

Substance Use Disorder – Higher Level of Care Initial 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

Precipitant for Admission

What was the primary precipitant/circumstances that led to this admission?*

Provide additional detail about the specific event leading to this treatment episode:*

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

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