RE-CERTIFICATION OF NEED

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

Date of RON: _____ Time of RON: _____

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 continued stay, must meet specifications in a, b, c, d, e or f, circle all that apply:

a. Individual continues to withdraw from alcohol and the CIWA-Ar score is 10 or above, or

Individual continues to withdraw from sedative-hypnotics with moderate to severe symptoms, or

Individual continues to withdraw from opiates with moderate to severe symptoms, or

Individual continues to withdraw from stimulants with moderate to severe lethargy, hypersomnolence, agitation, paranoia, depression of psychotic symptoms and continues to exhibit poor impulse control and/or coping skills to prevent immediate continued use, or

There is continued strong likelihood the individual (who continues to need 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 (circle all that apply):

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, or
2) Individual has a recent history of detoxification at less intensive levels of service that was 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 continues to increase the clinical severity of the withdrawal and complicated detoxification.

Other: (Specify)_____

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

a. 24 hour CD Behaviroal 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 Behavioral 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 Detoxification Physician's Name (Print) Physician's Signature Date

RON Valid for person 21 yo or older: Max is 60 days RON 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