INSTRUCTIONS
COMPLETING THE BEACON HEALTH OPTIONS INPATIENT TREATMENT REPORT (ITR)

NOTE: The form for completion and submission is at: http://www.valueoptions.com/providers/Forms/Clinical/Inpatient_Treatment_Report.pdf. This document is provided for informational purposes only to assist with completion of the form.

Please note: For most efficient and timely service – use of authorization request flow on ProviderConnect℠ is the preferred method of submitting requests for network Providers. For providers that are not part of the Beacon network or who do not have access to the web-based application the following instructions should be followed for completing the Inpatient/HLOC Treatment Report. To ensure timely processing of your Inpatient Treatment Report, please complete all sections for submission to Beacon. TYPE or PRINT LEGIBLY. Check/Circle responses where applicable.

Treatment Request:

Information requested	How to complete this section
Admit Date	Date of this admission
Requested Start Date for this Authorization	For a new request, this is the date of admission. For a continuing stay request, this is the first covered day for continued stay authorization.
Level of Care	Please see your Provider Relations Handbook for Level of Care definitions (Or see www.valueoptions.com)
Tx Unit/Program	If the patient is on a specialty unit please indicate (e.g., Eating Disorder Unit)

Type of Review Option	Definition
Prospective	The patient has not yet started the program or was admitted on an emergent basis without preauthorization within the prior 72 hours
Concurrent	The patient is currently enrolled in the program.
Discharge	The patient is being/has been released from the program.
Retrospective	The patient has already been admitted to and released from the program prior to submission of an ITR/request for authorization.

Demographics:

Information Requested	**How to complete this section**
Member/Policyholder ID #	This is usually the ID# from the member's benefit card. However, for some plans it is still the policy holder's SSN or Alternate ID#.
Insured's Employer/Benefit Plan	This is either the policy holder's employer's name or the Health Plan the member belongs to depending on who holds the contract with Beacon.
Fac. ID#	The Beacon Facility ID#
Attending Provider & Phone #	This is the provider who will follow the member throughout the admission.
UR Name and UR Phone #	This is the contact at the facility for clinical reviews/additional information.

Diagnostic Information

Symptomatology	Behavioral Diagnoses	Medical Diagnoses		Social Elements Impacting Diagnosis	Functional Assessment	Additional Medical Information
"Why now" Please explain the reason for current admission (describe symptoms) and include the precipitant (what stressor or situation led to this decompensation). If this is a concurrent review, please list both the progress that has been made to date, and what symptoms still remain.	Minimum requirement of primary behavioral diagnosis. List Primary; add additional as appropriate. Please list appropriate ICD code and description. Please see DSM-5for further instructions.	Options include: •Infectious & Parasitic - Other •Infectious & Parasitic - HIV •Cancer & Neoplasms •Blood, blood-forming organs, & immunological •Endocrine, nutritional & metabolic - Thyroid •Endocrine, nutritional & metabolic - Diabetes •Endocrine, nutritional & metabolic - Other •Endocrine, nutritional & metabolic - Overweight •Mental, Behavioral, Neurodevelopmental •Nervous system - Other •Nervous system - Parkinsons, EPS •Nervous system - Multiple Sclerosis •Nervous system - Migraine, Epilepsy, Stroke •Nervous system - Chronic pain, other •Eye - Other •Eye - Blindness •Circulatory system - Other	•Circulatory system - Hypertension •Circulatory system - Heart •Respiratory system - Other •Respiratory system - COPD, Asthma, Emphysema •Digestive system - Other •Digestive system - Liver •Skin & subcutaneous tissue •Musculoskeletal system & connective tissue •Genitourinary system - Kidney •Genitourinary system - Other •Pregnancy, childbirth •Perinatal period •Congenital malformation, deformation, & chromosome abnormality •Symptoms, signs & abnormal clinical/lab •Injury, poisoning & other effects of ext causes - TBI •Injury, poisoning & other effects of ext causes - Other •External causes of morbidity	Options include: •Educational problems •Financial problems •Problems with access to health care services •Problems related to interaction w/legal system/crime •Problems with primary support group •Housing problems •Occupational problems •Problems related to social environment •Other psychosocial & environmental problems (list details) •Unknown	Optional. May enter functional assessment from following list and score: •WHO_DAS •GAF •SF12 •SF36 •FAST •CDC HRQOL •OMFAQ •Other	Information concerning the individual's comorbid medical conditions as well as information concerning the individual's body mass index & potential impact on overall health may be entered for this section.

Current Risks:
Key: 0 = None, 1 = Mild or Mildly Incapacitating, 2 = Moderate or Moderately Incapacitating, N/A = Not Assessed

Information Requested	How to complete this section
Risk to self (SI)	Indicate individual's level of, or absence of, suicidality by circling the appropriate value. **This must be completed**
Risk to others (HI)	Indicate individual's potential for, or absence of, violence and/or abuse by circling the appropriate value. **This must be completed**.
Substance Use	Indicate individual's level of, or absence of, substance use by circling the appropriate value. This must be completed.

Primary Behavioral Diagnosis/ Risk Assessment

Suicide Symptom Complex :

- Presenting Problem (behavioral description of acuity; describe any attempt, rescue, self-rescue, lethality, medical treatment received):
- Ideation:
- Plan:
- Intent:
- Means:
- Baseline (include any suicidality, parasuicidality or self-injurious behavior at baseline):
- Describe any history of attempts:
- Treatment History:
- ICM needs (including Community, VO, CM, DM, etc):
- Other Information pertinent to member's history and current treatment request:

Eating Disorder Symptom Complex:

- Presenting Problem (describe any binging, purging, restricting, over-exercising, food rituals, etc):
- % IBW:
- Orthostatic BP: Standing ___ / _____; Sitting ____ / _____
- EKG, electrolytes, other lab info:
- Co-morbid medical issues:
- Co-morbid psychiatric issues:
- Baseline:
- Treatment History:
- ICM needs (including Community, VO, CM, DM, etc):
- Other Information pertinent to member's history and current treatment request:

Homicide Symptom Complex:

- Presenting Problem (who is the intended victim? Why does the member want to commit homicide or harm?):
- Ideation:
- Plan:
- Intent:
- Means:
- How is this reflective of mental illness versus maladaptive social behavior?
- Is there a Duty to Warn?
- Will provider do the Duty to Warn? (Note, if provider will not do duty to warn speak with your supervisor):
- Baseline:
- Describe any history of violence (including if member has ever attempted to kill or inflict serious harm):
- Legal involvement (past or present)?
- Treatment History:
- ICM needs (including Community, VO, CM, DM, etc):
- Other Information pertinent to member's history and current treatment request:

Comorbid Organic Brain Syndrome-Psychiatric Disorder Symptom Complex:

- Presenting Problem (behavioral description of acuity):
- Medical work up needed to rule out causality of symptoms?
- Has a neurological work up been completed?
- Does member have a UTI?
- Other labs completed:
- What is the member's baseline? And when was s/he last at baseline?
- Is the OP med regimen monitored for under or over medicating?
- Treatment History:
- Does the family have reasonable expectations about member's ability to return to baseline (or inability to return to baseline)?
- Is the member from a nursing home? If so, will the nursing home hold the bed for member's return?
- If member was living at home, will member be able to return home if recent baseline is achieved?
- ICM needs (including Community, VO, CM, DM, etc):
    - Other Information pertinent to member's history and current treatment request:

Psychosis Symptom Complex:

- Presenting Problem (behavioral description of symptomatology):
- Delusions:
- Hallucinations:
- Command Hallucinations:
- Thought Disorder:
- Baseline:
- First episode?
- Neurological workup needed?
- Is member medication compliant?
- Has provider explored past medications, compliance, effectiveness?
- Is there a need for different medication(s)?

Substance Use Symptom Complex:

- Presenting Problem (drug(s) of choice, route of administration, amount of use, frequency of use, age of first use, date of last use etc):
- Psychological & Legal consequences of use:
- Baseline:
- Treatment History (previous attempts at treatment & outcome):
- ICM needs (including Community, VO, CM, DM, etc):
- History of DTs or seizures:
- Could the patient be using drugs that wouldn't show on UDS?
- Other Information pertinent to member's history and current treatment request:

• Describe plan for medication compliance (including supports to assist prn): • Treatment History: • ICM needs (including Community, VO, CM, DM, etc): • Other Information pertinent to member's history and current treatment request:	
Child/ Adolescent Behavior Symptom Complex: • Presenting Problem (behavioral description of behavioral issues): • When do these behaviors tend to happen? • When was the last time these behaviors occurred? • Do these behaviors occur in the school? • Is school involved in current treatment plan? Describe coordination with school. • Is member involved with Special Ed? • Do these behaviors occur in the home? • Have family sessions occurred as often as necessary? • Do the behaviors occur in the community? • Legal/social service involvement? • Baseline: • Treatment History: • Specific to behavior plan, what assistance will family/guardians need in order to maintain behavior plan? • ICM needs (including Community, VO, CM, DM, etc): • Other Information pertinent to member's history and current treatment request:	**Mood Disorder Symptom Complex:** • Presenting Problem (behavioral description of acuity): • Baseline: • Treatment History: • If there are any psychotic symptoms, how are they being addressed? • If an antipsychotic is being used (for psychosis or as a mood stabilizer), has metabolic testing been done? • Is there a seasonal component? • Is this postpartum onset? • ICM needs (including Community, VO, CM, DM, etc): • Other Information pertinent to member's history and current treatment request:

Psychotropic Medications	**How to complete this section**
Current Psychotropic Medications	List current medications including start date, dosage, side effects, adherence, effectiveness, prescribing provider and any specific target symptoms. On concurrent – if medication is discontinued – please note date and details.
Free text section for additional medication information	With respect to all medications above, please enter any additional details that would assist in coordinating care.

Urine Drug Screen	**How to complete this section**
UDS completed?	Note details of urine drug screen
Outcome of UDS	Note details of urine drug screen
Positive For	Note details of urine drug screen

ASAM Dimensions (Required if request is Substance Use related):

Information requested	**How to complete this section**
Intoxicated/Withdrawal Potential	• Low – Not under the influence; no withdrawal potential • Medium – Recent use; moderate withdrawal potential requiring 24 hour monitoring • High – Severe withdrawal history; presenting with severe withdrawal; history or current seizure activity
Biomedical Conditions	• Low – No current medical problems or complications • Medium – Diagnosed medical condition requiring monitoring but not intensive treatment • High – History of, or identified medical condition that requires 24 hour medical/nursing monitoring and/or intensive treatment
Emotional/Behavioral/Cognitive Conditions	• Low – No current cognitive/emotional/behavioral conditions • Medium – Impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs. • High – Active suicidal/homicidal ideations; acutely psychotic/delusional/labile; impacting ability to engage in treatment; symptoms require 24 hour psychiatric care.
Readiness to Change	• Low – Ready for/Accepting need for treatment; attending, participating, and can ID future goals, plans • Medium – Ambivalent about treatment; seeking help to appease others; avoiding consequences; variable to poor engagement. • High – Lacks awareness of need for treatment despite severe consequences; refusing or is unable to engage; mandated for treatment by workplace, CPS and/or court system.
Relapse Potential	• Low – Recognizes onset signs; uses coping skills with CD or psychiatric problems • Medium – Awareness of relapse triggers or onset signs for MH/SA issues but requires close monitoring. • High – Continues to use; unable to recognize potential signs and triggers for MH/SA issues despite consequences; unable to control use without 24 hour structured setting.
Recovery Environment	• Low – Supportive recovery environment for MH/SA issues.

	• Medium – Moderately supportive environment/resources for MH/SA issues. • High – Environment does not support recovery behaviors or efforts; resides with active substance users or abusive individuals; coping skills and recovery requires a 24 hour structured setting.

	How to complete this section
Recovery and Resiliency Environment	To be completed on each review and updated as the recovery & resiliency plan is further developed.
Best Practice Endorsement	Best practice guidelines can be found for reference at http://beaconhealthoptions.com/providers/Handbook/treatment_guidelines.htm

Discharge Plan:

Information requested	**How to complete this section**
Planned D/C level of care	This should be completed for both admission and continued stay requests.

Discharge Information: To be completed upon discharge.

Information requested	**How to complete this section**
Actual Discharge Date	Date patient was discharged from the program
Primary discharge Diagnosis	Primary Diagnosis upon discharge from the program
Discharge Condition	Has the patient's condition improved, worsened or had no change from onset of treatment?
Treatment involved the following	Check all that apply. This must be completed
Total # Days/Sessions used	The total number of days/sessions used during this course of treatment
Discharge plans in place?	This must be completed
Actual Discharge Level of Care	This must be completed
Actual Discharge Residence	This must be completed
Follow Up Contact Information	Information to allow for aftercare followup with the individual
AfterCare Behavioral Health Provider	If arranged, enter provider's name, telephone #, scheduled appointment date and type of appointment. **This must be completed**
Prescribing Physician	If arranged, enter the physician's name, telephone #, check what type of physician it is and appointment date. **This must be completed**