NH Substance Use Disorder (SUD) Outpatient Treatment Request (OTR) Guidance Document for Providers

Prior authorization can be requested by completing the SUD OTR form and faxing to the Utilization Management Department at NH Healthy Families. You can use the Pre-Auth Needed Tool located on the NH Healthy Families website under Provider Resources to check authorization requirements, or please refer to the services that require Prior Authorization below:

894-897 (DRG codes)	Medically Managed Inpatient Hospital Withdrawal Management (ASAM Level 4-WM)
H2034-U4	Low-Intensity Adolescent (ASAM Level 3.1)
H2034	Low-Intensity Adult (ASAM Level 3.1)
H0018-U4	Medium- Intensity Adolescent (ASAM Level 3.5)
H0018	High-Intensity Adult (ASAM Level 3.5)
T1006	Specialty Residential Services for Pregnant & Parenting Women
H2036-HH	Partial Hospitalization Services (ASAM Level 2.5)
H0010	Medically Monitored Residential Withdrawal Management (ASAM Level 3.7-WM)
H0015	Intensive Outpatient Services

For the OTR to be accepted, it needs to be completed in its entirety and signed by the appropriate staff.

For all requests, please be sure to request the number of units, or days, of the treatment that are necessary within 30 days after the expected start date.

If you would like to attach clinical to the OTR, you can. However, clinical attachments can't substitute an incomplete OTR.

The OTR is to be faxed as soon as treatment determinations have been made. This can be any time of day, any day.

If the OTR is sent after 5pm EST during business days, on the weekend or on a holiday, you must also call to notify of the request at: 1-866-769-3085 (Choose option 4 "Behavioral Health" from the Medical Management Menu then option 3 "Behavioral Health Authorization" from the Behavioral Health Menu to reach a live representative). This ensures timely determination for improved access to care.

If you have questions regarding the completion of the SUD OTR, please feel free to call the Utilization Management department at 1-833-404-1061.

PLEASE fax this form to the Utilization Management Department at 1-866-270-8027 for all authorization requests. For any after hours (after 5 pm), weekend or holiday requests, you **MUST submit the form AND call 1-866-769-3085** (follow the prompts) to notify of the request.

nh healthy families

Substance Use Disorder Treatment Request Form

Please print clearly - incomplete of illegible forms will delay processing. Please mail or fax completed form to the above address.

Date: _____

MEMBER INFORMATION

Member Name: _____

DOB: _____

SS #: _____

Member ID #: _____

Last Auth #: _____

CURRENT ICD-10 DIAGNOSIS CODE(S)

Primary: _____

Secondary: _____

Tertiary: _____

Additional: _____

Additional: _____

REQUESTING PROVIDER INFORMATION

Requesting Provider NPI: _____

Taxonomy: _____

Taxpayer Identification Number (TIN): _____

Provider Name: _____

RENDERING PROVIDER INFORMATION (REQUIRED)

Rendering Provider NPI: _____

TIN: _____

Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Fax: _____

LEVEL OF CARE CONSIDERATION

Describe any risk for alternate level of care, out-of-home placement, change of placement or inability to attend work/school:

WHY IS THIS TREATMENT MEDICALLY NECESSARY?

Date of Assessment: _____ ASAM Level of Care Determination: _____

Using the American Society of Addiction Medicine (ASAM) Criteria, Dimensions 1-6, please provide clinical for each dimension used for determining level of care:

Dimension 1: Meets This Dimension ☐

Dimension 2: Meets This Dimension ☐

Dimension 3: Meets This Dimension ☐

Dimension 4: Meets This Dimension ☐

Dimension 5: Meets This Dimension ☐

Dimension 6: Meets This Dimension ☐

_____Member Name

SUBSTANCE USE DISORDER

☐ None ☐ By History ☐ Current/Active Use

DRUG	AMOUNT	METHOD OF ADMINISTRATION	FREQUENCY	FIRST USE (DATE)	LAST USE (DATE)

Is member attending AA/NA meetings, 12 Step meeting, SMART Recovery, or any peer-led support group? ☐ Yes ☐ No

If yes, how often? _____

TREATMENT DETAILS

Reason for admission:_____

What therapeutic approach (e.g. evidence-based practice, therapeutic model, etc.) will be utilized with this Member?

_____

Are the member's family/supports involved in treatment? ☐ Yes ☐ No If no, why? _____

Date of last family therapy session and progress made?_____

_____

What other services are being provided to this Member that are not requested in this OTR? Please include frequency:

Is care being coordinated with Member's other service providers? ☐ Yes ☐ No ☐ N/A

Has information been shared with PCP regarding behavioral health provider contact information, presenting problem, date of initial visit, diagnoses and any meds prescribed? ☐ Yes_____(date) ☐ No/ If no, why? _____

Discharge plans:_____

TREATMENT GOALS (PLEASE ENSURE THAT GOALS ARE S.M.A.R.T : SPECIFIC, MEASURABLE, ACHIEVABLE, REALISTIC, AND TIME BOUND)

Describe measurable goals and treatment plan agreed upon by member.

MEASURABLE GOAL	DATE INITIATED	CURRENT PROGRESS (Please note specific progress made.)

_____Member Name

TREATMENT CHANGES

How has the treatment plan changed since the last request?

DISCHARGE CRITERIA

Objectively describe how it will be known that the member is ready to discontinue treatment.

Admission Type: ☐ Voluntary Admission ☐ Court Ordered ☐ Unknown

Stage of Change: _____

Internal Motivators: _____

External Motivators: _____

CIWA Score:_____ COWS Score:_____

Recovery Supports Available?: ☐ No ☐ Yes (list): _____

REQUESTED AUTHORIZATION

Please provide treatment intensity anticipated over the next 30 days from your expected start date.

EXPECTED START DATE FOR CURRENT REQUEST	PROCEDURES/ SERVICE CODES	MODIFIERS		SERVICE DESCRIPTION	PLACE OF SERVICE (POS)	UNITS/DAYS/SESSIONS FOR NEXT 30 DAYS

Additional Information?

Please attach additional documentation to support your request (e.g. Assessment, progress notes, updated treatment plan).

Clinician Signature

Date (Within 30 days of submission)

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