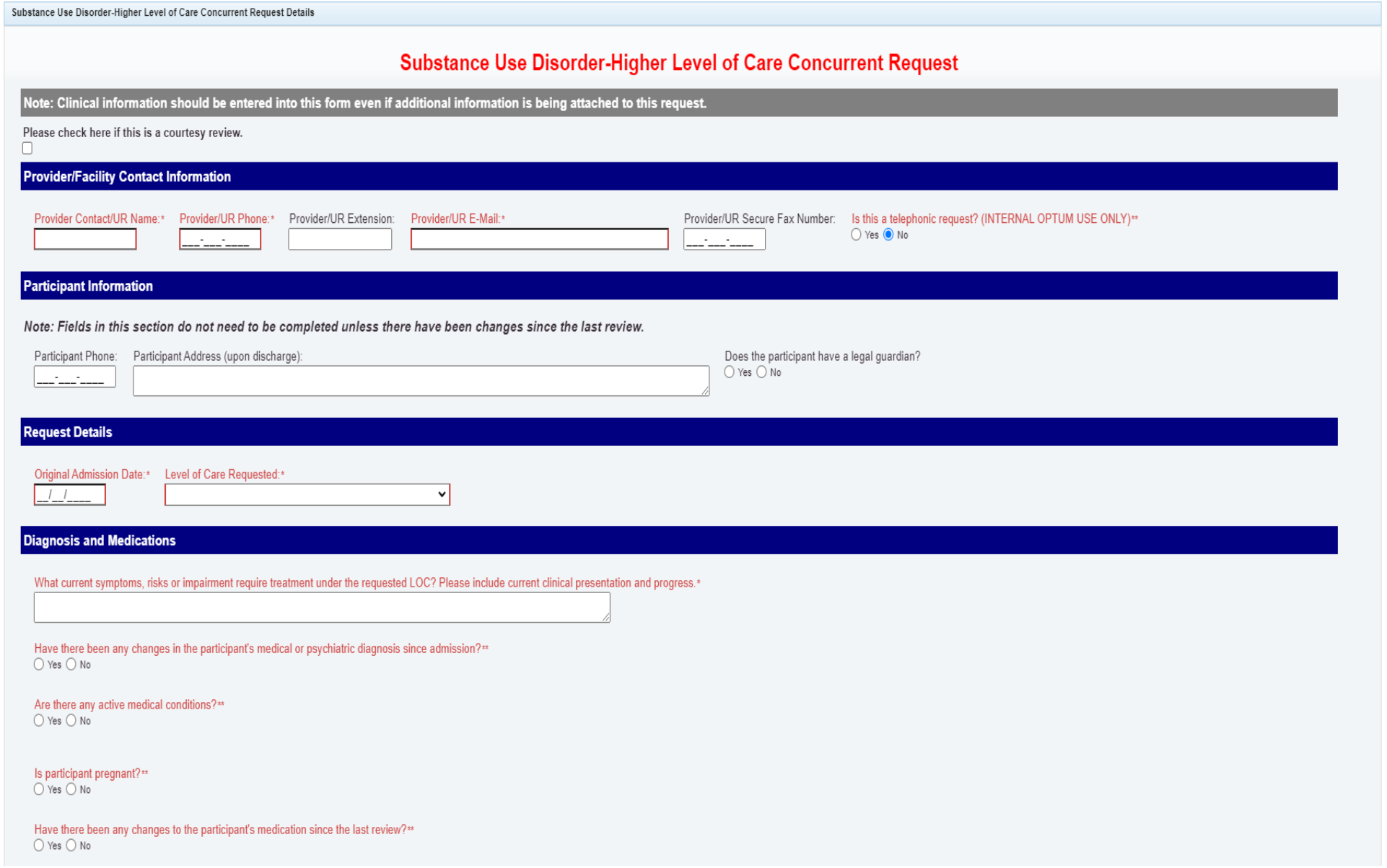
Substance Use Disorder – Higher Level of Care Concurrent Request



Substance Use Disorder-Higher Level of Care Concurrent Request Details

Substance Use Disorder-Higher Level of Care Concurrent Request

Note: Clinical information should be entered into this form even if additional information is being attached to this request.

Please check here if this is a courtesy review.

☐

Provider/Facility Contact Information

Provider Contact/UR Name:* | Provider/UR Phone:* (___-___-____) | Provider/UR Extension: | Provider/UR E-Mail:* | Provider/UR Secure Fax Number: (___-___-____) | Is this a telephonic request? (INTERNAL OPTUM USE ONLY)** ○ Yes ◉ No

Participant Information

Note: Fields in this section do not need to be completed unless there have been changes since the last review.

Participant Phone: (___-___-____) | Participant Address (upon discharge): | Does the participant have a legal guardian? ○ Yes ○ No

Request Details

Original Admission Date:* (__/__/____) | Level of Care Requested:*

Diagnosis and Medications

What current symptoms, risks or impairment require treatment under the requested LOC? Please include current clinical presentation and progress.*

Have there been any changes in the participant's medical or psychiatric diagnosis since admission?** ○ Yes ○ No

Are there any active medical conditions?** ○ Yes ○ No

Is participant pregnant?** ○ Yes ○ No

Have there been any changes to the participant's medication since the last review?** ○ Yes ○ No

Are there any barriers/issues related to the medication regimen?**
Yes No

Substance Use Information

Current Vitals:*

Current vitals within normal limits?**
Yes No Not Applicable

Was a urine drug screen (UDS) completed?**
Yes No

Blood Alcohol Level:

Any history of medically-treated withdrawal seizures or DT's?**
Yes No

Is participant currently receiving Medication Assisted Treatment (e.g. Vivitrol, Naltrexone, Methadone)?**
Yes No

Opioid Use Disorder Diagnosis?**
Yes No

Has MAT been tried in the past?**
Yes No

Primary Care Physician (include name and contact information):

Outpatient Mental Health Provider (include name and contact information):

Substances

Primary Substance

Primary Substance of Use*

Route of Administration:*

Frequency of Use:*

Date of Last Use:* __/__/____

Age at First Use:*

Additional Substances?**
Yes No

ASAM Dimension Risk Ratings

Dimension 1-Acute Intoxication and/or Withdrawal

Dimension 1 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 1 (include CIWA or COWS, if applicable):*

Dimension 2-Biomedical Conditions and Complications

Dimension 2 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 2:*

Dimension 3-Emotional, Behavioral or Cognitive Conditions and Complications

Dimension 3 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 3:*

Dimension 4-Readiness to Change

Dimension 4 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 4:*

Dimension 5-Relapse, Continued Use or Continued Problem Potential

Dimension 5 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 5:*

Dimension 6-Recovery/Living Environment Risk

Dimension 6 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 6:*

Recovery/Discharge Plan

What specific actions or treatment are planned to address the acute symptoms or behaviors?*

Facility planned discharge level of care:*

Estimated Length of Stay (ELOS)/number of days:*

Discharge Plan:*

Barriers to discharge and plans to address them to promote sustained recovery:*

Please provide any relevant information not otherwise discussed that is important for the review of this case?

Confirmation & Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

I attest all of the information provided is accurate and reflected in the participant's medical record.*

☐

Important:

1) When this form is saved a pop-up box will appear regarding an additional form being recommended.

2) Click Continue to move to the next form, DO NOT click Decline.

3) Do NOT click Cancel or the "X" on the top right of the screen before completing the Data Capture form.

4) After completing the Data Capture form, click Save and you will be returned to the authorization screen.

Data Capture Required:

◉ Yes