, but not intensive treatment
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Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

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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.