CERTIFICATION OF NEED

Medically Monitored Psychiatric Acute Hospital-Detoxificiation (ASAM Level III.7-D)

Date of CON: _____ Time of CON: _____

Individual's Name:_____ Individual D.O.B. & Age:_____ - _____

Treating Facility: _____ Date of Admission_____

Title 19/21: Yes/No Emergency Admission: Yes No

1. DSM – IV Diagnostic Codes AXIS I _____; _____

AXIS II _____ **AXIS III** _____ **AXIS IV** _____ **AXIS V** ____

2. Reason For Admission, must meet specifications in a, b, c or d – circle all that apply:

a. Individual is experiencing signs and symptoms of severe withdrawal, as evidenced by one of the following:
   1) Individual is withdrawing from alcohol and the CIWA-Ar score is 10 or above, or
   2) Individual has ingested sedative-hypnotics at more than therapeutic levels daily for 4 weeks and is not responsive to recent efforts to maintain the dose at therapeutic levels, or
   3) Individual has ingested sedative hypnotics at more -altering substance known to pose a risk of withdrawal, and the individual cannot be stabilized in an ambulatory detoxification setting, or
   4) Individual has marked lethargy or hypersomnolence due to intoxication with alcohol or other drugs, and a history of severe withdrawal syndrome, or the individual has not stabilized in an ambulatory detoxification setting, or
   5) Individual has used injectable opiates daily for more than two weeks and has a history of inability to complete withdrawal as an outpatient, or
   6) Individual has marked lethargy, hypersomnolence, agitation, paranoia, depression or mild psychotic symptoms due to stimulant withdrawal, and has poor impulse control and/or coping skills to prevent immediate continued use.

b. There is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition and/or emotional, behavioral or cognitive condition) that a severe withdrawal syndrome is imminent.

c. There is strong likelihood the individual (who requires medication) will not complete detoxification at another level of care because of inadequate home supervision or support structure, as evidenced by one of the following:
   1) Individual requires medication and has a recent history of detoxification at a less intensive level of care, marked by past and current inability to complete detoxification. The individual continues to have insufficient skills or supports to complete detoxification, or
   2) Individual has a recent history of detoxification at less intensive levels of service that is marked by inability to complete detoxification and continues to have insufficient skills to complete detoxification, or
   3) Individual has a comorbid physical, emotional, behavioral or cognitive condition (such as chronic pain with active exacerbation or post-traumatic stress disorder with brief dissociative episodes) that is manageable in a Level III.7-D setting but which increases the clinical severity of the withdrawal and complicates the detoxification.

d. Other: (Specify) _____

3. Likely therapeutic discharge plan – circle letter and check option reflecting the listed diagnosis:

a. 24 hour CD Behavioral Health Residential treatment, 12 Step AA, NA, CA meeting attendance: **drug / alcohol dependence, history of chronic use pattern, chronic relapse pattern, ASAM DIM5 high severity**.

b. Intensive Outpatient, 12 Step AA, NA, CA meeting attendance: **drug/alcohol dependence, history of moderate to intensive use pattern, DIM5 medium-high severity**.

c. Standard Outpatient, 12 Step AA meeting attendance: **drug/alcohol abuse, leading to dependence, history of low to moderate use pattern, DIM5 low-medium severity**.

d. 24 hour co-occurring Behaviroal Health Residential treatment - **psychiatric disorder, chemical dependency use pattern co-existing, interfering**.

e. IOP-SOP with ½-way house placement - **ASAM DIM 4, 5 and 6 are affected, co-existing need for treatment, housing**.

f. Discharge, refer for medical, psychiatric, substance use evaluation, follow-up – assess for further needs, care and treatment.

4. Estimated length of stay (Specify number): _____ Days (required)

5. Based upon physical, mental and social evaluations, I certify the above named individual requires sub acute psychiatric treatment and that all of the below accurately describes the situation for inpatient hospitalization according to 42 CFR Part 456 subpart C; under 21 42 CFR subpart D:

- Above circled items are fully documented in the individual's clinical record.
- Ambulatory care resources available in the community do not meet the treatment needs of the individual; and
- Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- Level III.7-D services can reasonably be expected to improve the Individual's condition or prevent further regression so that the services will no longer be needed.

_____ _____ _____

Psychiatric Acute Hospital Physician's Name (Print) Physician's Signature Date

If above physician signature is from the Psychiatric Acute Hospital treatment Team, then a physician independent of the Psychiatric Acute Hospital treatment team must certify this admission below on all Title 19/21 Individuals under the age of 21

_____ _____ _____ _____

Outpatient Physician's Name (Print) Independent Physician's Signature Date Agency

CON Valid for person 21 yo or older: Max is 60 days CON for person 20 yo or under : Max is 30 days

Call Magellan Care Management @ 1-800-564-5465 FAX CON to: 1-888-290-1285 Revised: 2/5/2014