Ohio | Department of Medicaid

SUD Prior Authorization (PA) Request Form Training

July 29, 2021

Agenda

1 | Form overview and completion guidance

2 | Summary of submission methods

3 | Best practices and example form submissions
- Presented by provider and plan representatives

Form overview and completion guidance

Form overview and completion guidance

The SUD PA request form will be used to request authorization of treatment stays for SUD services (residential and partial hospitalization)

It was developed by a workgroup including providers, stakeholders, and managed care organizations (MCOs)

The PA Form Pilot Program was conducted from March 1, 2021 - April 30, 2021, and included 7 payers and 12 providers

Once rolled out statewide, the form will be optional, but strongly encouraged, for providers

Goals of the SUD PA request form

- Improve/support adherence to ASAM Criteria
- Increase consistency in the prior authorization process
- Standardize documentation required and align with MHAS documentation requirements
- Minimize administrative burden
- Ensure patient perspective is considered

The SUD PA request form is available on the Medicaid Forms page and at the link below:
https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10276Fillx.pdf

Ohio Department of Medicaid

Substance Use Disorder Services Prior Authorization Request

Instructions

This request form is for use by providers of substance use disorder (SUD) treatment services requiring prior authorization in accordance with Ohio Administrative Code (OAC) rule 5160-27-09.

1. Complete Sections I through VII of this form entirely *(as applicable)*.
2. Submit both of the following with this form, unless previously submitted:
   - ☐ A copy of the most recent initial or comprehensive assessment in accordance with OAC 5122-29-03
   - ☐ A copy of the most recent individualized treatment plan (ITP) in accordance with OAC 5122-27-03
3. Requests should be submitted in sufficient time to ensure authorization is received prior to rendering services requiring authorization.

Managed care plans must process prior authorization requests in accordance with OAC rule 5160-26-03.1 and the Medicaid Managed Care Plan (MCP) or MyCare Ohio Plan (MCOP) provider agreement.

Section I: Member Information

Plan ☐ Medicaid MCP ☐ MyCare ☐ Fee for Service (FFS)	Date of Request

Authorization Request Type

☐ Initial *(The first prior authorization request per admission, in accordance with paragraph (F) of OAC 5160-27-09)*

☐ Continued Stay *(A request for additional days/units beyond those previously authorized)*

Member Name	Date of Birth
Member ID Number	Member Phone

Requested Authorization Decision Type

☐ Standard *(Plan authorization decision required no later than ten calendar days after receipt)*

☐ Expedited* *(Plan authorization decision required no later than forty-eight hours after receipt)*

**Select Expedited: (1) when the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function; or (2) for all SUD residential treatment requests.*

Section II: Provider Information

Billing Provider/Agency Name	Service Location Address
Provider/Agency NPI	Provider/Agency Tax ID
Contact Name	Phone Number
Email Address	Fax Number
Practitioner's Name & Credentials	Practitioner's NPI

Network Status with Managed Care Plan, if applicable ☐ Participating ☐ Non-Participating

Section III: Authorization Request

Admission Date	Has client had two or more prior admissions to residential treatment in this calendar year *(at your agency or another agency, if known)*?	
Number of Days/Units Requested	Requested Authorization Start Date	Requested Authorization End Date

Service Requested

☐ Partial Hospitalization ASAM 2.5 (H0015 TG)

☐ Clinically Managed Low Intensity Residential ASAM 3.1 (H2034)

☐ Clinically Managed Population-Specific High Intensity Residential (Adults) ASAM 3.3 (H2036 HI)

☐ Clinically Managed High-Intensity Residential ASAM 3.5 (H2036)

☐ Medically Monitored Intensive Inpatient Treatment (Adults) ASAM 3.7 (H2036 TG)

☐ Medically Monitored High-Intensity Inpatient Treatment (Adolescents) ASAM 3.7 (H2036 TG)

Enter ICD-10 diagnosis code with specifiers for the primary diagnosis in box 1. below, then enter any applicable co-occurring diagnosis codes.

1.	2.	3.
4.	5	6.

Section IV: Medications

Enter medications *(including dosage, frequency, and form, as applicable)* or attach list. Include prescribed, over the counter, vitamins, or dietary supplements. If previously provided, note changes or additions only.

Section V: Client Perspective on Progress & Continued Needs

Provide a summary of the client's perspective on progress and continued needs. For adolescents, include family/caregiver perspective on progress and continued needs, as applicable.

Describe how the requested service will benefit the client.

Section VI: American Society of Addiction Medicine (ASAM) Criteria[i] Summary of Dimension Ratings

Summary of ASAM dimension ratings should be completed to the extent necessary to support the requested service.

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Risk Rating: Choose a rating

Potential Withdrawal

- ☐ Unstable vital signs in active withdrawal
- ☐ Level and duration of use would indicate potential withdrawal
- ☐ Client verbalizing possible withdrawal symptoms
- ☐ Results of toxicology screening

Potential Intoxication if client is not in a secure setting

- ☐ Craving
- ☐ Post-acute withdrawal (continuing episodic periods of intense anxiety and craving)
- ☐ Ambivalent about stopping use

Additional rating explanation *(if applicable)*

Dimension 2: Biomedical Conditions and/or Complication (BMC/C)

Risk Rating: Choose a rating

Complicating medical condition: diagnosis or complaint:

☐ Unstable ☐ Stable	☐ Under a Medical Provider's care ☐ Not under a Medical Provider's care	☐ Other

Additional rating explanation *(if applicable)*

Dimension 3: Emotional/ Behavioral/ Cognitive Conditions and/or Complications (EBC/C)

Risk Rating: Choose a rating

Coping Skills

- ☐ Unable to respond without regression to:
  - ☐ mild stressors
  - ☐ moderate stressors
  - ☐ severe stressors
- ☐ Impulse driven, limited ability to utilize external supports

Problem Solving

- ☐ Continues to react rather than developing an appropriate action plan
- ☐ Problem solving is ineffective, immature, reactionary

Cognitive Functioning

- ☐ Difficulty processing information in a manner that prevents him/her from using the information effectively and
- ☐ Negatively impacts the implementation of new skills of daily living

Behavioral

- ☐ Individual is currently engaged in active substance use
- ☐ Poor and difficult engagement with external supports

Mental health diagnosis or complaint

- ☐ Mental health condition unstable
- ☐ Mental health condition stable
- ☐ Mental health condition under clinical care
- ☐ Other mental health condition:

- ☐ Psychological, emotional, or physical trauma history or issues including Adverse Childhood Experiences (ACES) are interfering with daily life
- ☐ Suicidal/homicidal behavioral and/or ideation

Additional rating explanation *(if applicable)*

Dimension 4: Readiness to Change

Risk Rating: Choose a rating

- ☐ Client was a self-referral
- ☐ Client was referred by _____ and is responsive to their input/direction
- ☐ Client's motivation to change is internal
- ☐ Client's motivation to change is external
- ☐ Client is in the _____ Stage of Change for _____
- ☐ Client is attending treatment but marginally engaged
- ☐ Client's attendance is intermittent / inconsistent
- ☐ Client is attending and participating in all activities, is benefiting but still struggles with changes
- ☐ Client is fully engaged and continues to improve

Additional rating explanation *(if applicable)*

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Risk Rating: Choose a rating

- ☐ Scores/conditions noted in Dimensions 1,3,4, and 6 indicate a high probability of relapse if not stabilized
- ☐ Client continues to experience post-acute withdrawal,including but not limited to episodes of intense craving, anxiety and agitation
- ☐ Client continues to engage in relapse behaviors even though he/she has not yet returned to use
- ☐ Client's relapse prevention plan is simplistic, too vague, or the client's commitment to the plan indicate a poor prognosis
- ☐ Client does not evidence the skills/understanding toeffectively follow/utilize the relapse prevention plan

Additional rating explanation *(if applicable)*

Dimension 6: Recovery/Living Environment

Risk Rating: Choose a rating

- ☐ The client's family *(includes significant others and parents)* is *(select one)*:
  - ☐ not supportive or
  - ☐ actively sabotaging of the client's efforts
- ☐ Client is engaged in interpersonal relationships with persons in active substance use
- ☐ The client does not have safe and sober housing. Client's current living situation is with persons in active substance use.
- ☐ Does not have transportation to continue engagement in recovery and to support employment
- ☐ Client lacks regimentation and requires a structure environment to continue recovery
- ☐ Client is not employed or engaged in education /training
- ☐ Client does not have resources for childcare
- ☐ Client is not engaged in a sober support group and/or sober support

Has not engaged in nor have scheduled continuation in:

- ☐ Mental health counseling
- ☐ Family counseling
- ☐ Aftercare or the next level of care in their treatment

Additional rating explanation *(if applicable)*

Section VII: Request for Continuing Services

Complete this section when

- This is an *initial* request for a client who is currently in residential treatment (i.e., client is in the initial 30 days of the first or second admission in a calendar year) and this request is for residential treatment beyond the initial 30 consecutive days; or
- This is a *continued stay* request.

Request is based on one of the following

☐ The patient is making progress, but has not yet achieved the treatment goals articulated in ITP

☐ The patient is not making progress or is making some progress, but has the capacity and is actively working toward the treatment goals articulated in the ITP

☐ A new problem has been identified that is appropriately treated at the present level of care

Additional explanation *(if applicable)*

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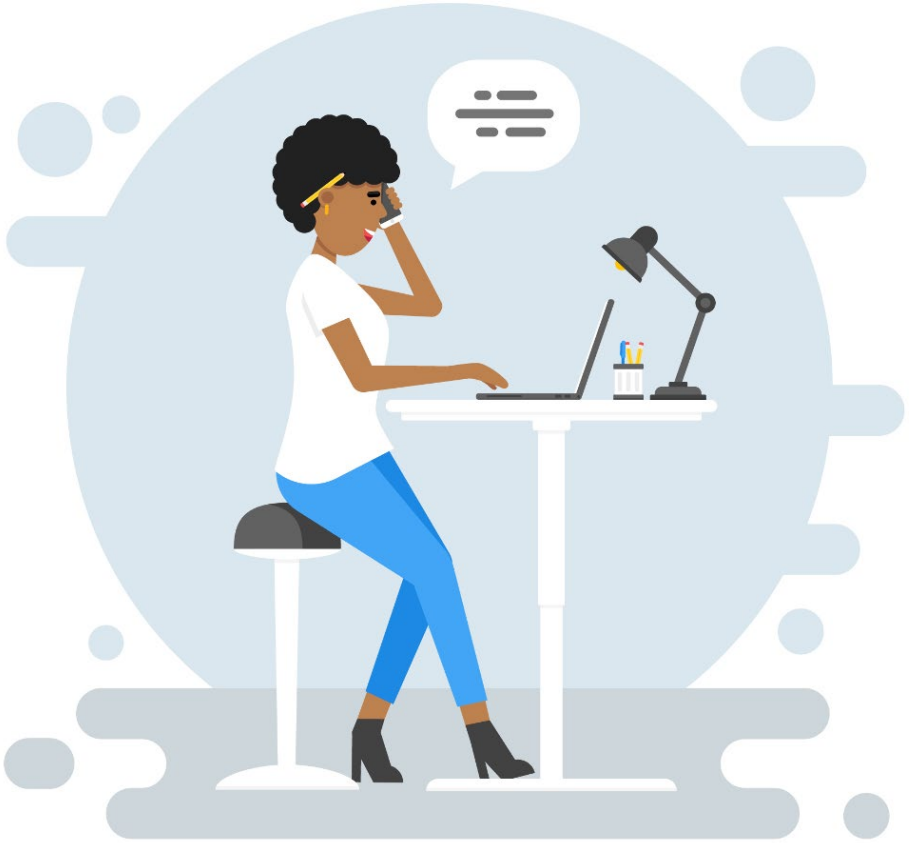
[i] *Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright 2013 by the American Society of Addiction Medicine*

Substance Use Disorder Prior Authorization Request Form Additional Guidance

Additional Guidance/Notes
Documentation: Supporting clinical documentation is required to be submitted with the Substance Use Disorder (SUD) Services Prior Authorization Form, as described in item 2. in the *Instructions* section. Information submitted with this request should reflect the current clinical status at the time of the request, including the individualized treatment plan (ITP) that covers the time period of the services being requested. Medication information requested in *Section IV* should include current medications. If an assessment has already been submitted with a prior request and there have been no changes there is no need to resubmit the documentation with the subsequent request. **Other Insurance:** This form is for use by Medicaid Managed Care Plans (MCPs), MyCare Ohio Plans (MCOP), and Fee-for-Service (FFS) Medicaid. Providers should verify primary insurance prior to submission. Other insurance prior authorization requirements or policies may apply and should be followed prior to submitting a request to a Medicaid MCP, MCOP, or FFS. **Expedited Requests**: All requests for SUD residential services are required to be processed as expedited (no later than 48 hours) in accordance with MCP and MCOP contract requirements; however, providers should indicate situations that require an expeditious decision due to the member's health condition. In these instances, the MCP or MCOP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires, but no later than forty-eight hours after receipt of the request for service. **Prior Admission to Residential Treatment:** OAC 5160-27-09 requires prior authorization for residential stays that continue beyond the thirty days for the first or second residential stay in the same calendar year. Third and subsequent residential admissions during the same calendar year must be prior authorized from the first day of admission. Providers are expected to make a good faith effort to determine if a client has had prior admissions to residential treatment. In addition to requesting information directly from the client regarding prior stays, providers can contact managed care plans to verify if prior residential stays have occurred within the calendar year and to confirm if/when prior authorization is required. Requirements of 42CFR Part 2 may apply. **Client Perspective on Progress & Continued Needs:** *Section V* allows for a summary of the client's perspective on progress and continued needs to support the request for services. This section should be completed as appropriate based on client input and preferences. This section can also be used to indicate the client's level of involvement in the development of the treatment plan. The description of how the requested services will benefit the client should include how the provider is assisting the client towards progress. This section may include information such as precipitating events, drug history, or scope and severity of use that may be helpful in describing how the requested services will benefit the client. **Summary of Dimension Ratings:** *Section VI* includes checkboxes as well as additional rating explanation fields to allow providers to include narrative to support the request for services. This section is intended to be a summary to support prior authorization requests. This does not take the place of otherwise required clinical documentation. **Request for Continuing Services:** *Section VII* should be used for all initial requests for clients who are currently in residential treatment (i.e., requests for residential treatment beyond the first 30 days), and for continued stay requests (i.e., requests for additional days beyond those previously authorized). Provider should include information related to client progress, or lack thereof, towards successful completion of goals, and any summarize interventions the provider is using to assist the member in making progress in their course of treatment. Progress changes or new problems necessitating an update to the ITP should be described in the narrative and supported by the attached updated ITP.

Summary of submission methods



Summary of submission methods for providers

	aetna	buckeye health plan	CareSource	MOLINA HEALTHCARE	PARAMOUNT ADVANTAGE Affiliate of ProMedica	UnitedHealthcare COMMUNITY & STATE	permedion an HMS company
Secure online portal	✓	✓	✓	✓	✓	✓	✓
Phone	✓	✓	✓			✓	
Fax	✓	✓	✓	✓	✓	✓	
Mail			✓				

A comprehensive list of submission methods and contact information is available in the [Medicaid Managed Care Plan Resource Guide Information Grid]

Best practices and example form submissions

SUD PA request form best practices

Wendy Banas, Chief Operating Officer, The LCADA Way

Providers should use the SUD PA request form to:

Justify medical necessity of requested services

- Narrative boxes allow providers to explain what they feel will happen to a patient if they don't receive the requested services
- Make sure to complete all checkboxes and add additional narrative to explain medical necessity

Demonstrate patients' progress through weekly accomplishments

- Record details of patient progress to justify the need for continued services

SUD PA request form best practices

Tracey Izzard, Executive Director, Optumhealth Behavioral Solutions | UHC Community Plan

Providers should use the SUD PA request form to:

Complete all checkboxes and use narrative boxes to add additional information (e.g., patient history)

Streamline information and eliminate the need for additional paperwork

- When used correctly, the form provides all the information plans need

The SUD PA request form improves the process by:

Reducing or eliminating the need for follow up questions

Expediting the PA request process

Enabling plans to respond to PA requests more quickly

- Less paperwork to review

Substance Use Disorder Services PILOT Prior Authorization Request Form

Instructions
This request form is for use by providers of substance use disorder (SUD) treatment services requiring prior authorization in accordance with Ohio Administrative Code (OAC) rule 5160-27-09. 1. Complete Sections I through VII of this form entirely (as applicable). 2. Submit both of the following with this form, unless previously submitted: ☐ A copy of the most recent initial or comprehensive assessment in accordance with OAC 5122-29-03 ☐ A copy of the most recent individualized treatment plan (ITP) in accordance with OAC 5122-27-03 3. Requests should be submitted in sufficient time to ensure authorization is received prior to rendering services requiring authorization. Managed care plans must process prior authorization requests in accordance with OAC rule 5160-26-03.1 and the Medicaid Managed Care Plan (MCP) or MyCare Ohio Plan (MCOP) provider agreement.

Section I: Member Information	
Plan: X Medicaid MCP ☐ MyCare ☐ Fee for Service (FFS)	**Date of Request:** /2021
Authorization Request Type: ☐ Initial *(The first prior authorization request per admission, in accordance with paragraph (F) of OAC 5160-27-09)* ☐ Continued Stay *(A request for additional days/units beyond those previously authorized)*	
Member Name:	**Date of Birth:**
Member ID Number:	**Member Phone:**
Requested Authorization Decision Type: ☐ Standard *(Plan authorization decision required no later than ten calendar days after receipt)* ☒ Expedited* *(Plan authorization decision required no later than forty-eight hours after receipt)* **Select Expedited: (1) when the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function; or (2) for all SUD residential treatment requests.*	

Section II: Provider Information	
Billing Provider/Agency Name:	**Service Location Address:**
Provider/Agency NPI:	**Provider/Agency Tax ID:**
Contact Name:	**Phone Number:**
Email Address:	**Fax Number:**
Practitioner's Name & Credentials:	**Practitioner's NPI:** Click to enter text
Network Status with Managed Care Plan, if applicable: ☒ Participating ☐ Non-Participating	

Section III: Authorization Request

Admission Date: [redacted]21	**Has client had two or more prior admissions to residential treatment in this calendar year (at your agency or another agency, if known)?** No
Number of Days/Units Requested: 14	**Requested Authorization Start Date:** [redacted]21 **Requested Authorization End Date:** [redacted]21

Service Requested:

- ☐ Partial Hospitalization ASAM 2.5 (H0015 TG)
- ☐ Clinically Managed Low Intensity Residential ASAM 3.1 (H2034)
- ☐ Clinically Managed Population-Specific High Intensity Residential (Adults) ASAM 3.3 (H2036 HI)
- X Clinically Managed High-Intensity Residential ASAM 3.5 (H2036)
- ☐ Medically Monitored Intensive Inpatient Treatment (Adults) ASAM 3.7 (H2036 TG)
- ☐ Medically Monitored High-Intensity Inpatient Treatment (Adolescents) ASAM 3.7 (H2036 TG)

Enter ICD-10 diagnosis code with specifiers for the primary diagnosis in box 1. below, then enter any applicable co-occurring diagnosis codes.

1. F11.20	2. F14.20	3. Click to enter text
4. Click to enter text	5. Click to enter text	6. Click to enter text

Section IV: Medications

Enter medications (including dosage, frequency, and form, as applicable) or attach list. Include prescribed, over the counter, vitamins, or dietary supplements. If previously provided, note changes or additions only.

Subutex 8mg/ two times daily, remeron 30mg, and zanaflex 4mg

Section V: Client Perspective on Progress & Continued Needs

Provide a summary of the client's perspective on progress and continued needs. For adolescents, include family/caregiver perspective on progress and continued needs, as applicable.

Client is in need of treatment at this level of care. Client reports that she is done with using as she has been using for quite some time. She reports that she always said that the only reason she would stop using is if she had a child. "Now I'm pregnant." Client reports that she has a boyfriend and aunt who are great support persons.

Describe how the requested service will benefit the client.

The clinical team provides SUD/MH groups, Ind MH/SUD sessions, Crisis Sessons, Life Skills Groups, psychiatric services. The counselors also provide CBT, TF-CBT, MI, identifying thinking distrotions that lead to relapsing.

Section VI: American Society of Addiction Medicine (ASAM) Criteria Summary of Dimension Ratings

Summary of ASAM dimension ratings should be completed to the extent necessary to support the requested service.

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Risk Rating: 1 = Mild

Potential Withdrawal:	**Potential intoxication if client is not in a secure setting:**
☐ Unstable vital signs in active withdrawal ☐ Level and duration of use would indicate potential withdrawal ☐ Client verbalizing possible withdrawal symptoms ☐ Results of toxicology screening	☐ Craving ☐ Post-acute withdrawal (continuing episodic periods of intense anxiety and craving) X Ambivalent about stopping use

Additional rating explanation (if applicable): Client is currently on subutex reporting that it is helping her with cravings. She reports that taking 8mg twice daily helps regulate mood.

Dimension 2: Biomedical Conditions and/or Complication (BMC/C)

Risk Rating: 2 = Moderate

Complicating medical condition: diagnosis or complaint: High-Risk Pregnancy; Chronic Pain

☐ Unstable X Stable	X Under a Medical Provider's care ☐ Not Under a Medical Provider's care	☐ Other: Click to enter text

Additional rating explanation (if applicable): Client is currently pregnant with first child and is considered high risk. Client reports that she has a slipped disc is back and has had this issue for over ten years. She reports this too plays a part in her drug use due to being in constant pain and simply wanting to be numb all around.
Update: Client's pregnancy and age has caused client to have issues with health. Client has had severe swelling in legs and feet reporting that it feels as if she will bust. Client reports constant pain daily due to this. Client reports that doctors are asking that client sit with legs elevated but client reports that this is not working for her. The medical team is asking that client remain wearing compression stockings and has offered client to lay down in between groups to help. Client has not been compliant with this.

Dimension 3: Emotional/ Behavioral/ Cognitive Conditions and/or Complications (EBC/C)

Risk Rating: 2 = Moderate

Coping Skills:	**Problem Solving:**
X Unable to respond without regression to: ☐ mild stressors X moderate stressors ☐ severe stressors X Impulse driven, limited ability to utilize external supports	X Continues to react rather than developing an appropriate action plan ☐ Problem solving is ineffective, immature, reactionary
Cognitive Functioning	**Behavioral**
X Difficulty processing information in a manner that prevents him/her from using the information effectively and ☐ Negatively impacts the implementation of new skills of daily living	☐ Individual is currently engaged in active substance use X Poor and difficult engagement with external supports

Mental health diagnosis or complaint: Client reports being diagnosed with depression some time back but is not currently prescribed medication.

☐ Mental health condition unstable X Mental health condition stable ☐ Mental health condition under clinical care ☐ Other mental health condition: Click to enter text	☐ Psychological, emotional, or physical trauma history or issues including Adverse Childhood Experiences (ACES) are interfering with daily life ☐ Suicidal/homicidal behavioral and/or ideation

Additional rating explanation (if applicable): Client's emotional state is concerning as client has a very hard time having a regular conversation as she cries through it. She avoids talking at all cost due to this. She does not seem to be open about about the possibility of taking medications that can help regulate mood due to being pregnant.
Update: Client continues to get emotional when having a conversation but is finally having one which is better than not. Client reports that she continues to have her inner battles with self but knows that she is here for a reason. Slowly but surely client is opening up.

Dimension 4: Readiness to Change

Risk Rating: 2 = Moderate

☐ Client was a self-referral X Client was referred by Courts and is responsive to their input/direction X Client's motivation to change is internal X Client's motivation to change is external X Client is in the contemplation Stage of Change for Click to enter text	X Client is attending treatment but marginally engaged ☐ Client's attendance is intermittent / inconsistent X Client is attending and participating in all activities, is benefiting but still struggles with changes ☐ Client is fully engaged and continues to improve

Additional rating explanation (if applicable): Client is currently in the early contemplation stage of treatment as client reports knowing she is in need of learning about her addiction and what factors play the most part but also reports that she would like to fast track treatment. Cleint seems to be going back and forth with herself about what she wants v. what she needs. Client has been attending group thus far but rarely engages repoting it is due to her emotions.
Update: As of [redacted]21, client has finally began to speak up about her needs. Sessions are no longer about her health and wanting to continue care "at home". Client has asked about boundary setting along with coping skills. This is a move in the right direction.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Risk Rating: 3 = Substantial

☐ Scores/conditions noted in Dimensions 1,3,4, and 6 indicate a high probability of relapse if not stabilized ☐ Client continues to experience post-acute withdrawal, including but not limited to episodes of intense craving, anxiety and agitation ☐ Client continues to engage in relapse behaviors even though he/she has not yet returned to use	X Client's relapse prevention plan is simplistic, too vague, or the client's commitment to the plan indicate a poor prognosis X Client does not evidence the skills/understanding to effectively follow/utilize the relapse prevention plan

Additional rating explanation (if applicable): Client has yet to identify a relapse prevention plan after reporting that she would like to fast track her stay in the womens program. This is concerning as client has yet to identify what her triggers or evern coping skills are to deal with her daily stressors. This could impact her recovery a great deal. Client reports that the courts will keep her accountable however client has already been linked with the courts and continued in active addiction before being placed in care. Client has minimized her use or potential to use.
Update: Client's surroundings alone can and will cause continued relapse. Client is in need of changing her people, places and things if she truly would like to live a life of recovery.

Dimension 6: Recovery/Living Environment

Risk Rating: 3 = Substantial

☐ The client's family (includes significant others and parents) is (select one): ☐ not supportive or ☐ actively sabotaging of the client's efforts ☐ Client is engaged in interpersonal relationships with persons in active substance use ☐ The client does not have safe and sober housing. Client's current living situation is with persons in active substance use. X Does not have transportation to continue engagement in recovery and to support employment X Client lacks regimentation and requires a structure environment to continue recovery	X Client lacks regimentation and requires a structure environment to continue recovery X Client is not employed or engaged in education/training X Client does not have resources for childcare X Client is not engaged in a sober support group and/or sober support ☐ Has not engaged in nor have scheduled continuation in: ☐ Mental health counseling X Family counseling X Aftercare or the next level of care in their treatment
Additional rating explanation (if applicable): Client reports that she will be able to go live with her aunt who is not in active addiction. However, client continues to minimized the fact that she was living with aunt before going to jail and being placed in program. Aunt seems to enable her. Update: Client has finally been homest about the father of her unborn child. Client refused to give important information such as child's father being in recovery himself. Child's father is not living a life of recovery but client reports that he is "clean". Client is in need of healhy support persons who will call her out when they see her reverting back. She currently surrounds herself with those who enable her and encourage her unhealthy ways.	

Section VII: Request for Continuing Services
Complete this section when: • This is an *initial* request for a client who is currently in residential treatment (i.e. client is in the initial 30 days of the first or second admission in a calendar year) and this request is for residential treatment beyond the initial 30 consecutive days; or • This is a *continued stay* request.
Request is based on one of the following: X The patient is making progress, but has not yet achieved the treatment goals articulated in ITP ☐ The patient is not making progress or is making some progress, but has the capacity and is actively working toward the treatment goals articulated in the ITP ☐ A new problem has been identified that is appropriately treated at the present level of care
Additional explanation (if applicable): The clinical team is asking that client remain in Leve of Care 3.5 due to client not having a healthy relapse prevention plan but already asking to be fast tracked out of the program, client being 28 weeks pregants with no resources, and client feeling as if she is unable to process due to not being ready to feel her feelings. Update: The clinical team is asking that client remain in 3.5 level of care due to client just accepting that this is where she should be. Client has finally reached out to ask for help with setting boundaries and finding coping skills. These are two things client lacks when "home". If discharged client will go back into an unhealthy setting. Client is not open to any thing else and has yet to complete a plan conducive to recovery or preventing a relapse.

[i] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright 2013 by the American Society of Addiction Medicine

SUD PA request form best practices

Tracey Izzard, Executive Director, Optumhealth Behavioral Solutions | UHC Community Plan

- ✓ Clearly indicated LOC request, and form was completed in its entirety
- ✓ Identified evidence-based practices used in treatment in Section V: Client Perspective on Progress & Continued Needs
- ✓ Included relevant detail in Section VI: ASAM Criteria Summary of Dimension Ratings
  - Dimension 2 shows how the individual's existing medical issues relate to her SUD and how it could affect her engagement in treatment
  - Dimension 3 discusses her history of MH diagnoses and medication, and if she is open to receiving medication
  - Dimension 4 shows the current stage of change
- ✓ Included initial assessment

Next steps

- SUD PA request form is available for providers on the Medicaid Forms page and at the link below: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10276Fillx.pdf
- A recording of today's training recording is posted to the Training Opportunities section of the BH Medicaid site: https://bh.medicaid.ohio.gov/training
- Please send additional questions to: BH-Enroll@medicaid.ohio.gov