Hennepin Health
your community health plan

Check box for:
❑ Initial client treatment notification
❑ Extension request
❑ MA admit now enrolled with HH

HH SUD Treatment Notification_Extension request

Placement Notification - fill out this form in full and attach SUD Comprehensive Assessment
Extension Request - complete extension request sections and attach the most recent treatment plan

Request date _____ Name of person completing _____

Email/direct dial _____

Initial placement date	Extension start date	PMI# (Recip ID)	Client's legal name (Last name, first, middle)

Client alias (if any)	DOB (MM/DD/YYYY) / /	For extension requests,total units used (days)	For extension requests, total units used Hours: 15 min.:	Last county of residence before any excluded time

Date processed by county / /	County reviewer signature	SSIS WG#	Social Security number _ _

Marital status:		Gender:	Hispanic?	Language
❑ Divorced	❑ Never married	❑ Male	❑ Yes	
❑ Married	❑ Living apart	❑ Female	❑ No	
❑ Legally separated	❑ Widowed			
	❑ Unknown			

Race: ❑ White ❑ Black ❑ American Indian
❑ Asian/Pacific Islander ❑ Other ❑ Unknown

Placement & Financial

Comprehensive assessment date or date of update / /	Risk assessment ratings (0-4): Dim 1: _____ Dim 4: _____ Dim 2: _____ Dim 5: _____ Dim 3: _____ Dim 6: _____	Indicate if client is: ❑ Minor ❑ Pregnant ❑ Adult with minor	Diagnosis Code _____

Procedure code (if applicable)	Program specifics/modifiers (must check all that apply)	Drug code (if applicable)	Service start date	Service end date
❑ H2036	❑ Co-occurring services	❑ Methadone (M)	/ /	/ /
❑ H2035	❑ Recipients with children	❑ Naltrexone (N)		
❑ H2035-HQ	❑ Special populations	❑ Buphenorphine (B)		
❑ H0020	❑ Committed client			
❑ H0047	❑ Medical services			
	❑ Disability responsive			
	❑ Adolescent			

Revenue code: ❑ 944 Drugs ❑ 945 Alcohol ❑ 953 Drugs and Alcohol
❑ 0101 Hospital Daily ❑ 1002 Room and Board same location ❑ 1003 Room and Board different location
❑ (Sober housing-recovery residence)

Total # units ___ Days ___ Hours _____ 15 min.	NPI # ___ ASAM Level of Care	Provider name and location or address where services will be delivered

Glossary on page 3.

Client initials _____

Date of birth _____

Procedure code (if applicable)	Program specifics/modifiers (must check all that apply)	Drug code (if applicable)	Service start date	Service end date
❑ H2036 ❑ H2035 ❑ H2035-HQ ❑ H0020 ❑ H0047	❑ Co-occurring services ❑ Recipients with children ❑ Special populations ❑ Committed client ❑ Medical services ❑ Disability responsive ❑ Adolescent	❑ Methadone (M) ❑ Naltrexone (N) ❑ Buphenorphine (B)	/ /	/ /

Revenue code: ❑ 944 Drugs ❑ 945 Alcohol ❑ 953 Drugs and Alcohol
❑ 0101 Hospital Daily ❑ 1002 Room and Board same location ❑ 1003 Room and Board different location
❑ (Revenue code/sober housing-recovery residence)

Total # units	NPI #	Provider name and location or address where services will be delivered
___ Days ___ Hours _____ 15 min.	___ ASAM Level of Care	

Procedure code (if applicable)	Program specifics/modifiers (must check all that apply)	Drug code (if applicable)	Service start date	Service end date
❑ H2036 ❑ H2035 ❑ H2035-HQ ❑ H0020 ❑ H0047	❑ Co-occurring services ❑ Recipients with children ❑ Special populations ❑ Committed client ❑ Medical services ❑ Disability responsive ❑ Adolescent	❑ Methadone (M) ❑ Naltrexone (N) ❑ Buphenorphine (B)	/ /	/ /

Revenue code: ❑ 944 Drugs ❑ 945 Alcohol ❑ 953 Drugs and Alcohol
❑ 0101 Hospital Daily ❑ 1002 Room and Board same location ❑ 1003 Room and Board different location
❑ (Revenue code/sober housing-recovery residence)

Total # units	NPI #	Provider name and location or address where services will be delivered
___ Days ___ Hours _____ 15 min.	___ ASAM Level of Care	

For extension requests, you do not need to complete an assessment update. **On the blank sheet provided, or on a separate sheet**, please explain in 1-2 paragraphs why the client would benefit from continued services at the current level of care, and what specific issues or services need to be addressed/provided for the client to be ready to step down to the next level or to complete treatment. Show current risk ratings/rationale by attaching an updated treatment plan review.

Please submit within 10 days of admission or 10 days before initial units will be exhausted
Submit to: **Hennepin County Addiction and Recovery Services** **hc.reviewteam@hennepin.us**
Fax: **612-466-9546** (alternative analog fax 612-330-2318) Phone: 612-879-3671

Client initials _____

Date of birth _____

Initial placements will be limited to the following intervals before an extension request is required:

- 18 days for inpatient hospital-based stays
- 60 days for residential placements
- 300 group hours (30 one to one hours) for outpatient treatment services

Glossary

Modifiers

___ Co-occurring (HH)
___ Special Populations/Culturally Specific (U4)
___ Medical (U5)
___ Client with Child (U6)
___ Co-occurring and Medical combined (UC)
___ Committed Complex (HK)
___ Disability Responsive (U3)
___ Adolescent (HA)

Additional Billable Services

___ Comprehensive Assessments (H001)
___ Room and Board (1002)
___ Care Coordination (T1016 HN,U8)
___ Room and Board/different location (1003)
(15-minute increments-up to 2 hours per day per client)
___ Peer Support (H0038 U8)
(15-minute increments-up to 4 hours per day per client, maximum of 56 units month/14 hours per week)

Level of care

Adult outpatient (H2035 HQ Group) (H2035 one to one)

___ 1.0 outpatient up to 8 hrs. per week
___ 2.5 Partial Hospital 20 hours or more per week
___ 2.1 outpatient 9-19 hrs. per week

Adult Residential (H2036)

___ 3.1 Low Intensity 5 hrs. per week
___ 3.3 Disability responsive/daily skilled services 7 days per week
___ 3.1 Low Intensity 15 hrs. per week
___ 3.5 High Intensity daily skilled services 7 days per week

Hospital Inpt. (0101)

___ 3.7 Hospital Inpt. SUD

Opiate Treatment Program (180 Days)

___ MOUD Methadone (H0020) __ Plus 9 additional hrs. per week (UA)
___ MOUD Other (H0047) __ Plus 9 additional hrs. per week (UB)

Adolescent level of care

___ 1.0 outpatient up to 5 hours per week (H2035 HQ Group) (H2035 one to one)
___ 2.1 outpatient 6 or more hrs. per week (H2035 HQ Group) (H2035 one to one)
___ 3.5 Residential daily skilled services 7 days per week (H2036)

Extension Request Rationale

What has the client accomplished previously, what they are working on now, and what do they need to work on given additional time in treatment using ASAM criteria as a framework.

Client initials _____

Date of birth _____