Instructional Guide: Initial and Continued Stay Authorization Review Forms

Applicable Levels of Care

Psychiatric – Inpatient, Residential, Partial, Intensive Outpatient, 23 Hour Observation, Crisis Intervention Services
Eating Disorder – Inpatient, Residential, Partial, Intensive Outpatient
Substance Use – Inpatient Withdrawal Management, Residential/Subacute Withdrawal Management, Ambulatory Withdrawal Management, Inpatient Rehabilitation, Residential/Subacute Rehabilitation, Partial Day, Intensive Outpatient, Outpatient Rehabilitation, Crisis Intervention Services

Summary

Accurate and complete Authorization Forms are needed to make authorization determinations, establish effective and appropriate services are being delivered to members and ensure continuity of care. When a review is completed and submitted timely by higher level of care providers, adequate information is dissemination to New Directions to determine if services are in place for appropriate follow-up care for the member.

Authorization Reviews are utilized for authorization determination and are relied on to identify information needed to support members post discharge. Authorization Reviews also provide valuable information regarding treatment the member will receive and/or is receiving. Providers can complete the authorization forms through the internet (WebPass) or they can complete the discharge review telephonically by phone with a New Directions utilization staff member. The information below provides an outline of each item on the authorization form and the rationale for including it on the form for authorization determination reviews. The following are definition and guidance for the specific items in the Initial and Continued Stay Review Form.

Initial & Continued Authorization Review Form Items with Definitions and Guidance

Demographic

1. **Verification that the address information is correct *(Multiple Choice: Yes/No)***

Verification of accurate address information is necessary. If the address auto-fed into the form is not correct, the provider is asked to provide updated information. This information is needed to identify where the member authorization mailings are sent. In addition, this information assists in discharge planning and treatment resource location for member. The New Directions Clinical 365 team utilizes this information for future contacts with member if emergency services are needed for crisis intervention.

2. **Member Telephone Number:**

This information is important because it is used for post-discharge follow-up. This information auto-fills and should be edited if there is an updated number available.

3. **Does member have a parent/guardian?** ***(Multiple Choice: Yes/No)***
   Parent/Guardian Name: Parent/Guardian Phone Number:

This information is needed to understand if there are individuals in place for correspondence and decision-making regarding member care.

4. **Does state law require parental decision-making?** ***(Multiple Choice: Yes/No)***

Each state sets specific guidelines for when a minor can make decisions for themselves related to their behavioral health care. This information is needed to identify if the member can make decisions or if coordination with a parent/guardian is needed for decisions. It also provides information needed to know what information can be released to parent/guardian during coordination efforts.

5. **Facility Name/Tax ID/NPI/Address/State:**

This information is used to identify the facility where care is being provided and is a required component for a request to be considered valid. This information is used for the authorization. If it is not correct the claim will not be valid for payment and re-work will be required.

6. **Name/phone number of facility staff completing this form:**

This provides information so New Directions staff can connect if any information needs updated.

7. **Utilization Reviewer Information:**

New Directions coordinates with utilization review staff for coordination and authorization decision notification. This information is used if clarification is needed for any responses or additional information to render a decision. This information is used to identify point person who will be providing necessary clinical data for reviews.

8. **Discharge Planner Information:**

New Directions coordinates with discharge planners to assist in coordination of care and identifying resources for member. Care managers often reach out to the identified discharge planner to help and notify member of available care management services that may be available to the member through New Directions.

9. **Level of Service or Care requested:**

This information is needed to create the appropriate and accurate authorization for the member. This information also determines which medical necessity criteria will be applied. The form is customized to the level of care selected here and this item determines 68 questions that follow.

10. **Attending Provider Name, Credential Information and NPI:**

This information is needed for the member's authorization to ensure that the member's case has appropriate clinical oversight for decision making and that the medical necessity criteria is met.

11. **What number should be called if this case requires consultation with attending/licensed treatment team provider? (please include extension):**

This is who our medical scheduler will contact to arrange peer reviews. Having this contact allows for more efficient scheduling process for peer reviews.

12. **Is this treatment currently Involuntary or Voluntary Admit? *(Multiple Choice: Involuntary/Voluntary):***

This information is important in understanding how the member presented for admission. Involuntary admissions may need special consideration.

13. **Requested Start Date:**

This information is the first day member attended or is scheduled to attend requested level of care/admission. This is the date that the authorization will start if approved.

14. **Number of days requested on initial review: *(Multiple Choice: 1-15)***

This information is the number of days that are being requested by the provider.

15. **Which days of the week is member attending? (Select all that apply) *(Multiple Choice: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday)***

This item is used to calculate a correct end date/concurrent review date.

16. **When is the anticipated discharge date?**

This data does not need to be a set-in-stone date and may change over the treatment episode. This information allows the utilization management reviewer to gauge length of treatment that the member may expect. It allows care managers to be aware of timing for post-discharge appointments and care transitions coordination.

17. **Has member been admitted to the unit/started treatment? *(Multiple Choice: Yes/No)***

This is to identify whether the request is a preservice request or if they have already been admitted/started treatment.

Clinical Assessment

18. **Diagnosis *(Drop-down – List up to 5)***

To ensure that member is in the appropriate level of care based on diagnostic code (i.e., if dx is MDD and member admitted detoxing then this raises a concern)

19. **What life event(s)/stressor(s) led to this admission?**

This is used to identify what is going on in the member's life that may be contributing to this admission.

20. **Is this level of care needed to provide structure for treatment because the member is at a high risk for admission to an inpatient level of care? *(Multiple Choice: Yes/No)***

This information is used to determine acuity, appropriateness of selected level of care, whether member can be safely treated in selected level of care, and whether member would benefit from selected level of care per MNC.

21. **Does the intensity of psychiatric symptoms or cognitive deficits require treatment to prevent relapse? *(Multiple Choice: Yes/No)***

22. **The member's condition or stage of recovery require the need for daily treatment at least five days per week to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care. *(Multiple Choice: Yes/No)***

This information is used to determine acuity, appropriateness of selected level of care, whether member can be safely treated in selected level of care, and whether member would benefit from selected level of care per MNC. This question is asking for information to clarify the need for care to prevent worsening of member's condition.

23. **The member's coping skill deficits are significant and require daily assessment and intervention. *(Multiple Choice: Yes/No)***

24. **A crisis is present which requires a minimum of three days of treatment per week and cannot be treated safely at a lower level of care. *(Multiple Choice: Yes/No)***

This information is used to determine acuity, appropriateness of selected level of care, whether member would benefit from selected level of care per MNC, assist with treatment planning goals and help utilization management to understand current clinical presentation.

25. **The members condition or stage of recovery requires the need for a minimum of three days of treatment per week in order to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care. *(Multiple Choice: Yes/No)***

This information is used to determine acuity, appropriateness of selected level of care, whether member can be safely treated in selected level of care, and whether member would benefit from selected level of care per MNC.

26. **Marked challenges in managing day-to-day life situations. *(Multiple Choice: Yes/No)***

This information is used to determine acuity, whether member can be safely treated in selected level of care, and whether member would benefit from selected level of care per MNC and help utilization management understand current clinical presentation.

27. **A crisis is present which requires a minimum of three days of treatment per week and cannot be treated safely at a lower level of care. *(Multiple Choice: Yes/No)***

28. **Does the member require 24-hour supervision in order to care for themselves and perform activities of daily living? *(Multiple Choice: Yes/No)***

This information is used to determine acuity, appropriateness of selected level of care, whether member can be safely treated in selected level of care, and whether member would benefit from selected level of care per MNC and help utilization management understand current clinical presentation.

29. **Was a depression screening completed during this admission? *(Multiple Choice: Yes/No)***

This is a quality measure that is monitored. Depression is one of the most diagnosed mental health disorders and should be thoroughly screened in context of members treatment**.** A depression screening aims to detect symptoms in members admitted to a higher level of care and address them while in treatment. This also aides in coordination of care thereafter. New Directions collects information as to whether a depression screen was performed and if the result was positive during admissions. If left unidentified and untreated, the depression can complicate and hinder provider efforts to address the member's presenting problems. Depression places individuals at high risk for suicide and social and personal impairment. Select 'yes' if member was screened and is positive for depression. Documentation should be present in members record detailing how depression was addressed, and any supports identified. No specific depression screening tool is required.

30. **Was screening positive for depression? *(Multiple Choice: Yes/No)***

See item 29 above.

31. **Suicidality Assessment *(Multiple Choice: Ideation, Plan, Intent, Current Attempt, Current Means, None of the Above*)**

Has the member engaged in self-harm or in any way expressed a desire to harm themself? This item identifies the acuity of a member's current episode/symptoms requiring intervention. This item is a multi-select item, please make sure to select all the applicable options.

32. **Please describe members suicide plan, intentions and/or attempts, method, and means; including current and historical (include any medical interventions)**

These details clarify risk/acuity.

33. **Did the member overdose on their own prescribed medications? *(Multiple Choice: Yes/No)* If overdose on their own prescribed medication, please list prescribing physician name and phone number and the name of the prescribed medications(s)**

This is a quality measure. Having details on what medication was used and how much was taken clarifies the severity of the attempt/overdose. This allows us to appropriately follow up as needed and notify the prescriber of the overdose.

34. **Homicidality Assessment *(Multiple Choice: Ideation, Plan, Intent, Current Attempt, None of the Above)***

These items identify the acuity of a member's current episode/symptoms requiring intervention. This item is a multi-select item, please make sure to select all the applicable options.

35. **Please describe members homicidal plan, intentions and/or attempts, method, and means; including current and historical (include any medical interventions)**

These details clarify risk/acuity.

36. **Does the member exhibit current physically aggressive behavior or threats? *(Multiple Choice: Yes/No)***

    These items identify the acuity of a member's current episode/symptoms requiring intervention.

37. **Does the intensity of aggression require 24-hour medical management? *(Multiple Choice: Yes/No)***

These details clarify risk/acuity. The aggression is so intense that the member requires a physician (psychiatrist or addictionologist) or physician extender to be available 24 hours a day, seven days per week to provide daily medical management and evaluation services with documentation.

38. **Please describe aggressive behavior and list all interventions to address members aggressive behaviors (Verbal Redirect, PRN, One-on-One, Staff Assistance, Restraint, Seclusion, etc.):**

    These items identify the acuity of a member's current episode/symptoms requiring intervention.

39. **Are there current psychotic symptoms?** ***(Multiple Choice: Yes/No)***

These items identify the acuity of a member's current episode/symptoms requiring intervention. Some examples would include hearing voices that are not there, internally stimulated, having fixed false beliefs, delusions, catatonia, etc.

40. **Does the intensity of psychosis require 24-hour medical/psychiatric management?** ***(Multiple Choice: Yes/No)***

This information is needed to identify level of risk/acuity. The aggression is so intense that the member requires a physician (psychiatrist) or physician extender to be available 24 hours a day, seven days per week to provide daily medical management and evaluation services with documentation.

41. **Please describe psychosis and how psychosis affects risk to self or others:**

This information shows severity of illness and how far off baseline a member is and if they are a risk to themselves or others.

42. **Please identify [how] the members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment (select all that apply):** ***(Multiple Choice: Safety issues for either self or others/Primary Support/Social/Interpersonal/Occupational/Educational/None)***

    These items identify the acuity of a member's current episode/symptoms requiring intervention. This is a multi-select item and all applicable options should be selected.

43. **Please describe safety issues/primary support/social/interpersonal/occupational/educational for either self or others:**

This item identifies the acuity of a member's current episode/symptoms requiring intervention.

Substance Use

44. **Document any substance use:**

This information details each substance used, including amounts, frequency and last use date to clarify current symptoms and potential risk/treatment and discharge planning needs.

45. **Select all substances that apply:** ***(Multiple Choice: Alcohol/Amphetamines/Benzodiazepine/Cannabis/Cocaine/Hallucinogens/Inhalents/Opioids/Sedatives/Hypnotics/Anxiolytics/Other)***

This is a multi-select item and all applicable options should be selected.

46. **Date of last <substance> use:**

Please indicate the date of last use. For residential substance use disorder treatment, our MNC states that the date of last use must be within the last 7 days of hospitalization unless the member was incarcerated or hospitalized.

47. **Describe duration, frequency, and amount for each substance selected:**

How much, how often and for how long did the member use identified substance(s) prior to treatment? This information is vital to understand the member's history and treatment and inform the necessity for the level of care being requested. This contributes to the physiologic and psychological dependance on the substance.

48. **UDS Results *(Multiple Choice: Positive/Negative/Pending)* Enter Substances identified in UDS:**

This helps us to better understand the member's clinical presentation, risk of withdrawal and potential under-reporting and dx accuracy.

49. **Blood Alcohol Level/Breathalyzer, if applicable, document level/status:**

This helps us to better understand member's clinical presentation, risk of withdrawal and potential under-reporting and dx accuracy.

50. **What is member's CIWA Score?**

This score helps us to understand whether the member has begun withdrawal and if so the severity of withdrawal/need for medical intervention. The score provided should be the current score for the authorization period being requested.

51. **What is member's COW Score?**

This score helps with details about the withdrawal symptoms and help us understand whether the member has begun withdrawal and if so the severity of withdrawal/need for medical intervention. The score provided should be current score for the authorization period being requested.

52. **Any history of withdrawal symptoms? *(Multiple Choice: Yes/No)* Describe history of withdrawal symptoms:**

This information can give a better picture of severity / length of substance use and what interventions are appropriate for the treatment team. This also gives timeline of expected length of stay for some members. This helps provide information if the member has been in withdrawal before and the severity of the symptoms in the past.

53. **Did the treatment team/prescriber provide the member information about Medication Assisted Treatment (MAT) as part of their informed consent? *(Multiple Choice: Yes/No)***

Medication Assisted Treatment (MAT) has been identified as a highly effective treatment option (Surgeon General, 2016) for individuals with alcohol and opioid use

disorder. For this reason, verification that it was offered as a treatment option (*if clinically appropriate*) is required and if it was not the reason, the why is required.

54. **Please explain why MAT was not appropriate or the member was not provided with the information *(Multiple Choice: Patient medical condition/medication contra-indicated for MAT; Patient Refused; Not offered by program; Not available where member lives; LAI not covered; Financial barriers; Other)***

Having this information can determine if the facility needs further education r/t MAT or if care management can help with financial portion. If the member has a medical condition or a medication contraindication for the use of MAT or if the member refuses or declines MAT, specific details are required so that the documentation can be utilized for coordination of care.

55. **Explain contra-indications**

Sometimes this may be simply a lack of education on MAT by the facility and can be addressed by a care manager. If the member has a medical condition or a medication contraindication for the use of MAT or if the member refuses or declines MAT, specific details are required so that the documentation can be utilized for coordination of care.

56. **Why did patient refuse?**

If the member has a medical condition or a medication contraindication for the use of MAT or if the member refuses or declines MAT, specific details are required so that the documentation can be utilized for coordination of care. Sometimes this may be simply a lack of education on MAT by the facility and can be addressed by a care manager.

57. **Did the member agree to MAT? *(Multiple Choice: Yes/No)***

This can show member's willingness to seek ongoing treatment outside of the facility once discharged and / or highlight areas of education needed by facility or care management if cost is listed as a concern or barrier. Care management can provide referrals to facility for MAT providers in member's geo-access area prior to discharge.

58. **Do you need an outpatient MAT referral? *(Multiple Choice: Yes/No)***

Discharge appointments are required for members and information on why an appointment is not scheduled is required for any applicable cases. This determines if care management needs to be involved in assisting member with referrals.

Medical

59. **Medical Diagnosis, including how any medical conditions may be impacting the member's care or discharge planning:**

Medical co-morbidities are considered during the authorization determination process. Please include all medical diagnosis so that New Directions and the health plan can

help coordinate post-discharge care with any PCPs, specialists, to include medical care management through the health plan when appropriate, etc.

60. **Does member have a chronic pain condition? *(Multiple Choice: Yes/No)***

Chronic pain has long been associated with behavioral health and substance use disorders. Having this information is essential to obtaining a full understanding of the member's clinical presentation and assists with follow up needs.

61. **Current medications (include name, start date, dosage and frequency for ALL medications, psychiatric and medical, vitamins and homeopathic)**

This is information on all medications the member was prescribed and/or taking at time of each request or discharge summary, including name, dose, and frequency is required. Medication reconciliation is vital in coordinating care for the member post-discharge to prevent readmissions. It is important to update this each time an authorization request is submitted.

62. **Was UDS Completed? Please indicate results of UDS:**

This information is helpful because the use of substances impacts the course of treatment.

63. **Are there lab values that may impact member's care (Blood Alcohol Level/Breathalyzer, Hepatitis C, Drug Medication Levels, fasting blood sugar or glucose, etc.)? *(Multiple Choice: Yes/No)* Provide any lab values:**

Lab values are crucial pieces of information for the treatment team as it relates to medications, medical conditions and drug screens/ medication levels.

64. **Describe current eating disorder behaviors (include frequency, intensity, and duration):**

This information is used for authorization criteria.

65. **Current height; Current Weight; Current BMI:**

Necessary information for eating disorder treatment.

66. **Current % IBW:**

Can be an indicator of severity of eating disorder and component of our criteria.

67. **Does the member receive tube feedings? *(Multiple Choice: Yes/No)***

This is necessary information related to an eating disorder treatment.

Psychosocial

68. **Are there legal issues that may impact member's treatment or recovery? *(Multiple Choice: Yes/No)***

While authorization is based on MNC, this piece of information is important in the overall treatment history and can affect discharge planning and coordination of care inside and outside of the facility.

69. **Please describe legal issues:**

This provides a general synopsis of a member's difficulty managing their life, and to what extent they are affected by their choices, behaviors and/or substance use.

70. **Describe current living situation and will this be the anticipated living situation at time of discharge?**

Current living situation directly impacts discharge planning as it relates to step down of the member to a lower level of care, and / or follow up when the member is in outpatient services. If the member is not returning to their previous living situation, follow up appointments would need to be arranged with a different provider if they are no longer in their geo-access area.

71. **Is one of the reasons for admission a lack of safe housing? *(Multiple Choice: Yes/No)***

This information helps to identify care management needs and to assist with discharge planning.

72. **Barriers in treatment and after care (check all that apply):**

Identifying and addressing barriers/social determinants of health is important for improving health and reducing longstanding disparities in health and health care**.** Social determinants of health include factors like socioeconomic status, education, neighborhood and physical environment, transportation, language, employment, and social support networks, as well as access to health care. It is important to make sure that any identified barriers for follow-up are addressed and resolved prior to discharge (ex. appts are accessible to member). Some examples include:

- Transportation: it is important to secure available community supports or virtual options to assist member in participating in supports.
- Housing: it is important to secure available community supports.
- Financial: it is important to secure available community resources, such as sliding scale clinics, food stamps, etc.

73. Please identify member's support system(s):
This is helpful for coordinating support, obtaining collateral information and arranging discharge and safety planning.

Coordination of Care

74. **Is member in current outpatient treatment? *(Multiple Choice: Yes/No/Unknown)* What type of provider is it? *(Multiple Choice: Psychiatrist/APRN/Therapist/Care Manager/Community Support/ECT/Visiting Nurse/Other)***

This allows for collaboration, continuity of care and discharge planning.

75. **Please list <*provider*> Name, Credentials, Phone Number, and Appointment Information:**

This allows for collaboration, continuity of care and discharge planning. Accurate contact and appointment information is needed for follow-up. Discharge appointments that satisfy HEDIS requirements are important and tracked for hospital quality ratings.

(Members admitted with a primary mental health diagnosis must have an appointment with a valid HEDIS qualified service. Valid services include medication management with psychiatrist or ARNP, outpatient behavioral health therapy, electroconvulsive therapy, IOP, PHP, MH or SUD assessments, wrap-around or mental health day treatment services. Visits that occur on the same date of discharge are not reportable as part of the quality measure. Scheduling follow up appointments between the first and seventh day after hospital discharge ensures meaningful, effective engagement.)

76. **Has the <provider> been notified of admission? *(Multiple Choice: Yes/No)* Enter the name and telephone number of the Primary Care Physician:**

This allows for coordination and continuity of care between providers. It is important for the community provider to be aware of their patient's need for higher level of care and to facilitate a discharge appointment. The current treatment team may need information related to community-based treatment. This will encourage collaboration between higher level of care provider and outpatient providers.

77. **Is there any additional pertinent clinical information relevant to this admission that you would like to share?**

This allows the UR to discuss any items that they find clinically significant not touched on above.

78. **Please attach *Authorized Delegate Form* with member/guardian signature giving New Directions permission to communicate with member's family / support.**
    If you are a third-party biller, we require an *Authorized Delegate Form* to be attached for us to accept a request for authorization of services. Please attach Authorized Delegate Form with member/guardian signature giving New Directions permission to communicate with third party billers.

We require this to protect the members PHI in regard to parties that are not directly affiliated with member's direct care.