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.)	
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

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

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