Outpatient Withdrawal Management Authorization Request Form

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4211**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

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Attach a comprehensive assessment of client history, treatment plan, and/or progress notes to support medical necessity.

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

A. Client Information		
Client Name (*Last, First, M.I.*)*:		
Medicaid Number*:		Date of Birth*:
Age:	Sex:	Date of Submission:
Date Current Treatment Began:		Time:

B. Chemical Dependency Treatment Facility Information		
Rendering Facility Name*:		Contact Person:
Street Address*:		
City:	State:	ZIP + 4*:
Telephone:		Fax:
Tax ID*:		NPI*:
Taxonomy*:		Benefit Code*:

For admission requests, complete all sections except section G

C. Criteria for Admission		
The individual is expected to have a stable withdrawal from alcohol/drugs	☐ Yes	☐ No
Client has a seizure disorder or history of seizures during substance withdrawal	☐ Yes	☐ No
Disorientation to self	☐ Yes	☐ No
Alcoholic hallucinosis	☐ Yes	☐ No
Toxic psychosis	☐ Yes	☐ No
Stable vital signs without a history of past acute withdrawal syndromes	☐ Yes	☐ No
Presence of any presumed new asymmetric and/or focal findings	☐ Yes	☐ No
Altered level of consciousness	☐ Yes	☐ No
Clinical condition allows for a comprehensive assessment	☐ Yes	☐ No
Serious disulfiram-alcohol (Antabuse) reaction	☐ Yes	☐ No

D. Family/Social/Academic/Dysfunction		
Client's social system/significant others are supportive of recovery to the extent that the client can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the client's addiction	☐ Yes	☐ No
Client's family/significant others are willing to participate in the outpatient withdrawal management program	☐ Yes	☐ No
Client has the social skills to obtain such a support system and/or to become involved in a self-help fellowship	☐ Yes	☐ No
Client lives in environment where licit/illicit mood altering substances are used	☐ Yes	☐ No

* Essential/Critical field

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E. Emotional/Behavioral Status		
Client is coherent, rational, and oriented for treatment	☐ Yes	☐ No
Client can comprehend and understand the materials presented	☐ Yes	☐ No
Client can participate in outpatient withdrawal management process	☐ Yes	☐ No
Client expresses an interest to work toward withdrawal management goals	☐ Yes	☐ No
Client is free of neurological, psychological, or uncontrolled behavior that places the individual at imminent risk of harming self or others	☐ Yes	☐ No
Client is free of mental confusion or fluctuating orientation	☐ Yes	☐ No
F. Recent Chemical Substance Use		
Client's chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so	☐ Yes	☐ No
Client is motivated to stop using alcohol/drugs, and is in need of a supportive structured treatment program to facilitate withdrawal from chemical substances	☐ Yes	☐ No
G. Continued Stay Criteria for Outpatient Withdrawal Management (Complete only sections A, B, G, H, I, and J if additional withdrawal management days are needed)		
Client, while physically abstinent from chemical substance use, exhibits incomplete stable withdrawal from alcohol/drugs, evidenced by psychological and physical cravings	☐ Yes	☐ No
Client, while physically abstinent from chemical substance use, exhibits incomplete stable withdrawal from alcohol/drugs, evidenced by significant drug levels	☐ Yes	☐ No
Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt outpatient withdrawal management, but the client is again progressing in treatment	☐ Yes	☐ No

H. Current DSM Diagnoses

I. Number of Withdrawal Management Days Requested
Dates from*: to*:

J. Requesting Provider Information	
Requesting Provider Printed Name*:	
Requesting Provider License Number.:	Requesting Provider NPI*:
QCC Signature (stamped signatures not accepted):	Date:

* Essential/Critical field