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Behavioral Health Concurrent Review Form

Fill out this form completely and return it to Amerigroup Washington, Inc. by fax at **1-877-434-7578**. If you have any questions, contact Provider Services at **1-800-454-3730**.

To avoid delays in processing, please do not write *See attached*.

Do not attach/fax the MAR. Do not write *See MAR*. Do not attach/fax individual treatment plan notes or RN notes.

The last two prescriber notes must accompany this request. If there is no prescriber, attach the last two clinician/therapist notes. Please do not send RN notes and individual treatment plan notes. They are not required.

Today's date:		
Member information		
Name:		DOB:
Amerigroup ID #:	ProviderOne or last 4 digits of SSN:	
Address:	Phone #:	
Provider information		
Requesting facility name (if difference from admitting facility):		
Requestor's phone:	Requestor's fax:	
Admitting facility name:		
Date of admission:	NPI:	
Phone:	Fax:	
Current status: ☐ Voluntary ☐ Involuntary	Next ITA court date:	
☐ Urgent ☐ Planned ☐ Family-initiated treatment		
UMR contact name:		
UMR phone:	UMR fax:	
Attending physician first and last name (or clinician if none):		
Requested level of care (use words, not codes):		
If for substance use, provider specific ASAM level of care:		

Mental health and physical health diagnosis (Use both diagnosis names and codes. Include any changes to diagnoses.)

Risk assessment

Risk of harm to self in last 24-48 hours:

☐ None
☐ Suicidal ideations (SI) without plan
☐ SI with plan
☐ Suicidal plan:

☐ Recent attempt (date, description):

Risk of harm to others in last 24-48 hours:

☐ None
☐ Homicidal ideations (HI) without plan
☐ HI with plan
☐ Homicidal plan:

☐ Recent attempt (date, description):

Psychosis in last 24-48 hours:

☐ None
☐ Auditory hallucinations
☐ Auditory hallucinations
☐ Delusions
☐ Command hallucinations
Describe any psychotic symptoms:

Current/active physical health issues complicating this admission: ☐ Yes ☐ No
If yes, document the condition and treatment:

Medical consult ordered: ☐ Yes ☐ No
If yes, document the outcome:

Substance use (Please complete all 3 items. Write N/A if not applicable.)	
Substance used:	
Frequency and last use:	
Current UTOX results:	
Complete the following additional information only if this is a substance use admission using your current assessment.	
Current/active alcohol and/or substance withdrawal in last 24-48 hours: ☐ Yes ☐ No If yes, document the substance use and current/active withdrawal symptoms:	
CIWA, COWS scores and dates (if applicable):	
Vital signs (with dates):	
Medication assisted treatment (MAT) initiated: ☐ Yes ☐ No If no, document why not: If yes, document the medications under the current treatment plan/medication section below.	
Complete the ASAM assessment below (or send/include a completed copy of your current ASAM 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)	☐ Minimal/none — not under influence; minimal withdrawal potential ☐ Mild — recent use but minimal withdrawal potential ☐ Moderate — recent use; needs 24 hour monitoring ☐ Significant — potential for or history of severe withdrawal; history of withdrawal seizures ☐ Severe — presents with severe withdrawal, current withdrawal seizures
Dimension 2 (biomedical conditions and complications)	☐ Minimal/none — none or insignificant medical problems ☐ Mild — mild medical problems that do not require special monitoring ☐ Moderate — medical condition requires monitoring but not intensive treatment ☐ Significant — medical condition has a significant impact on treatment and requires 24 hour monitoring ☐ Severe — medical condition requires intensive 24 hour medical management

Dimension 3 (emotional, behavioral or cognitive complications)	☐ Minimal/none — none or insignificant psychiatric or behavioral symptoms ☐ Mild — psychiatric or behavioral symptoms have minimal impact on treatment ☐ Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs ☐ Significant — suicidal/homicidal ideations, behavioral or cognitive problems or psychotic symptoms require 24 hour monitoring ☐ 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)	☐ Maintenance — engaged in treatment ☐ Action — committed to treatment and modifying behavior and surroundings ☐ Preparation — planning to take action and is making adjustments to change behavior; has not resolved ambivalence ☐ Contemplative — ambivalent; acknowledges having a problem and beginning to think about it; has indefinite plan to change ☐ Precontemplative — in treatment due to external pressure; resistant to change
Dimension 5 (relapse, continued use or continued problem potential)	☐ Minimal/none — little likelihood of relapse ☐ Mild — recognizes triggers; uses coping skills ☐ Moderate — aware of potential triggers for MH/SA issues but requires close monitoring ☐ Significant — not aware of potential triggers for MH/SA issues; continues to use/relapse despite treatment ☐ Severe — unable to control use without 24-hour monitoring; unable to recognize potential triggers for MH/SA despite consequences
Dimension 6 (recovery living environment)	☐ Minimal/none — supportive environment ☐ Mild — environmental support adequate but inconsistent ☐ Moderate — moderately supportive environment for MH/SA issues ☐ Significant — lack of support in environment or environment supports substance use ☐ 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

Current treatment plan (Do not send/fax the MAR(or write *See MAR*), individual treatment plan notes or RN notes.)
List current standing medications for behavioral and physical health. (Include name of medication, mg strength and frequency for each.)
Write the most recent medication change and date of change:
Side effects: ☐ Yes ☐ No If yes, describe:
Compliant with medications: ☐ Yes ☐ No If no, what is being done:
Upcoming changes to medications and treatment plan:
SUD withdrawal protocol? How many days left?
Relevant lab results (Include lithium, Depakote, other medication levels and/or UTOX.):
As needed medications (PRNs) for agitation: ☐ Yes ☐ No If yes, document the name(s) of medication(s), date it was last given and the reason(s)/trigger(s) for PRN administration:
Other treatment and psychological interventions/plan:
Attending groups: ☐ Yes ☐ No
Family or supports involved in treatment: ☐ Yes ☐ No If no, why not: Include dates of recent and upcoming family therapy sessions at your facility:
Support system (Include coordination efforts with case managers, family, community agencies, etc. If there is social service/government agency involvement, list the reason why, agency name, contact, phone number and case number.):

Discharge plan	
Readmission within last 30 days: ☐ Yes ☐ No If yes, how does your discharge plan address reason for readmission?	
Housing (current plan and any issues):	
Psychiatry medication management (appointment date and time):	
Psychotherapy/mental health step down service(s) (Include level of care, appointment date and time):	
Physical health (appointment date and time):	
Substance use (Include level of care, and appointment date and time.):	
Number of days requested:	Estimated discharge date:
Submitted by (Print name.):	
Signature:	

Disclaimer: Authorization indicates that Amerigroup determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.