I. PURPOSE

To have a uniform policy and procedure for all WCHO clients requesting Methadone as a pharmacological support in Opioid Treatment Programs (OTPs) that meets required MDCH Enrollment Criteria for Methadone Maintenance and Detoxification Programs.

II. APPLICATION

Any client requesting Methadone treatment as a pharmacological support; Opioid Treatment Program (OTP) Providers; Health Services Access and Utilization Review Staff.

III. DEFINITIONS

ASAM PATIENT PLACEMENT CRITERIA 2-R

The American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM PPC-2R), the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems. The American Society of Addiction Medicine (ASAM) Level of Care (LOC) indicated for beneficiaries receiving methadone is usually outpatient. Outpatient services should be conducted by the OTP that is providing the methadone. This will provide same site coordination of substance abuse treatment. When the ASAM LOC is not outpatient or when a specialized service, such as a women’s specific program, is needed, separate service locations for OTP methadone dosing and other substance abuse treatment are acceptable.

ENCOMPASS

The WCHO’s web-based information management system for interfacing with providers; Access and Utilization Management, Finance and medical records.

MEDICAL DIRECTOR/DESIGNEE
The Medical Director of the WCHO may designate a consulting physician with additional expertise to assist with utilization review determinations in questionable methadone cases.

MEDICAID MEDICAL NECESSITY REQUIREMENT

Medicaid Managed Specialty Supports and Services Contract and Medical Necessity Criteria (see Attachment A) shall be used for all funded clients to determine medical necessity for methadone as an adjunct to substance abuse treatment. The Medicaid-covered services for methadone are listed below and apply equally to all other funded clients:

- the provision and administration of methadone
- nursing services
- physician encounters
- physical examinations
- laboratory tests, including toxicology screening
- physician ordered TB skin tests.

METHADONE

Methadone treatment is well established as an effective and safe approach to controlling opioid addiction. Properly prescribed methadone is not intoxicating or sedating, and its effects do not interfere with ordinary activities such as driving a car. The medication is taken orally and it suppresses narcotic withdrawal for 24 to 36 hours. Methadone is a medication with three major effects:

1) prevention of withdrawal symptoms
2) prevention of opioid cravings and
3) blocking the euphoric effects of opioid drugs.

Methadone is designed to address these physiological problems as an adjunct to counseling and/or other substance abuse treatment.

OPIOID TREATMENT PROGRAM

Opioid Treatment Programs (OTPs) are certified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). An OTP using methadone for the treatment of opioid dependency must be:

1) licensed by the state as a methadone provider,
2) accredited by CARF, the Council on Accreditation (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
3) certified by the SAMHSA as an OTP and
4) licensed by the Drug Enforcement Administration (DEA).

Compliance with state administrative rules and federal regulations is required as well.

PAIN MANAGEMENT WITH OPIOID THERAPY
In the case of opioid therapy is prescribed for Pain Management, pseudoaddiction should also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction. The following definitions from the “Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain” should be consulted to assist in determining when substance abuse treatment is appropriate. The guidelines can be found at http://www.michigan.gov/mdch/0,1607,7-132-27417_27648_29876_29878-91812--,00.html.

IV. POLICY

All clients requesting Methadone Treatment for Opioid Dependence are evaluated under state and federal guidelines and must meet ASAM and medical necessity criteria for initial and continuing care. It is the expectation that the course of Opioid Replacement Therapy (ORT) be completed within a two-year timeframe, with a titration protocol attempted during that time.

V. EXHIBITS

None

VI. REFERENCES

A. ASAM American Society of Addiction Medicine

B. Michigan Department of Community Health Request for Hearing Form

C. Michigan Department of Community Health, Medicaid Provider Manual, “Section 2 – Program Requirements” and “Section 12 – Substance Abuse Services” Updated 4/1/06


E. State of Michigan Substance Abuse Contract

F. WCHO Grievance and Appeals Policy

G. ATTACHMENT A: WCHO/Client/Provider Agreement

H. ATTACHMENT B: WCHO/LWSACA/HSA Concurrent Review Form

I. ATTACHMENT C: CMHPSM/WCHO Notice of Denial or Change of Services for Non-Medicaid Recipients

J. ATTACHMENT D: WCHO/LWSACA/HSA Client Information Release Authorization
K. ATTACHMENT E: WCHO/LWSACA/HSA Methadone Continuing Care Evaluation

VII. PROCEDURES

<table>
<thead>
<tr>
<th>WHO</th>
<th>DOES WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Services Access (HSA)</td>
<td>1. Will complete a telephone screening to determine eligibility for services and to review treatment options with the client including drug free treatment and methadone treatment. If the client meets eligibility criteria and chooses a drug free treatment, the client will be referred and authorized for treatment. If the client meets eligibility criteria and chooses methadone therapy a face to face appointment will be scheduled with the client.</td>
</tr>
<tr>
<td>Staff</td>
<td>2. During the face to face appointment, prior treatment history will be reviewed, including any records the client may bring regarding previous methadone therapy treatment they have received, and the methadone therapy program criteria for the program to be authorized. The client will sign and be given a copy of the WCHO/Client/Provider Agreement (see Attachment A).</td>
</tr>
<tr>
<td></td>
<td>3. The client may choose from WCHO’s list of Opioid Treatment program providers. An initial authorization is entered into the Encompass System. Appropriate release of information forms will be completed and signed. HSA will contact the selected provider and notify the provider of the referral. The client must complete a UDS at the provider prior to the initiation of methadone dosing. The provider will complete the admission process in order to obtain continuing authorization materials. Initial authorization may be up to 90 days.</td>
</tr>
<tr>
<td>Provider Clinician</td>
<td>1. If after the face-to-face evaluation Methadone therapy is not recommended, the reviewing clinician will make a recommendation on the most appropriate level of drug free substance abuse treatment for the client.</td>
</tr>
<tr>
<td></td>
<td>2. All clients will be issued a notice of grievance and appeals rights, and any pertinent Medicaid Notice of Hearing Rights upon denial of Methadone services within the required time frames.</td>
</tr>
</tbody>
</table>
Provider Clinician

3. Will Enter admission information in ENCOMPASS, complete physical and behavioral assessment of client’s current opioid dependence and other biopsychosocial needs. Develop individualized treatment plan.

REAUTHORIZATION OF METHADONE SERVICES

Utilization Review Manager

1. A medical necessity utilization review will be completed for all clients on a regular basis and at a minimum of every 90 days for determination of continuing Methadone therapy. The continuing stay authorization may be issued for a maximum of 90-days as determined by medical necessity and treatment planning process.

Provider Clinician

1. The provider will complete the Utilization Review form in the Encompass System (see Attachment B) and submit it through the Encompass System to the Utilization Manager along with the results of UDS obtained over the prior authorization time frame. Documentation of any prescriptions that would influence the UDS must also be sent for review, as well as evidence of coordination with the individual’s primary care physician.

Utilization Review Manager

1. The information on the Utilization Review form and the UDS will be reviewed for appropriateness of documentation and completeness.

2. If there is adequate documentation for the Utilization Review Manager to continue authorizing Methadone therapy treatment, a 90-day authorization will be generated and the process will continue every 90 days (unless otherwise indicated).

3. If there is insufficient evidence in the documentation to re-authorize Methadone services for another authorization period, Utilization Review Manager will request additional documentation via the Encompass system or may contact the provider for a telephonic review in order to adequately determine the current status of the client’s progress. Client must demonstrate compliance to the individual plan of care, progress toward achieving goals; including demonstrating progress toward becoming drug free.
<table>
<thead>
<tr>
<th>WHO</th>
<th>DOES WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCHO Medical Director</td>
<td>1. If there is still insufficient information to authorize treatment after review with the provider, the Utilization Review manager will refer the case to the WCHO Medical Director/designee for review.</td>
</tr>
<tr>
<td>2. The Medical Director/designee may authorize continued treatment or may conduct a physician-to physician telephonic review with the treating physician.</td>
<td></td>
</tr>
<tr>
<td>3. The Medical Director/designee may authorize, or deny treatment and redirect the client to an alternative level of care.</td>
<td></td>
</tr>
<tr>
<td>Utilization Review Manager</td>
<td>1. <strong>If the decision is to authorize continued Methadone therapy treatment:</strong></td>
</tr>
<tr>
<td></td>
<td>a. Will issue an authorization for 90 days (unless otherwise indicated).</td>
</tr>
<tr>
<td></td>
<td>b. Will communicate this information to the provider and client and issue an authorization.</td>
</tr>
<tr>
<td>2. <strong>If the decision is to deny treatment based on medical necessity criteria:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Will notify the client of their rights to file a recipient rights complaint and/or an appeal by sending them a Notice of Denial of Services (see attachment C).</td>
</tr>
<tr>
<td></td>
<td>b. Medicaid recipients will also be sent their notice of hearing rights (Refer to the Michigan Department of Community Health Request for Hearing form).</td>
</tr>
<tr>
<td></td>
<td>c. Will authorize up to 45 days per Medical Director/designee’s direction to allow for detoxification from Methadone.</td>
</tr>
<tr>
<td></td>
<td>d. Will notify the client to call HSA to be reevaluated for the most appropriate level of care. This information is communicated to the client either through the treating therapist (if the client is still in therapy) or sent in the mail.</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td><strong>DOES WHAT</strong></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Client</td>
<td>1. Contacts HAS for additional services.</td>
</tr>
<tr>
<td>Health Services (HAS) Staff</td>
<td>1. Will screen client for the most appropriate level of care and will be referred for continued treatment at that level.</td>
</tr>
</tbody>
</table>
I, ___________________________ agree this day ________________,

To the following conditions in order to receive and/or continue receiving the WCHO-funded methadone treatment benefit:

1. I agree to reduce my use of all illegal and non-prescribed drugs to the point of abstinence from all illegal and non-prescribed drugs.

2. I agree to reduce my alcohol intake to the point of abstinence from all alcohol.

3. I understand that methadone is used for the treatment of addiction to opioid drugs and not for pain management.

4. I agree to daily attend the methadone clinic for dosing (with the possible exception of Sundays and holidays).

5. I agree to participate with my provider to develop an individualized treatment plan which may include group and individual treatment sessions. Once this plan is developed, I agree to comply with the goals and objectives of the treatment plan.

6. I agree to follow all treatment program rules and policies. If I do not, I may be placed on probation and/or be detoxed from the methadone clinic.

7. I understand I am expected to give the names, addresses and phone numbers of all my doctors, dentists and pharmacies. I also understand I am to sign Authorizations to Release Information with my medical, dental and pharmacy providers in order to better coordinate my treatment. I am aware that if I refuse to meet these expectations, it could negatively impact my success with treatment.

8. I agree to produce a valid prescription or current medication bottle (s) with doctor’s name on the label for any controlled substances I take (especially pain medications and medications for anxiety). I understand I may be expected to authorize communication between my primary clinic and my methadone clinic in order to coordinate the best care for me.

9. I understand I may be asked to change my prescribed medications as part of my treatment plan for recovery.

10. I understand I am to submit random urine drug screens. I agree to submit to all urine drug screens, with the understanding that not doing so is the same as a positive screen. I understand specimens that have been tampered with will be considered a positive screen.
11. I understand if I test positive for a controlled substance that I have not previously provided a valid prescription for, I agree to present a valid prescription or current medication bottle(s) with the doctor’s name on the label for the controlled substance.

12. I understand that I can place myself at risk of discharge for the following reasons:

   a. Treatment goals not met within two (2) years
   b. Repeated or continued use of one or more other drugs/alcohol prohibited on the client’s treatment plan, or drug screens negative for methadone metabolites
   c. Failure to attend individual and/or group counseling sessions or psychiatric appointments
   d. Repeated failure to follow through on other referrals in the treatment plan
   e. Failure to comply with necessary medical care for a condition diagnosed by a licensed physician
   f. Failure to submit to drug testing as requested
   g. Failure to provide documentation of prescribed medications

13. I understand that if I continue to put myself at risk of discharge, I will be offered detoxification from methadone and my treatment will be terminated.

14. I understand that I am expected to taper off methadone by the end of two years or to have become rehabilitated to the point where I am able to assume payment for my treatment.

15. I agree to follow my treatment plan in order to get the most out of my time in treatment. I understand I may be offered a program of detoxification, stabilization and drug-free services for ongoing substance abuse treatment if I am discharged from the methadone clinic.

16. I understand that my treatment may also be terminated for the following violations:

   a. Possession of a weapon on clinic property
   b. Assaultive behavior against staff and/or other clients
   c. Verbal or physical threats against staff and/or other clients
   d. Diversion of controlled substances, including methadone
   e. Diversion and/or adulteration of drug screen samples
   f. Possession of controlled substance with intent to use/sell on methadone clinic property
   g. Sexual harassment of staff and/or other clients
   h. Loitering on clinic property or within one (1) block radius of clinic

I have read this agreement, have had it explained to me, and I understand it. I agree to comply with this WCHO/Client/Client Agreement.

Client signature and date

WCHO staff signature and date

From: Methadone Treatment Provider
To: WCHO
_______________________ has read and had the WCHO OTP Client Agreement explained to him/her and has agreed to meet the terms of this agreement by signing this document.

Please sign and date this document to ensure that you are aware that the client has agreed.

Clinician’s signature and date

Please fax the clinician signed copy back to the WCHO at 734-544-6726 and place the signed original in the client’s file. Thank you.
Concurrent Review Form

### Request more Authorization

<table>
<thead>
<tr>
<th>Date</th>
<th>Consumer</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Diagnosis

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<tr>
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<th>Rule Out</th>
<th>Rule Out</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXIS I</td>
<td></td>
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<tr>
<td>AXIS IV</td>
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</tr>
</tbody>
</table>

### Provider

Provider

### Therapist

Therapist

### List All Dates of Service

### Current Goals

1. **Stage of Change**
   - Precontemplation
   - Contemplation
   - Preparation/Determination
   - Action
   - Maintenance

2. **Stage of Change**
   - Precontemplation
   - Contemplation
   - Preparation/Determination
   - Action
   - Maintenance

3. **Stage of Change**
   - Precontemplation
   - Contemplation
   - Preparation/Determination
   - Action
   - Maintenance

4. **Stage of Change**
   - Precontemplation
   - Contemplation
   - Preparation/Determination
   - Action
   - Maintenance

5. **Stage of Change**
   - Precontemplation
   - Contemplation
   - Preparation/Determination
   - Action
   - Maintenance

### Progress toward above Goals

### Minkoff Quadrant

<table>
<thead>
<tr>
<th></th>
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<th>substance abuse only, no psych</th>
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</thead>
<tbody>
<tr>
<td>QI: (low psych, substance abuse)</td>
<td></td>
<td>QII: (high psych, substance abuse)</td>
</tr>
<tr>
<td>QIII: (low psych, substance dependence)</td>
<td></td>
<td>QIV: (high psych, substance dependence)</td>
</tr>
</tbody>
</table>

### Relapse/Continued Use Potential

### Other Factors

(Pregnancy, Biomedical, Emotional/Behavioral, Legal, Recovery Environment)
Changes in Employment/Insurance/Co-pay Status

Current Medications

Is this client being prescribed any opiates, barbiturates, or benzodiazepines?  ☐ Yes  ☐ No
If yes, by whom (PCP, psychiatrist, etc)?

If yes, has a doctor-to-doctor consult occurred?  ☐ Yes  ☐ No
When and what were the results?

Were non-narcotic alternatives discussed with client's physician?

Does Client continue to need this level of care?
If yes, justification for continued stay

Additional Units Requested

If no, request for step down; or Discharge/Aftercare plan

Date of First Follow-Up Appointment

Time of First Follow-Up Appointment

Resource referrals attempted/completed

Discharge Date

Discharge Reason

To Be Completed By Methadone Providers Only

DRUG SCREEN RESULTS MUST BE FAXED TO UR COORDINATOR PRIOR TO REVIEW

Current Dose of Methadone

MG

Length of time on this dose

Take home status/schedule

Client Attendance (# of individual Sessions)

Client Attendance (# of individual Groups)

Current Medical Complications

Coordination with the Primary Care Physician (Please elaborate)

If client has screened positive for any substances during this review period, has the treatment plan changed to reflect how this is being handled? Please elaborate

Has diminishing dose schedule been discussed with client? If so, please elaborate

Disposition and Authorization Form

Admission Date

Reviewer

Review Date

Units Previously Authorized

Additional Units Authorized

Total Units Authorized to Date

Next Review Date
Comments/Instructions for Provider (will appear at the top of the page for the provider)

Status
☐ Approved ☐ Denied ☐ Needs follow up from Provider

Denial Reason
☐ Doesn't Meet Criteria for this LOC ☐ Housing Issue ☐ Not a Resident of County
☐ Other Funding sources available: 
☐ Other Placement Issue: 

Enter your encompass password and click the SAVE button to save any changes. If you don't agree with the clinician's request for additional authorization, contact the clinician for modifications.

SAVE

Record Added Record Changed

CANCEL

Thursday, April 06, 2006  1:00 PM Eastern Time  Barbara Fortune
NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID RECIPIENTS

(Recipient Name and I.D. #)                                                                              (Date)

Following a review of the services that you are currently receiving, it has been determined that the following service(s) must be denied or changed as follows:

<table>
<thead>
<tr>
<th>Service(s)</th>
<th>Action to be Taken</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

If you do not agree with this action you may:

- Speak with your worker or his/her supervisor. They will be happy to discuss this with you and try to resolve your concerns. They can also help you access any available conflict resolution mechanisms.

- Ask for a second opinion if your application for services has been denied, or if hospitalization has been denied, by signing, dating and returning the enclosed Request for Second Opinion form to WCHO within 30 days.

- Ask for a review by the Washtenaw Community Health Organization Local Dispute Resolution Committee by contacting your local Grievance and Appeals Officer or your local Office of Recipient Rights at (734) 544-3000 within 90 days of the date of this Notice. In an emergency situation, an LDRC meeting may be held within 24 hours of receiving the necessary information.

- Once you receive a written decision from the Local Dispute Resolution Committee, if you are not satisfied with the outcome, you may then ask for a review by the Michigan Department of Community Health Alternative Dispute Resolution Process.

If you would like further information or if you want help in pursuing your appeal options, please contact your local Grievance and Appeals Officer, Member Services, or your local Office of Recipient Rights at (734) 544-3000.

You can also contact the Regional Fair Hearings Officer at (734) 544-3000 for help with your appeal.
CLIENT INFORMATION RELEASE AUTHORIZATION

I, _______________________________ Date of Birth: ________________ am currently receiving Methadone Therapy and hereby authorize, Name of Clinic _____________________________ its director or designee, counselor, and/or case manager to release and obtain information contained in my client records under the following conditions:

1. Name of person(s) or organization to whom disclosure is to be made:
   
   LIVINGSTON-WASHTENAW COUNTY COORDINATING AGENCY – Health Services Access

2. Specific type of information to be disclosed: The information pertaining to the diagnosis, participation, progress, treatment and prognosis of the above named client during the course of treatment including HIV/AIDS/ARC, psychiatric/mental health and substance abuse information. This includes information via telephone, facsimile or U.S. Mail. Other: _____________________

3. Purpose and need for the disclosure: Medical evaluation for continuing Methadone Therapy and coordinating treatment, planning and follow up services:
   
   Other: ________________________________________________

4. This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished.

5. Without expressed revocation, this consent expires for the following specified reasons:
   
   DATE: ______________________________ EVENT: ________________________________
   
   CONDITION: _________________________________________

   If none is specified, release automatically expires upon the client’s discharge from the agency or organization to which the client was referred for treatment, or within 1 year from the date of the client’s signature.

   I understand that my records cannot be disclosed without my written permission as stated in the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, unless otherwise provided for in the regulations. According to Reference MCL 333.5131 (5) (s), I acknowledge that my records contain or may contain HIV or AIDS information.

   Client To Initial One:
   
   _____ I do not wish to continue Methadone Treatment and request Detoxification from Methadone
   _____ I wish to continue Methadone Therapy with the goal of becoming drug free.
   _____ I wish to continue Methadone Treatment and agree to the conditions of treatment.

   Client comments:
   
   ____________________________________________________________________________________
   
   ___________________________ ____________________________
   Client signature (or parent/guardian, if applicable) Date

   ___________________________ ____________________________
   Physician Signature Date

Attachment E
Methadone Continuing Care Evaluation

To be completed by treating physician

Date: ____________________
Client Name: ________________________________________________________________
Clinic Name: ________________________________________________________________
DSM IV Diagnosis: ____________________________________________ Code: _________
HIV Status: __________________________________
Hepatitis Status: _______________________________

To determine whether a patient should continue in Methadone treatment, the program physician in cooperation with the clinical staff must use the following ASAM Patient Placement criteria in evaluating the client.

1. Acute narcotics dependence and/or potential relapse (check at least one):
   _____ Continued Methadone maintenance is required to prevent relapse to illicit narcotic use.
   _____ The patient needs ongoing medical monitoring and access to medical management.
   _____ Patient continues to have adequate support systems to ensure commitment to continuing Methadone maintenance treatment.

   Explain:
   __________________________________________________________________________
   __________________________________________________________________________

2. Biomedical Conditions and Complications (check at least one):
   _____ There is a current or chronic illness and opiate addiction problem that requires medical monitoring and management.
   _____ There is a presence of or potential for:
   episodic use of drugs other than narcotics; Positive HIV Status or AIDS; Chronic health conditions that could be medically compromised with discontinuation of Methadone maintenance treatment, including but not limited to liver disease or problems with the hepatic decompensation, Pancreatitis, Gastrointestinal, cardiovascular, and other systems disorders, Sexually transmitted diseases, Concurrent psychiatric illness requiring psychotropic medications; Tuberculosis, Hepatitis.
   _____ Patient is pregnant and narcotic dependent.

   Explain:
   __________________________________________________________________________
   __________________________________________________________________________

3. Emotional/Behavioral Conditions and Complications (check at least one):
   _____ Patient’s emotional/behavioral functioning may be jeopardized by discontinuation of Methadone maintenance treatment.
   _____ Patient demonstrates the ability to benefit from Methadone treatment but may not have achieved significant life changes.
   _____ Patient’s making progress toward resolution of an emotional/behavioral problem, but has not sufficiently resolved problems to benefit from a transfer from Methadone maintenance to a less intensive level of care.
   _____ Patient’s emotional/behavioral disorder continues to distract the patient from focusing on treatment goals, however, the patient is responding to treatment, and it is anticipated that with additional intervention the patient will meet treatment objectives.
   _____ Patient continues to exhibit risk behaviors endangering self or others but the situation is improving.
   _____ Patient is being detained pending transfer to a more intensive treatment service.
   _____ Patient has a diagnosed but stable emotional/behavioral or neurological disorder which requires monitoring, management, and/or psychotropic medication due to the patient’s history of being distracted from recovery and/or treatment.
4. Treatment Acceptance/Resistance (check at least one):

   - Patient recognizes the severity of the drug problem, however, the patient exhibits little understanding of the detrimental effects of drug use, including alcohol, yet the patient is progressing in treatment. 
   - Patient recognizes the severity of the addiction and exhibits an understanding of his/her relationship with narcotics, however, the patient does not demonstrative behaviors that indicate the patient has assumed responsibility necessary to cope with the situation. 
   - Patient is becoming aware of responsibility for addressing the narcotic addiction, but still requires current level of treatment and psychotherapy to sustain person responsibility in treatment. 
   - Patient has accepted responsibility for addiction and has determined that ongoing Methadone treatment is the best strategy for preventing relapse to narcotics dependence.

Explain: ____________________________________________________________________________________
___________________________________________________________________________________________

5. Relapse Potential (check at least one):

   - Due to continued relapse attributable to physiological cravings, the patient requires structured outpatient psychotherapy with Methadone to promote continued progress and recovery. 
   - Patient recognized relapse cures, but has not developed or exhibited coping skills to interrupt, postpone or neutralize gratification, or to change impulse control behavior. 
   - Narcotic symptoms are stabilized, but have not been reduced to support successful functioning without structured outpatient treatment. 
   - Pharmacotherapy (Methadone) has been effective as an adjunct to psychotherapy and as a strategy used to prevent relapse, however, withdrawal from Methadone is likely to lead to recurrence of addiction symptoms and, possibly, relapse.

Explain: ____________________________________________________________________________________
___________________________________________________________________________________________

6. Recovery Environment (check at least one):

   - Patient has not integrated and exhibited coping skills sufficient to survive stressful situations in the work environment, or has not developed vocational alternatives. 
   - Patient has not developed coping skills sufficient to successfully deal with a nonsupportive family and social support environment or has not developed alternative living support systems. 
   - Patient has not integrated and exhibited the socialization skills essential to establishing a supportive family and social support environment. 
   - Patient has responded to treatment of psychosocial problems affecting patient’s social and interpersonal life; however, the patient’s ability to cope with psychosocial problems would be limited if the patient is transferred to a less intensive level of treatment. 
   - Patient’s social and interpersonal life has not changed or deteriorated, however, the patient needs additional treatment to cope with his/her social and interpersonal life or to take steps to secure an alternative environment. 
   - Emotional and behavioral complications of addiction are present, however, the behavioral complications are manageable in a structured outpatient program. The behaviors include: 1) criminal activity involving illicit drugs, 2) victim of abuse or domestic violence, 3) inability to maintain a stable household, including the provision of food, shelter, supervision of children and health care, and 4) inability to secure or retain employment.

Explain: ____________________________________________________________________________________

Has client been consistent with clean urines? Yes No
If no, explain reason and plan: ____________________________________________________________________________________
___________________________________________________________________________________________

Has client been consistent with attending Individual and/or Group Therapy sessions? Yes No
If no, explain reason and plan:
____________________________________________________________________________________________
____________________________________________________________________________________________

Does the client have any medical conditions that are currently being treated?  Yes  No
If yes, explain: ________________________________________________________________________________
____________________________________________________________________________________________

Client’s Mental Status:
____________________________________________________________________________________________
____________________________________________________________________________________________

Physician comments (include any information client treatment information that is not covered in this review that must be considered for re-evaluation of medical necessity for continuing Methadone Therapy):
____________________________________________________________________________________________
____________________________________________________________________________________________

Print Physician Name  ____________________  Signature  ____________________  Date  ____________________
Attach copy of last 6 months of Urine Drug Screens, Concurrent Review Form and Treatment Plan

CLIENT: ________________________________  CLINIC: _________________________ DATE: __________

TO BE COMPLETED BY REVIEWING PHYSICIAN CONSULTANT

Please initial

_____ Client meets medical necessity for continuation of Methadone Therapy.

_____ Client does not meet medical necessity for continuation of Methadone Therapy.
   Alternative treatment is recommended.

Explain: __________________________________________________________________________

_____ Client should be placed on probationary status and re-reviewed in ______ months.

Explain: __________________________________________________________________________

_____ Face to face evaluation is needed with the client to gather further information. Schedule within ____________

_____ Physician to physician review is recommended.

Comments:
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Print Physician Name   Signature   Date

Date of Face to Face Evaluation (if applicable): ___________ Time in: ___________ Time out: ___________

Comments:
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Print Physician Name   Signature   Date

Date of Physician to Physician review: _______________ Provider/client’s physician: ____________________

Comments:
______________________________________________________________________________________________________

Print Physician Name   Signature   Date

Please initial for final recommendation:

_____ Client meets medical necessity for continuation of Methadone Therapy.

_____ Client does not meet medical necessity for continuation of Methadone Therapy.
   Alternative treatment is recommended.

Explain: __________________________________________________________________________

_____ Client should be placed on probationary status and re-reviewed in ______ months.

Explain: __________________________________________________________________________

Print Physician Name   Signature   Date

___________________________  _______________________________   ____________________
Print Physician Name   Signature   Date

Utilization Review     Agency    Date