

Best Practices for SUD Prior Authorization & Care Coordination

Anthem.

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Disclosures

Planning Committee Disclosure

- During the planning stages of this activity, all planning committee members have declared there are no financial interest/arrangement or affiliation with the organization that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

Planner	Relationship	Entity	Resolution
La-Risha Ratliff	No Relationship with a commercial entity	Anthem	No resolution needed
Kristi Carney	No Relationship with a commercial entity	CareSource	No resolution needed
Stacy Watson Holli Mahoney	No Relationship with a commercial entity	MDwise	No resolution needed
Margaret Richardson	No Relationship with a commercial entity	MHS	No resolution needed

FSSA Bulletin re: SUD

- The State issued Bulletin BT201906 in February 2019 outlining the required PA forms

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

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Prior Authorization forms re: SUD

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-Inc Service	<input type="radio"/> Cooperative Managed Care Services (CMCS)	P: 1-800-269-5720	F: 1-800-689-2759
		<input type="radio"/> Anthem Hoosier Healthwise	P: 1-866-408-6132	F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229
		<input type="radio"/> Anthem Hoosier Healthwise - SFTN	P: 1-800-291-4140	F: 1-800-747-3693
	Hoosier Healthwise	<input type="radio"/> CareSource Hoosier Healthwise	P: 1-844-607-2831	F: 1-844-432-8924
		<input type="radio"/> MDwise Hoosier Healthwise	P: 1-888-961-3100	F: 1-888-465-5581
		<input type="radio"/> MHS Hoosier Healthwise	P: 1-877-647-4848	F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649
	Healthy Indiana Plan (HIP)	<input type="radio"/> Anthem HIP	F: 1-844-533-1995	F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229
		<input type="radio"/> CareSource HIP	P: 1-844-607-2831	F: 1-844-432-8924
		<input type="radio"/> MDwise HIP	P: 1-888-961-3100	F: 1-866-512-1642
	Hoosier Care Connect	<input type="radio"/> MHS HIP	P: 1-877-647-4848	F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649
		<input type="radio"/> Anthem Hoosier Care Connect	P: 1-844-284-1798	F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229
		<input type="radio"/> 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			Requesting Provider Information		
IHCP Member ID (RID):			Requesting Provider NPI:		
Date of Birth:			Taxonomy:		
Patient Name:			Tax ID:		
Address:			Provider Name:		
City/State/ZIP Code:			Rendering Provider Information		
Patient/Guardian Phone:			Rendering Provider NPI:		
PMP Name:			Tax ID:		
PMP NPI:			Name:		
PMP Phone:			Address:		
Ordering, Prescribing, or Referring (OPR) Provider Information			City/State/ZIP Code:		
OPR Physician NPI:			Phone:		
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)			Fax:		
Dx1	Dx2	Dx3	Preparer's Information		
Name:			Phone:		
Address:			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

Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission

Intake assessment Clinical assessment Psycho-social assessment Treatment goals and plans

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 <input type="checkbox"/>				
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)
<input type="radio"/> Critically Managed Low-Intensity Residential Services (Adult)	3.1	H2034 U1	
<input type="radio"/> Critically Managed Low-Intensity Residential Services (Adolescent)	3.1	H2034 U2	
<input type="radio"/> Critically Managed High Intensity Residential Services (Adult)	3.5	H0010 U1	
<input type="radio"/> Critically Managed Medium Intensity Residential Services (Adolescent)	3.5	H0010 U2	
<input type="radio"/> Medically Managed Inpatient Services (Adult)	4.0	Inpatient Billing	
<input type="radio"/> 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	
<input type="radio"/> No withdrawal	
<input type="radio"/> Minimal risk of severe withdrawal	
<input type="radio"/> Moderate risk of severe withdrawal	
<input type="radio"/> No withdrawal risk, or minimal or stable withdrawal	
<input type="radio"/> At minimal risk of severe withdrawal	
<input type="radio"/> Patient has the potential for life-threatening withdrawal	
<input type="radio"/> 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	
<input type="radio"/> None or not sufficient to distract from treatment	
<input type="radio"/> None/stable or receiving concurrent treatment - moderate stability	
<input type="radio"/> Require 24-hour medical monitoring, but not intensive treatment	
<input type="radio"/> 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	
<input type="radio"/> None or very stable	
<input type="radio"/> Mild severity, with potential to distract from recovery, needs monitoring	
<input type="radio"/> Mid to moderate severity, with potential to distract from recovery, needs to stabilize	
<input type="radio"/> None or minimal, not distracting to recovery	
<input type="radio"/> Mid to moderate severity, needs structure to focus on recovery	
<input type="radio"/> Demonstrates repeated inability to control impulses, or unstable with symptoms requiring stabilization	
<input type="radio"/> Moderate severity needs 24-hour structured setting	
<input type="radio"/> Severely unstable requires 24-hour psychiatric care	

Prior Authorization forms re: SUD

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 level 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/HSP

Name (print): _____

Signature of Physician/HSP: _____ Date: _____

Mandatory Additional Documentation Checklist

Intake assessment Clinical assessment Psychosocial assessment Treatment plan/goals

PLEASE FAX FORM and the mandatory additional documentation with the Residential/Inpatient SUD Prior Authorization Request Form TO THE APPROPRIATE ENTITY.

Initial Assessment Form for SUD Treatment Admission
V1.0, February 2019

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 or 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)
<input type="radio"/> Clinically Managed Low-Intensity Residential Services (Adult)	3.1	H2034 U1	
<input type="radio"/> Clinically Managed Low-Intensity Residential Services (Adolescent)	3.1	H2034 U2	
<input type="radio"/> Clinically Managed High-Intensity Residential Services (Adult)	3.5	H0010 U1	
<input type="radio"/> Clinically Managed Medium-Intensity (Adolescent)	3.5	H0010 U2	
<input type="radio"/> Medically Managed Inpatient Services (Adult)	4.0	Inpatient Billing	
<input type="radio"/> Medically Managed Inpatient Services (Adolescent)	4.0	Inpatient Billing	

For inpatient psychiatric facilities/hospitals, please provide your prior authorization revenue code below.

Reassessment Form for Continued SUD Treatment
V1.0, February 2019

Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

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

Reassessment Form for Continued SUD Treatment
V1.0, February 2019

Reassessment Form for Continued Substance Use Disorder (SUD) Treatment

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 level 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 CLINICAL 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 SUD Treatment
V1.0, February 2019

Prior Authorization forms re: SUD

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.

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SIGNATURE OF SIGNATURE OF PHYSICIAN/HSPP

Name (print):

Signature of physician/HSPP:

Date:

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

Best Practice for sending a Prior Authorization

Anthem:

- Providers may call Anthem to **request** prior authorization for **medical and behavioral** health services using the following phone numbers:
 - Hoosier Healthwise: **1-866-408-6132**
 - HIP: **1-844-533-1995**
 - Hoosier Care Connect: **1-844-284-1798**
- **Fax physical health clinical** information for all Anthem members to:
 - Physical health inpatient: **1-888-209-7838**
 - Physical health outpatient: **1-866-406-2803**
- **Fax behavioral health clinical** information for all Anthem members to:
 - Behavioral health inpatient: **1-877-434-7578**
 - Behavioral health outpatient: **1-866-877-5229**
- **Web Portal:** ICR is available using www.availity.com or through <https://mediproviders.anthem.com/in>

Anthem does not do live clinical reviews



Best Practice for sending a Prior Authorization

MHS:

- ▶ Fax #: 844-288-2591
- ▶ Call for live review: 877-647-4848
- ▶ Web Portal: <https://provider.mhsindiana.com>

CareSource:

- ▶ Fax #: 937-487-1664
- ▶ IMD Fax #: 937-487-0688
- ▶ Web Portal: <https://Caresource.com> (follow prompts to provider portal)

CareSource does not do live clinical reviews



Best Practice for sending a Prior Authorization

MDWise:

- ▶ HIP:

- ▶ Outpatient fax number: 866-613-1642

- ▶ Inpatient fax number: 866-613-1631

- ▶ HHW:

- ▶ Inpatient and outpatient fax number: 888-465-5581

The “Do’s” for Prior Authorization

Do...

- ▶ Complete the SUD PA request form in its entirety.
- ▶ Send all listed documentation with the PA form.
- ▶ Send documentation that supports the 6 dimensions of ASAM.
- ▶ Send the most current clinicals; documentation from the last 24-72 hours.
- ▶ Send a summary of why the specific level of care is being requested.
 - ▶ Why is this level of service necessary?
 - ▶ Why can't the member be treated at a lower level of care?
- ▶ Send withdrawal assessment scores (COW/CIWA).
- ▶ Make sure the diagnosis matches the service being requested.
- ▶ Send progress in treatment and adjustments to treatment plan when submitting concurrent PA.
- ▶ Submit a complete and detailed initial assessment, not just check boxes and add the information that lead to the checking of the box



Treatment options beyond Acute Inpatient Care

- Clinical Best Practices indicate that Acute Inpatient Care is not the preferred level of care for Opiate detox.
- We encourage all Providers to work collaboratively with our Case Management and Utilization Management teams to discuss alternative treatment options. We want to ensure our members are receiving the correct level of care at the correct time.
- Alternatives to consider:
 - Outpatient treatment (including Medication Assisted Treatment MAT)
 - Intensive Outpatient Programming (IOP)
 - Partial Hospitalization Programming (PHP)
 - Residential Treatment Programming (RTC)

What is Case Management at an MCE?

Case Management encompasses all aspects of a member's health care.

- Coordinating a member's medical and behavioral healthcare.
- Assisting members with securing transportation to/from medical and behavioral health appointments.
- Providing education re: disease states and medication adherence.
- Explaining each member's healthcare benefits.
- Providing information re: community resources.
- Providing crisis management to members.
- Collaborating with each member's providers

Managing high risk/high need members

- ▶ For members who have an inpatient admission, Case Managers begin intervening as soon as they are notified of the event.
- ▶ Outreach is made to the hospital social worker, discharge planner & family prior to discharge to coordinate follow up appointments.
- ▶ Notification of admission is sent to the member's PMP and the identified behavioral health provider within five (5) days of admission. **Written consent from the member is required when their admission is related to substance abuse. Written consent is NOT needed for mental health treatment (IC 16-39-2-6(a)). Please get a signed ROI at admission.*
- ▶ Once discharge occurs, a call is placed to the member, parent or guardian within 48 hours and a reminder is given about follow up appointments.
- ▶ The member is then enrolled in case management for a minimum of 90 days.

What a Provider can expect from an MCE

✓ **Support!**

- ▶ Each Case Manager is available to assist in managing the care of the member.

✓ **Communication!**

- ▶ Case Managers call providers re: admissions, readmissions, follow up appointments, and ongoing treatment.

✓ **Information!**

- ▶ Case Managers have access to a member's healthcare profile which includes ER visits, medication adherence, medical & behavioral health services, care gaps, and future risk scores.

What the MCE needs from the Facilities

✓ **Communication!**

- ▶ Case Managers need to speak with facility discharge planners and/or social workers shortly after the member's admission re: the discharge plan which should include follow up appointments, medications, barriers and overall care of the member.

✓ **Discharge Summaries!**

- ▶ Case Managers need discharge summaries, immediately after discharge, that include diagnoses, medications, follow up appointments and other pertinent information.

✓ **Scheduled Follow-up Care!**

- ▶ Members discharging from an inpatient admission need to be seen within 7 days of discharge with a master level clinician or higher.

Contact Us

Anthem:

La-Risha Ratliff, LMHC, LCAC
Manager Behavioral Health Services
317.287.2172

La-risha.ratliff@anthem.com

MDWise:

Holli Mahoney, LMHC
Behavioral Health Specialist
317.983.7768

hmahoney@mdwise.org

CareSource:

Kristi Carney, MSW, LSW, CCM
Director of Behavioral Health
317.982.6427

Kristi.carney@caresource.com

MHS:

Margaret Richardson, LCSW
Director of Behavioral Health
317.684.9478

Margaret.e.Richardson@mhsindiana.com