

## ***Behavioral Health Concurrent Review Form for Inpatient and Partial Hospital Programs***

Instead of faxing this form, submit your request electronically using our preferred method at <https://www.availity.com>. \* If you use this form, fax it to **1-844-430-1702**.

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| Today's date:                                  |  |
| <b>Contact information</b>                     |  |
| Level of care:                                 |  |
| <input type="checkbox"/> Inpatient psychiatric | <input type="checkbox"/> Inpatient detox         |
| <input type="checkbox"/> PHP mental health     | <input type="checkbox"/> PHP substance use rehab |
| Member name:                                   |  |
| Member ID or reference #:                      | Member DOB:                                      |
| Member address:                                |  |
| Member phone:                                  |  |
| Hospital account #:                            |  |
| For child/adolescent, name of parent/guardian: |  |
| Primary spoken language:                       |  |
| Name of utilization review (UR) contact:       |  |
| UR contact phone number:                       | UR contact fax number:                           |
| Admit date:                                    |  |
| Admitting facility name:                       | Facility provider # or NPI:                      |
| Attending physician (first and last name):     |  |
| Attending physician phone:                     | Provider # or NPI:                               |
| Facility unit:                                 | Facility phone:                                  |

\* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup.

**<https://providers.amerigroup.com>**

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| Discharge planner name:  |
| Discharge planner phone:   |
| <b>Diagnosis (psychiatric, chemical dependency and medical)</b>  |
|  |
| <b>Risk of harm to self (within the last 24 to 48 hours)</b>   |
| If present, describe:  |
|  |
| If prior attempt, date and description:  |
|  |
| Risk rating (Select all that apply.)<br><input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt   |
| <b>Risk of harm to others (within the last 24 to 48 hours)</b>   |
| If present, describe:  |
|  |
| If prior attempt, date and description:  |
|  |
| Risk rating (Select all that apply.)<br><input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt   |
| <b>Psychosis (within the last 24 to 48 hours)</b>  |
| Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):<br><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A |
| If present, describe:  |
|  |
| Symptoms (Select all that apply.):<br><input type="checkbox"/> Auditory/visual hallucinations <input type="checkbox"/> Paranoia<br><input type="checkbox"/> Delusions <input type="checkbox"/> Command hallucinations  |

| Substance use (within the last 24 to 48 hours)  |  |
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| Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):  |  |
| <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A  |  |
| Substance (Select all that apply.)  |  |
| <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine<br><input type="checkbox"/> PCP <input type="checkbox"/> LSD <input type="checkbox"/> Methamphetamines<br><input type="checkbox"/> Opioids <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepines<br><input type="checkbox"/> Other (Describe.): |  |
| Urine drug screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  |
| Result (if applicable):   |  |
| <input type="checkbox"/> Positive (If selected, list drugs.): <input type="checkbox"/> Negative <input type="checkbox"/> Pending  |  |
| For substance use disorders, please complete the following additional information, based on current assessment.   |  |
| Current assessment of American Society of Addiction Medicine (ASAM) criteria  |  |
| Dimension (Describe or give symptoms.)  | Risk rating  |
| Dimension 1 (acute intoxication) and/or withdrawal potential (such as vitals, withdrawal symptoms)  | <input type="checkbox"/> Minimal/none — not under influence; minimal withdrawal potential<br><input type="checkbox"/> Mild — recent use but minimal withdrawal potential<br><input type="checkbox"/> Moderate — recent use; needs 24 hour monitoring<br><input type="checkbox"/> Significant — potential for or history of severe withdrawal; history of withdrawal seizures<br><input type="checkbox"/> Severe — presents with severe withdrawal, current withdrawal seizures   |
| Dimension 2 (biomedical conditions and complications)   | <input type="checkbox"/> Minimal/none — none or insignificant medical problems<br><input type="checkbox"/> Mild — mild medical problems that do not require special monitoring<br><input type="checkbox"/> Moderate — medical condition requires monitoring but not intensive treatment<br><input type="checkbox"/> Significant — medical condition has a significant impact on treatment and requires 24 hour monitoring<br><input type="checkbox"/> Severe — medical condition requires intensive 24 hour medical management |

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| Dimension 3 (emotional, behavioral or cognitive complications)      | <input type="checkbox"/> Minimal/none — none or insignificant psychiatric or behavioral symptoms<br><input type="checkbox"/> Mild — psychiatric or behavioral symptoms have minimal impact on treatment<br><input type="checkbox"/> Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs<br><input type="checkbox"/> Significant — suicidal/homicidal ideations, behavioral or cognitive problems or psychotic symptoms require 24 hour monitoring<br><input type="checkbox"/> Severe — active suicidal/homicidal ideations and plans, acute psychosis, severe emotional lability or delusions; unable to attend to ADLs; psychiatric and/or behavioral symptoms require 24-hour medical management |
| Dimension 4 (readiness to change)                                   | <input type="checkbox"/> Maintenance — engaged in treatment<br><input type="checkbox"/> Action — committed to treatment and modifying behavior and surroundings<br><input type="checkbox"/> Preparation — planning to take action and is making adjustments to change behavior; has not resolved ambivalence<br><input type="checkbox"/> Contemplative — ambivalent; acknowledges having a problem and beginning to think about it; has indefinite plan to change<br><input type="checkbox"/> Precontemplative — in treatment due to external pressure; resistant to change   |
| Dimension 5 (relapse, continued use or continued problem potential) | <input type="checkbox"/> Minimal/none — little likelihood of relapse<br><input type="checkbox"/> Mild — recognizes triggers; uses coping skills<br><input type="checkbox"/> Moderate — aware of potential triggers for MH/SA issues but requires close monitoring<br><input type="checkbox"/> Significant — not aware of potential triggers for MH/SA issues; continues to use/relapse despite treatment<br><input type="checkbox"/> Severe — unable to control use without 24-hour monitoring; unable to recognize potential triggers for MH/SA despite consequences   |
| Dimension 6 (recovery living environment)                           | <input type="checkbox"/> Minimal/none — supportive environment<br><input type="checkbox"/> Mild — environmental support adequate but inconsistent<br><input type="checkbox"/> Moderate — moderately supportive environment for MH/SA issues<br><input type="checkbox"/> Significant — lack of support in environment or environment supports substance use<br><input type="checkbox"/> Severe — environment does not support recovery or mental health efforts; resides with an emotionally/physically abusive individual or active user; coping skills and recovery require a 24-hour setting  |

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| <b>Current treatment plan</b>   |
| <b>Medications</b>  |
| Have medications changed (type, dose and/or frequency) since admission? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, give medication, current amount and change date:  |
| Have any PRN medications been administered? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, give medication, current amount and change date:  |
| <b>Member's participation in and response to treatment</b>  |
| Attending groups? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A   |
| Family or other supports involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A   |
| Adherent to medications as ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A   |
| Member is improving in (Select all that apply.):<br>Thought processes <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Affect <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Mood <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Performing ADLs <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Impulse control/behavior <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Sleep <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Support system</b> (Include coordination activities with case managers, family, community agencies and so on. If case is open with another agency, name the agency, phone number and case number.)   |
|   |
| <b>Discharge plan</b> (Note changes and barriers to discharge planning in these areas and plan for resolving barriers. If a recent readmission, indicate what is different about the plan from last time.)  |
| Housing issues:   |
|   |
| Psychiatry:   |
|   |
| Therapy and/or counseling:  |
|   |

|                                  |
|----------------------------------|
| Medical:                         |
| Wraparound services:             |
| Substance use services:          |
| Planned discharge level of care: |
| Expected discharge date:         |
|                                  |
| <b>Submitted by:</b>             |
| <b>Phone:</b>                    |