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 ProviderConnectSM 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:

<table>
<thead>
<tr>
<th>Information requested</th>
<th>How to complete this section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit Date</td>
<td>Date of this admission</td>
</tr>
<tr>
<td>Requested Start Date</td>
<td>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.</td>
</tr>
<tr>
<td>Level of Care</td>
<td>Please see your Provider Relations Handbook for Level of Care definitions (Or see <a href="http://www.valueoptions.com">www.valueoptions.com</a>)</td>
</tr>
<tr>
<td>Tx Unit/Program</td>
<td>If the patient is on a specialty unit please indicate [e.g., Eating Disorder Unit]</td>
</tr>
</tbody>
</table>

Demographics:

<table>
<thead>
<tr>
<th>Information Requested</th>
<th>How to complete this section</th>
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</thead>
<tbody>
<tr>
<td>Member/Policyholder ID #</td>
<td>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#.</td>
</tr>
<tr>
<td>Insured’s Employer/Benefit Plan</td>
<td>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.</td>
</tr>
<tr>
<td>Fac. ID#</td>
<td>The Beacon Facility ID#</td>
</tr>
<tr>
<td>Attending Provider &amp; Phone #</td>
<td>This is the provider who will follow the member throughout the admission.</td>
</tr>
<tr>
<td>UR Name and UR Phone #</td>
<td>This is the contact at the facility for clinical reviews/additional information.</td>
</tr>
</tbody>
</table>

Diagnostic Information

<table>
<thead>
<tr>
<th>Symptomatology</th>
<th>Behavioral Diagnoses</th>
<th>Medical Diagnoses</th>
<th>Social Elements Impacting Diagnosis</th>
<th>Functional Assessment</th>
<th>Additional Medical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Why now?&quot; 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.</td>
<td>Minimum requirement of primary behavioral diagnosis. List Primary; add additional as appropriate. Please list appropriate ICD code and description. Please see DSM-5 for further instructions.</td>
<td>Options include:  •Circulatory system - Hypertension  •Circulatory system - Heart  •Respiratory system - Other  •Respiratory system - COPD, Asthma, Emphysema  •Digestive system - Other  •Digestive system - Liver  •Skin &amp; subcutaneous tissue  •Musculoskeletal system &amp; connective tissue  •Genitourinary system - Kidney  •Genitourinary system - Other  •Pregnancy, childbirth  •Perinatal period  •Congenital malformation, deformance, &amp; chromosome abnormality  •Symptoms, signs &amp; abnormal clinical/lab  •Injury, poisoning &amp; other effects of ext causes - TBI  •Injury, poisoning &amp; other effects of ext causes - Other  •External causes of morbidity</td>
<td>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 &amp; environmental problems (list details)</td>
<td>Optional. May enter functional assessment from following list and score:  •WHO_DAS  •GAF  •SF12  •SF36  •FAST  •CDC HRQOL  •OMFAQ  •Other</td>
<td>Information concerning the individual’s comorbid medical conditions as well as information concerning the individual's body mass index &amp; potential impact on overall health may be entered for this section.</td>
</tr>
</tbody>
</table>
### 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:

#### 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:

#### 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)?

#### 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:

#### 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:

#### 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:

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

<table>
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</table>
| 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. |

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**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
- 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.

Recovery and Resiliency Environment

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>To be completed on each review and updated as the recovery &amp; resiliency plan is further developed.</td>
</tr>
</tbody>
</table>

Best Practice Endorsement

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<tr>
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**Discharge Plan:**

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Planned D/C level of care</td>
<td>This should be completed for both admission and continued stay requests.</td>
</tr>
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**Discharge Information:** To be completed upon discharge.

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