Residential Rehabilitation Services (RRS) First Clinical Review Form for In-Network Providers Only

Tufts Health Together - Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans (ACPPs): fax to: 888.977.0776

Tufts Health Unify, fax to: 857.304.6304

Today's date: ___/___/_____ Requested dates of service: from ___/___/___ *to* ___/___/____

To ensure continuous authorization, requests must be received within one week before or after the previous authorization's end date. Use this form for the first clinical review; subsequent reviews are to be completed telephonically with a masters-level clinician from the RRS facility by calling 888.257.1985.

RSS Level: ☐ Adult ☐ Family ☐ Transitional ☐ Youth ☐ Pregnant/Post-Partum ☐ Co-occurring/enhanced

MEMBER INFORMATION

Member name: _____ Tufts Health Plan Member ID: _____
Member address: _____ Member phone: ____ / ____/ _____
City: _____ Member DOB: ____/____/_____
State: _____ ZIP:_____

PROVIDER INFORMATION

Provider organization name: _____ Organization phone: _____
NPI _____ Tax ID _____
Provider address: _____
Provider City/State/Zip: _____
Clinical contact name: _____ Supervisor name: _____
Clinical contact phone: _____ Supervisor phone:_____
Fax to send authorization to: ____/____/____

CLINICAL INFORMATION

1. ICD-10 Alpha Numeric Diagnosis Code: _____
Additional Alpha Numeric Diagnosis Code: _____
Additional Alpha Numeric Diagnosis Code: _____
Additional Alpha Numeric Diagnosis Code: _____

2. Is member involved with state agencies? (Select all that apply) ☐ None ☐ DMH ☐ DCF ☐ DDS ☐ DYS ☐ Other _____

3. Progress since admission:

_____
_____
_____
_____
_____

4. Please attach the most recent individualized recovery treatment/service plan as outlined in the Performance Specifications for this level of care.

5. Outline progress on goals and interventions to achieve goals and address barriers below:

_____
_____
_____

TUFTS Health Plan

6. How does member currently meet ASAM criteria for RRS?

Risk Ranking:

Risk Ranking	**4**	This rating would indicate issues of **utmost severity**. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an **"imminent danger"** concern.	**High**
	3	This rating would indicate a **serious issue** or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near "**imminent danger**."	**Moderate**
	2	This rating would indicate **moderate difficulty** in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.	
	1	This rating would indicate **a mild difficulty issue**, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.	**Low**
	0	This rating would indicate a **non-issue or very low-risk issue**. The patient would present no current risk and any chronic issues would be mostly or entirely stabilized.	

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Check one risk rating: ☐ 1 ☐ 2 ☐ 3 ☐ 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

_____
_____
_____
_____

Dimension 2: Biomedical Conditions/Complications

Check one risk rating: ☐ 1 ☐ 2 ☐ 3 ☐ 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

_____
_____
_____
_____

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
Check one risk rating: ☐ 1 ☐ 2 ☐ 3 ☐ 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

_____
_____
_____
_____

Dimension 4: Readiness to Change

Check one risk rating: ☐ 1 ☐ 2 ☐ 3 ☐ 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

_____
_____
_____
_____

Dimension 5: Relapse, Continued Use or Continued Problem Potential

Check one risk rating: ☐ 1 ☐ 2 ☐ 3 ☐ 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

_____
_____
_____
_____

Dimension 6: Recovery/Living Environment

Check one risk rating: ☐ 1 ☐ 2 ☐ 3 ☐ 4

As evidenced/demonstrated by these specific symptoms, behaviors, risks, needs, strengths, skills, barriers, resources:

_____
_____
_____
_____

7. Attach After Care Plan

8. Is Member receiving Medication Assisted Treatment (MAT)? ☐ Yes ☐ No

9. If yes, where is the treatment being administered?

_____

ATTESTATION

I attest that we are meeting the performance specifications for this level of care.

Signature: _____

Print Name: _____ Date:_____