BLUE SHIELD OF CALIFORNIA
INTENSIVE OUTPATIENT TREATMENT (IOP)
SUBSTANCE USE DISORDERS - CONCURRENT REVIEW (CCR)
SEND COMPLETED FORM TO SECURE FAX 1-888-656-0818

Patient name: _____ DOB: _____
Subscriber ID#: _____ Case #: _____
1. Total sessions authorized to date for this admission: ___
2. Sessions authorized based on last review (included in # listed above): ___
3. Date span of sessions authorized in #2 above _____ to _____ **Next review due date**: _____

Magellan accepts verbal or written requests for IOP CCR. This form is provided for ease and convenience to facilitate the concurrent review process. Use of this form will reduce delays resulting from insufficient information.

TO BE COMPLETED BY FACILITY ON OR BEFORE THE "NEXT REVIEW DUE DATE" INDICATED ABOVE:

☐ I attest that the information contained in this treatment request is accurate and supported by the medical record.
Utilization reviewer name: _____ Phone: _____ Fax: _____
Credentials: _____ License number: _____ Date: _____

Number of sessions attended to date for this admission: _____
Days member attends IOP: M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐

Last date attended: _____ Projected discharge date: _____
Are you requesting an extension to the authorization end date? Yes ◯ No ◯ If so, to what date?
Reason for extension:
If you selected "Yes", indicate the reason and date of the extension. No additional information is needed.

Indicate diagnosis codes:
Behavioral: _____
Medical: _____

Do you verify that all clinically appropriate assessments have been completed? Yes ◯ No ◯
If no, explain:
What progress has the member made on the symptoms presented upon admission? Include changes in severity and frequency since admission/last review:

Describe any withdrawal symptoms the member may still be experiencing and how they are being addressed:

CIWA / COWS scores:_____
Vitals: BP_____ Pulse _____ Temp_____ RR_____
Current drug screens/BAL results:_____ What is the member's current assessed motivation for change and recovery? (Internal/External)

BLUE SHIELD OF CALIFORNIA
INTENSIVE OUTPATIENT TREATMENT (IOP)
SUBSTANCE USE DISORDERS - CONCURRENT REVIEW (CCR)
SEND COMPLETED FORM TO SECURE FAX 1-888-656-0818

Patient name:_____ Subscriber ID#:_____

Does the member have any co-morbid conditions that are impacting their substance abuse treatment? Yes ◯ No ◯

If so, identify conditions and how the program is addressing:

Describe the member's support system and how they are engaged in the treatment program:

Sponsor engaged: Yes ◯ No ◯ If no, explain why not:

Attending AA/NA groups: Yes ◯ No ◯ Onsite or offsite:

Describe any risk factors the member is presenting currently. Include harm to self, harm to others, and threats of violence. Include severity and interventions associated with current risk.

How often are you validating the member's level of safety?

What is the member's current treatment plan specific to the presenting and current symptoms?

Describe any barriers and interventions the member has that are preventing him/her from progressing in their treatment goals:

Has the member been seen by a medical professional/psychiatrist since last review? Yes ◯ No ◯
If yes, provide the date: _____

Has the member been assessed for MAT medications/outcome of assessment? Yes ◯ No ◯

Is the patient a candidate for OBOT services (ongoing Suboxone treatment in the community to help reduce cravings)? Yes ◯ No ◯

Medications (include dosage/frequency indicating changes/updates since last review):

Explain reasons the member cannot be managed in an outpatient or community-based program currently:

Patient name:_____ Subscriber ID#:_____

Discharge planning:

Indicate the current discharge plan for the member (home with others, home alone, shelter, SLE, outpatient psychiatrist, OBOT, therapist, PCP):

Include coordination of care that is occurring with other providers involved in member's care (PCP, therapist, psychiatrist, etc.):

Does the member have any medical conditions that are impacting their behavioral health treatment?
Yes ○ No ○ If yes, describe:

If the member is being discharged on medications, has the member been educated on their medications, dosages, regimen and importance of compliance?

Yes ○ No ○ Describe:

What is the main barrier for discharge from IOP currently?

BLUE SHIELD OF CALIFORNIA
INTENSIVE OUTPATIENT TREATMENT (IOP)
SUBSTANCE USE DISORDERS - CONCURRENT REVIEW (CCR)
SEND COMPLETED FORM TO SECURE FAX 1-888-656-0818

Patient name:_____ Subscriber ID#:_____

FINAL DISCHARGE INFORMATION

****SUBMIT THIS PAGE ONLY UPON DISCHARGE****

Utilization reviewer name: _____ Phone: _____
Member name: _____
Member address: _____
Member city: _____ State: _____ Zip: _____
Member phone: Home: _____ Cell: _____

Discharge date: _____
Total number of IOP sessions used: _____

Discharge plan:
Therapist name: _____ Phone: _____
Appointment date and time: _____

MD name: _____ Phone: _____
Appointment date and time: _____

Other referrals and community resources provided at discharge:

Discharge status (completed program/AMA):

Discharge medications: