

*The Request form and instructions are provided as a single file within a fillable document.
Please type directly onto the form and please make sure the request form is complete and legible.*

Clinician Instructions

- **For initial authorization or authorization of continued stay, the following documents must be submitted:**
 1. Authorization Request form
 2. Copy of current Service Plan with anticipated Discharge Date indicated
 3. A comprehensive, clinical update of the ASAM dimensions
- **Initial authorization is required within two (2) business days of intake.** To avoid the possibility of denial of authorization after an individual has already entered treatment, providers are strongly encouraged to submit authorization requests in advance of initiating treatment when possible. If the initial authorization request is submitted beyond the two-business-day requirement, the authorization effective date will correspond to the date the request form was submitted.
- **Continued stay authorizations are required within five (5) business days of the expired initial authorization.** If the continued stay request is submitted beyond the five-business-day requirement, the delay may result in unauthorized days during the treatment episode.
- If additional information is requested for authorization by Health Share, **the provider must provide requested information within 5 business days.** If Health Share does not receive the requested information by the deadline, an approved authorization for services (based on established medical necessity) will begin on the date requested documents are submitted.

For questions, or to submit documents via secure email to the appropriate Behavioral Health Plan:

Clackamas County

Casey Palmer: cpalmer@clackamas.us ; Phone 503-742-5968; Fax 503-742-5355

**Providers must fax all Clackamas authorization request forms & attachments to
503-742-5355, Attn SUD Team**

Multnomah County

Trina Connolly – Fairchild: adreporting@multco.us; Phone 503-201-5037

Washington County

Nancy Griffith: nancy_griffith@co.washington.or.us; Phone 503-846-3280

Day Treatment/Partial Hospitalization 2.5 alcohol and other drug treatment programs

Authorization Type	
<input type="checkbox"/> Initial	<input type="checkbox"/> Reauthorization
<input type="checkbox"/> 28 Day Authorization	
<input type="checkbox"/> Adult	<input type="checkbox"/> Youth

Member Information		
First Name:	MI:	Last Name:
Date of Birth:		
Provider Agency Name:	Agency Fax:	
Date of client's enrollment in services with this provider (for this treatment episode):		
Date of request:	Anticipated Date of Discharge:	
If less than the standard 28 day authorization, number of days requested:		
Substance Use Diagnosis:		
Is there a history of IV drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current IV drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the client pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Referral Source:	Referral Contact:	

Insurance Eligibility Information
Medicaid ID:
Member's Health Share Behavioral Health Plan (<i>please select one</i>):
<input type="checkbox"/> Multnomah County Behavioral Health Plan
<input type="checkbox"/> Clackamas County Behavioral Health Plan
<input type="checkbox"/> Washington County Behavioral Health Plan
<i>To verify member eligibility, please look in CIM or contact Health Share Customer Service at 503-416-8090 or 1-866-519-3845</i>

Admission/Eligibility Criteria

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| <ul style="list-style-type: none"> • Substance Use Disorder – <ul style="list-style-type: none"> • DSM-5 criteria <ul style="list-style-type: none"> ○ Moderate or High Severity diagnosis ○ Low severity only if pregnant woman or high risk of medical/behavioral complication ○ ICD-10 codes- F10.10, F10.20, F11.10, F11.20, F12.10, F12.20, F13.10, F13.20, F14.10, F14.20, F15.10, F15.20, F16.10, F16.20, F18.10, F18.20, F19.10, F19.20 | <ul style="list-style-type: none"> • Meet ASAM Level III criteria and it is the least restrictive appropriate level of care. • Withdrawal symptoms, if present, are not life threatening and can be safely monitored at this level of care. • No medical complications that would preclude participation in this level of care • Cognitively able to participate in and benefit from treatment. |
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Direct admission to a Level 2.5:

- **Patient must meet specification in Dimension 2 (if any biomedical conditions or problems exist)**
- **Patient must meet specification in Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist)**
- **Patient must meet specification in at least one of Dimensions 4, 5, or 6.**

Transfer to Level 2.5 program from a higher Level of Care is appropriate, for a client who has:

- A. met essential treatment objectives at a more intensive level of care
and
 B. requires the intensity of services provided at Level 2.5 in at least one dimension

A client transferring to level 2.5 from a level 1 or 2.1 program:

- When the services provided at the less intensive level have proved insufficient to address the patient's needs.
- Or when those services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admission criteria.

In addition to this form, the following documentation is required:

Copy of current Service Plan

Continued Stay Criteria

(complete this section only for continued stay)

- For continued stay, the individual must continue to meet all the basic elements of medical necessity as defined in the Health Share authorization guide.
- An individualized discharge plan must have been developed/updated which includes specific, realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion must be in place but discharge criteria have not yet been met.

1. **One or more** of the following criteria must be met:

- The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- There is evidence of ongoing reassessment and modification to the ISSP, if the Individual Services and Support Plan (ISSP) implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care.
- The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

2. **All of the following** must be met:

- The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- Continued stay is not primarily for the purpose of providing a safe and structured environment (unless discharge presents a safety risk to a minor child).
- Continued stay is not primarily due to a lack of external support unless discharge presents a safety risk to a minor child.

The following documentation is required in addition to this form:

- Copy of current ISSP or treatment plan
- A comprehensive, clinical update in each of the ASAM dimensions.

Discharge Criteria

Do not seek authorization for continued stay if any of the following are true:

1. The individual’s documented treatment plan goals and objectives have been substantially met.
2. The individual is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care, nor is treatment at this level of care required to maintain the current level of functioning.
3. Support systems, which allow the individual to be maintained in a less restrictive treatment environment, have been thoroughly explored and/or secured.
4. The individual can be safely treated at an alternative level of care.
5. An individualized discharge plan is documented with appropriate, realistic, and timely follow-up care in place.
6. The individual poses a safety risk to other participants, dependents, or staff (for example, physical/verbal violence, smoking in building, or the use or presence of alcohol or drugs on premises).
7. The individual’s MH or medical or SUD symptoms increase to the point that continued treatment is not beneficial at this level of care. The individual has been referred to the appropriate level.

ASAM Summary
Please give comprehensive clinical justification of Level of Care in each dimension

Dimension 1 LOC:	
Dimension 2 LOC:	
Dimension 3 LOC:	
Dimension 4 LOC:	
Dimension 5 LOC:	
Dimension 6 LOC:	
Clinical Summary placing client at assigned LOC	
Date Completed:	
A&D Clinician Name:	
Email:	
Phone Number:	