ADULT 18 TO 64 MEDICAL DETOX PA REQUEST

(instructions available online here)

Request Type: CHOOSE REQUEST	
Date Submitted:	

OKLAHOMA Health Care Authority

MEMBER INFORMATION	
Name:	Medicaid ID: fadsfasdf
Medicare Part C or other policy name and ID#:	☐ Check box if submitting request because member has exhausted Medicare benefits. Documentation required or request will be deemed incomplete.
Type of Residence: Choose Residence Type	Age with DOB:
Please provide member's complete contact information including address and phone number. As applicable, document the member's guardian complete contact information as well:	

PROVIDER INFORMATION	
Name:	Provider ID w/ Service Loc:
Utilization Contact Name:	Utilization Contact Phone:
Date/Time of Face to Face Assessment:	Utilization Contact Email:
Attending Physician:	
Date of Admit:	Estimated Date of Discharge:
Requested Start Date:	Requested End Date:

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USE FOR RECONSIDERATION REQUESTS ONLY - provide new and/or additional clinical information supporting your original request. For Admission Requests - only behaviors occurring prior to the admission will be considered. For Extension Requests - only behaviors occurring the last approved period will be considered.

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Document who referred the member and how they were transported to your facility. Discuss any recent stressful life events triggering or exacerbating the member's condition, e.g. legal offenses, family/interpersonal/work/financial issues etc.

PSYCHIATRIC MEDICAL NECESSITY CRITERIA
Criteria #1 List the member's substance use and co-occurring mental health diagnoses (use the ICD-10-CM codes and descriptors listed in the DSM manual) and medical diagnoses. List the primary focus of treatment as the first diagnosis. The primary focus of treatment must be a psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies. Requests without ICD-10-CM codes and descriptors will not be accepted.

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Criteria #2 Attesting Yes or No, is the member's condition directly attributable to a substance use disorder as the primary need for professional attention (this does not include placement issues, criminalbehavior, or status offenses).

◯ YES ◯ NO

Criteria #3 Demonstrate that the current disabling symptoms could not be managed, or have not been manageable, in a less intensive treatment program. Example - Describe a recent failure in outpatient services indicating what services and how often the member was participating. If member has not participated in outpatient services, specifically describe the disabling symptoms that cannot be managed onan outpatient basis.

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Criteria #4 Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by one or more of the following items: A. Need for active and aggressive pharmacological interventions. If Yes, please provide medications that will be used in the detoxification process; or B. Need for stabilization of acute psychiatric symptoms. If Yes, please describe symptoms; or C. Need extensive treatment under physician direction. If Yes, please describe; or D. Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision. If Yes, please describe.

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Criteria #4 Supplemental Clinical Please document current vitals signs (Temp, BP, HR, SpO2, and RR) and any lab results for drugs and/or alcohol levels. Additionally, document the substance requiring detox, the method of abuse, the amount and frequency of the abuse, how many months or years the member has been abusing the substance and any previous history of withdrawal symptoms, Finally, document when the member last used the substance and the amount just prior to presenting for services.

OPTIONAL - Additional Clinical Use this space to provide additional information such as physician or individual/family/group therapy notes or any other information documented in the medical record you believe would support the case for treatment at this level of care. Please do not duplicate information that has already been documented elsewhere in the request.

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FIELDS "A" to "C" ARE REQUIRED FOR EXTENSION REQUESTS BY PSYCHIATRIC HOSPITALS – In addition to updating criteria fields #1 to #4 above, fields "A" to "C" below must be documented each extension request.
(A) Document the reason for requesting additional treatment days and what active treatment will be provided:

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(B) Medications (document changes and current regimen including strength and frequency at time of submission):

(C) Discharge Plan (include recommended follow-up treatment and where the member will live):