Provider Training: Updated Inpatient Forms

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Banner University Health Plans

Agenda

1. Notification Process (Reminder)
    a) Requirements
    b) Time Frame
    c) Authorization
    d) Options
        1. EMR
        2. Notification only
        3. Notification with Initial Forms
2. Initial Review Form
3. Concurrent Review Form

MOST RECENT FORMS WILL BE ADDED TO THE WEBSITE

https://www.banneruhp.com/materials-and-services/behavioral-health#Behavioral-Health-Materials-and-Forms

This link is also in the signature of Lynda and Beth's emails.

Notification Process

****Notification applies to all facilities. The review forms apply *only to those facilities where we do not have access to your EMR.*****

a) **Requirements**: For notification, the Face Sheet is required for all lines of business. The CON is required for Medicaid (TXIX).

b) **Time Frame**: Facilities have 72 hours from member's admission to send CON and Face Sheet (CON not required for Medicare). Once we send the review forms for completion, you have 24 hours from our request to return the review forms.

c) **Authorizations**: Let's review the time frame from notification, to first auth, and concurrent. This can easily be a 4-5 day initial authorization. Then we need information to support continued stay.

d) **Options for notification and review:**

1. EMR: If you have EMR and your organization will grant access to our reviewers, please contact us to start the process.
2. Notification only (Face Sheet, CON). *Informs of admit.* Subacutes please provide more info on the CON for detox (withdrawal symptoms, protocol, scoring).
3. Notification with Initial Forms

Initial Review Form

Initial Form

- Broken down by sections
- Primary purpose is to determine reason for the admission, demographics, facility information, and if discharge planning has begun.
- Updates were made:
  - Pay particular attention to the highlighted areas.
- Please Type the Forms

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Initial Facility Inpatient Review Form

This form is to be TYPED.

Email the completed form to BUHPBHUMPAMailbox@bannerhealth.com on the date of review.
Cc: A copy of the form to your current health plan reviewer

Today's Date:			
AHCCCS Number:		Member Name:	
Facility Name:		Date of Birth:	☐ Child ☐ Adult
Parent/Guardian Name:			
Mental Health POA: ☐ Yes ☐ No		Guardian Phone Number:	
Member and/or Guardian's Primary Language:			

General Information

Admit Date:	✔ ✔		
Is there a Court Ordered status: ☐ COE ☐ COT ☐ RCOT ☐ Voluntary Select One	✔	Date of Status:	
Legal issues impacting treatment or discharge:			

Initial Form Continued

- This section has only a couple of updates. Both are important.
  - We need the court documents related to COE/COT
  - Knowing the lifetime Medicare days available upon admit would be helpful.

Please forward the court documents to your reviewer

DCS Involvement? ☐ Yes ☐ No

Facility Information

Attending BHMP:	
Facility UM Reviewer Name:	Phone Number:
Email Address:	
Discharge planner/Social Worker Name:	
Phone Number:	Email Address:

Insurance Information

Other Insurance Name:	ID #:

How many lifetime Medicare days are available:

Initial Form Continued

- The bottom of the first page is for coordination of care amongst providers.
- If a member is not connected, we want to make sure they get connected.

Primary Care Physician Name:	Phone Number:
Current BH Provider:	Date of Contact:
Date of Urgent Enrollment Request:	Date of Urgent Enrollment Completion:

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AHCCCS Number:	Member Name:	Review Date:

Insurance Information Cont.

Initial Form Continued

- The living situation prior to admission is important information.
- Natural supports are as important as system supports.
- Clinical history is needed.

Date of scheduled Discharge Planning meeting/ART/CFT:

Date H&P completed:	Date Psych Eval completed:

Living Situation Prior to this Admission: SNF, Home, Residential, Homeless or unknown — Select One
What specific event occurred just prior to this admission that lead to the admission:
What supports does the member have (include natural):
Admission criteria:
Dates of Previous Inpatient Admissions:

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Initial Form Continued

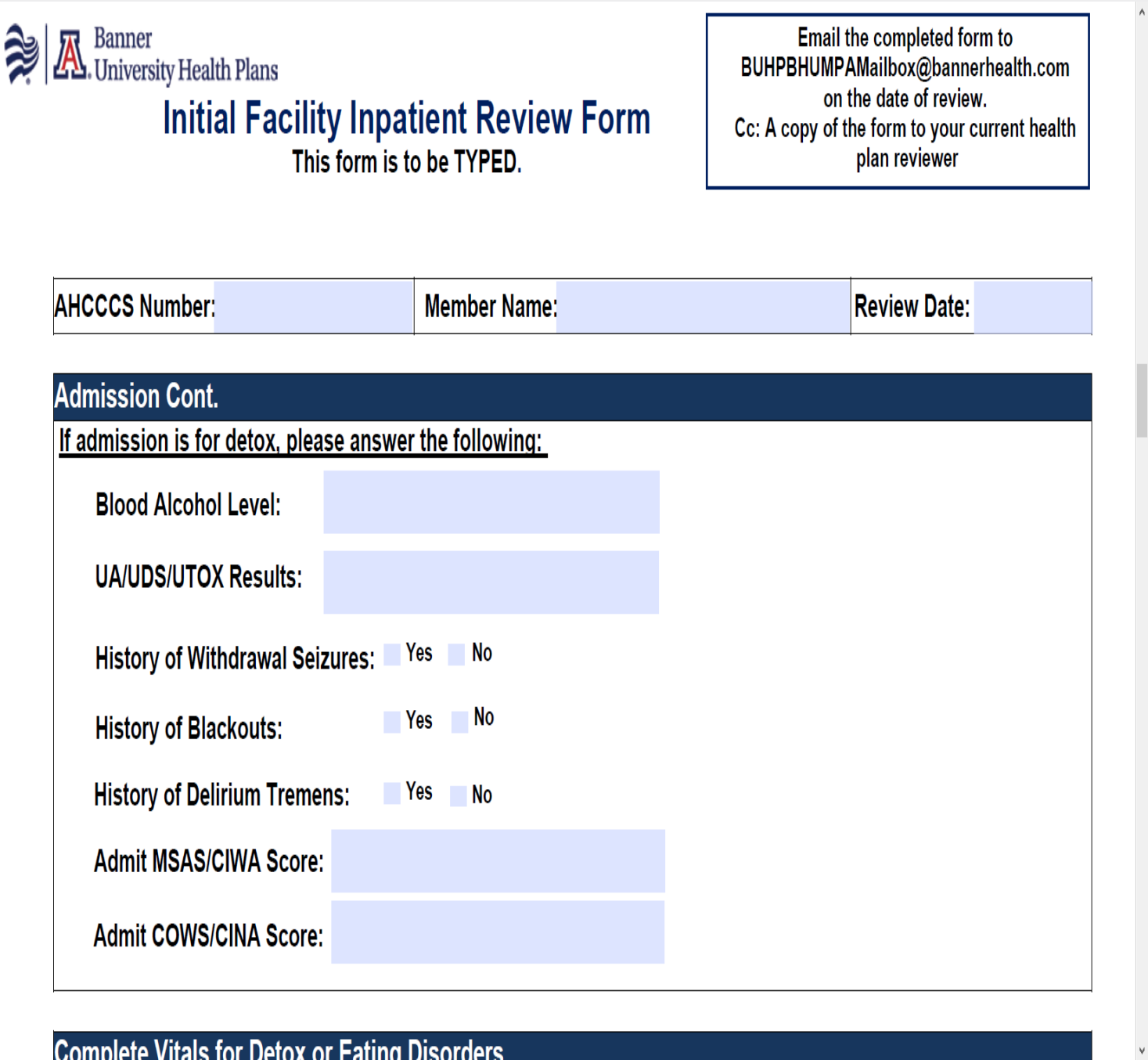
- Eating disorders was added as an option to this section.

Type of Admission: Behavioral, Detox, Eating Disorder or Both	Select One
BH diagnoses: Primary:	
Secondary:	
Tertiary:	
Medical Diagnoses:	

	Substance Used	How Much	How Often	Route	Date of Last Use
1.					
2.					
3.					
4.					

Initial Form Continued

- This area is to provide information specific to those receiving detox.
- For the initial information, we need the admission scores, not those that show a decrease after medication has been administered. We need to know the scores that led to the decision to place a patient on a detox protocol.



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Initial Facility Inpatient Review Form

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AHCCCS Number:	Member Name:	Review Date:

Admission Cont.

If admission is for detox, please answer the following:

Blood Alcohol Level:

UA/UDS/UTOX Results:

History of Withdrawal Seizures: Yes No

History of Blackouts: Yes No

History of Delirium Tremens: Yes No

Admit MSAS/CIWA Score:

Admit COWS/CINA Score:

Complete Vitals for Detox or Eating Disorders

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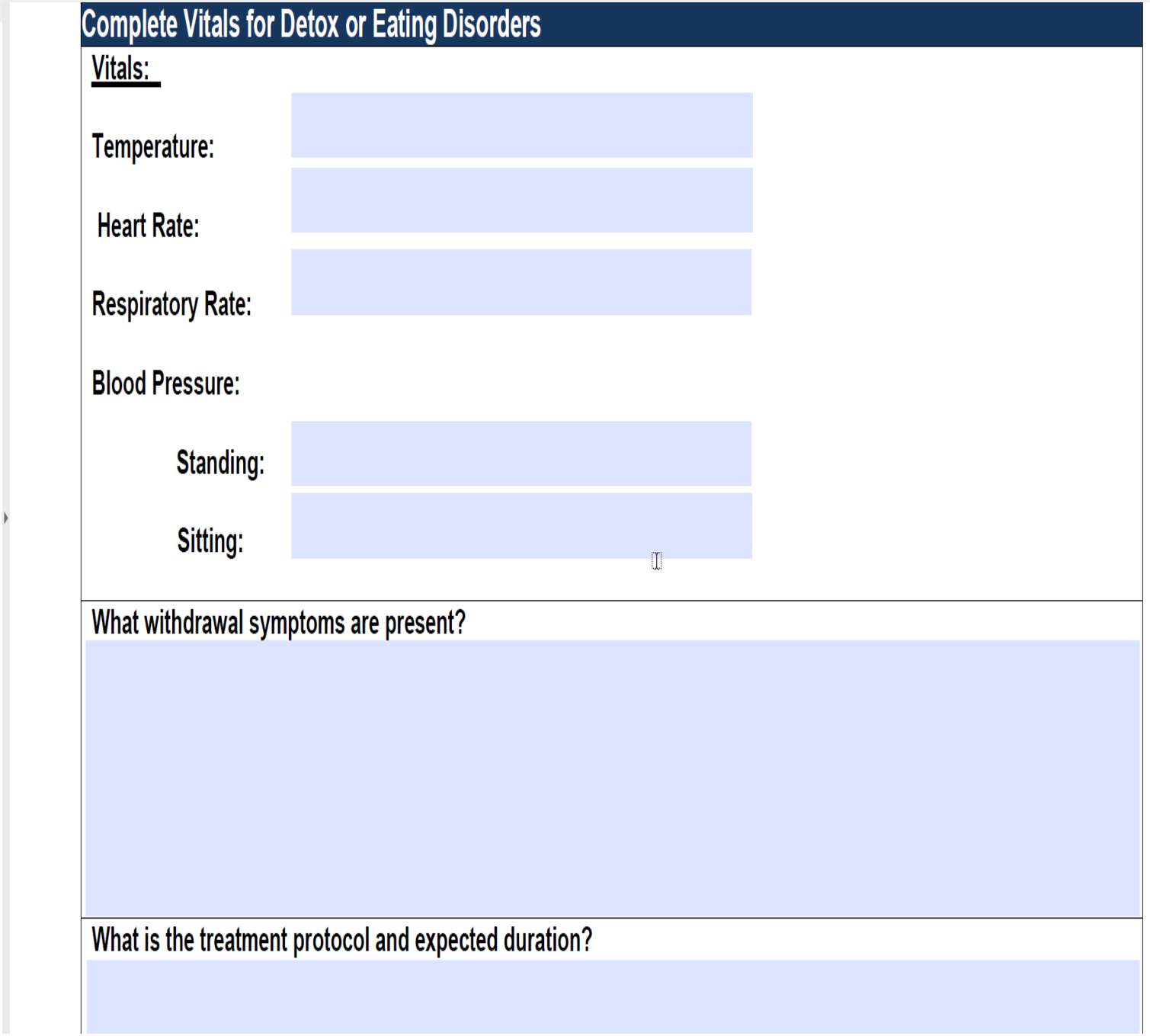
Initial Form Continued

- Vitals are important for those with eating disorders or in detox. We use Milliman Care Guidelines (MCG) and this information is an important part of our criteria.
- We need the vitals that were taken at admission, that contributed to the person being admitted.
- Only ED needs both standing and seated BP.



Complete Vitals for Detox or Eating Disorders

Vitals:

Temperature:

Heart Rate:

Respiratory Rate:

Blood Pressure:

Standing:

Sitting:

What withdrawal symptoms are present?

What is the treatment protocol and expected duration?

Initial Form Continued

- We would like to know the medications the patient was previously taking.
- We need to know if meds are prn vs regularly scheduled, if the member is compliant, date of any changes, and what the change was.

From MD Notes including date:

Medications patient was taking prior to admission:

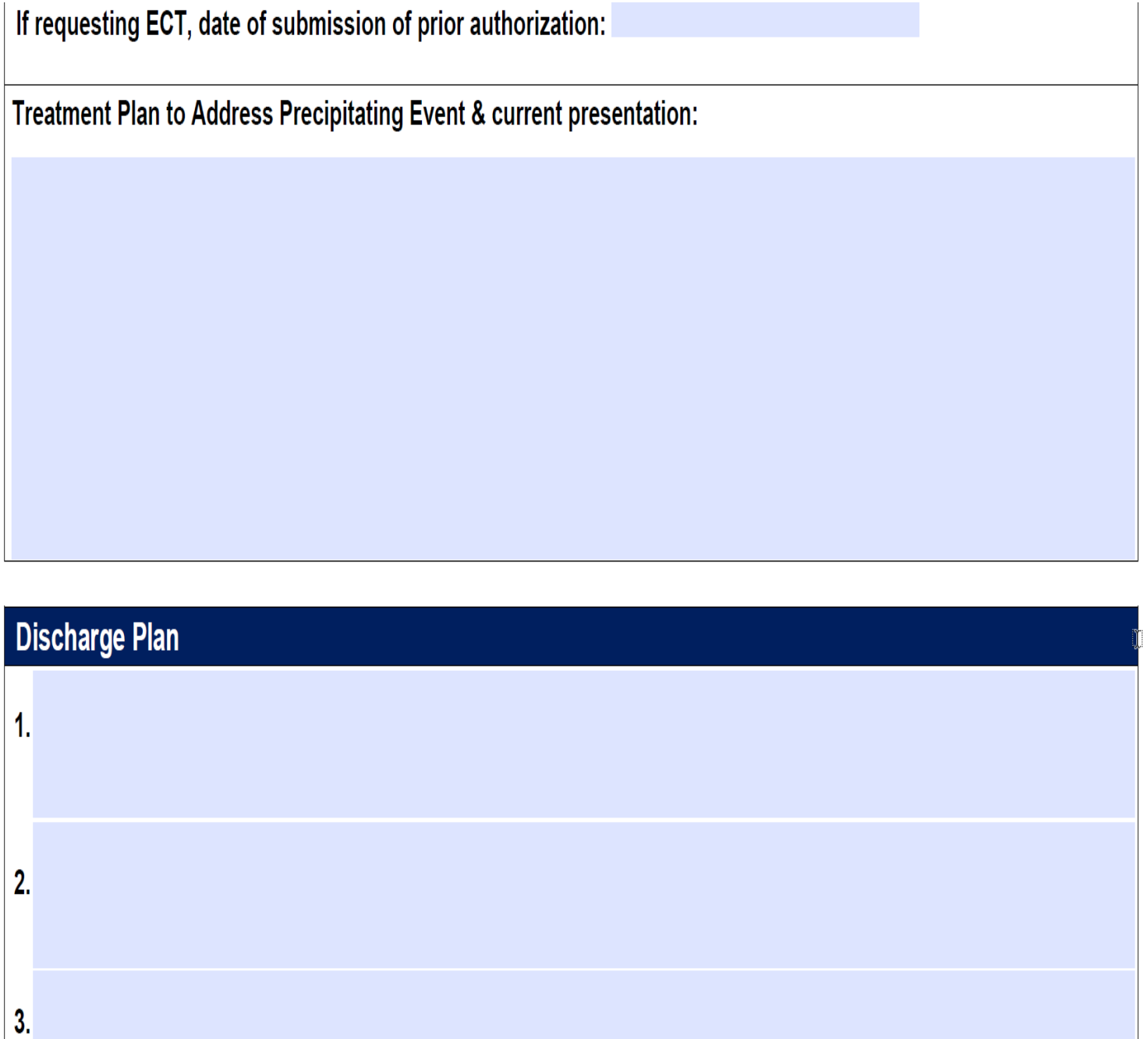
Current Medications

Medication/Dose/Frequency/Compliant: Please note if medication is PRN.

Medications	Dose	Frequency	Compliant	PRN (Y or N)	Note Date of Changes	Increase, Decrease or Discontinued
1.	1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.	2.

Initial Form Continued

- For the treatment plan please include items such as the medication plan (titration, changes due to side effects, intent to add long acting injectable, placing on 1:1 etc.).
- Information as to the response to patient refusing medication or being intrusive.
- Plans to obtain collateral information.



Initial Form Continued

- We need to know very specific information about the discharge plan.
- I will address this more in the concurrent review area.

If plan is to step down to an out of home level of care, What facilities have been contacted, When were they contacted, and What was the outcome?

Barriers to Discharge:

How are the barriers being addressed:

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Initial Form Continued

- You may not have made discharge appointments initially, but if you have, we need the information.
- At any time, if you need assistance with discharge coordination please let us know.
- Our discharge coordinators will troubleshoot issues, provide contact information for you, make recommendations, and escalate provider concerns.

Discharge Plan Cont.

If discharge appointments have been made, please list the service, provider, and date of appointment:

Service:	Provider:	Date of Appointment:
1.	1.	1.
2.	2.	2.
3.	3.	3.

Do you need assistance with discharge coordination? ☐ yes ☐ no

If yes, please provide the name/title/email/phone number of the person our discharge coordinator can contact:

ELOS

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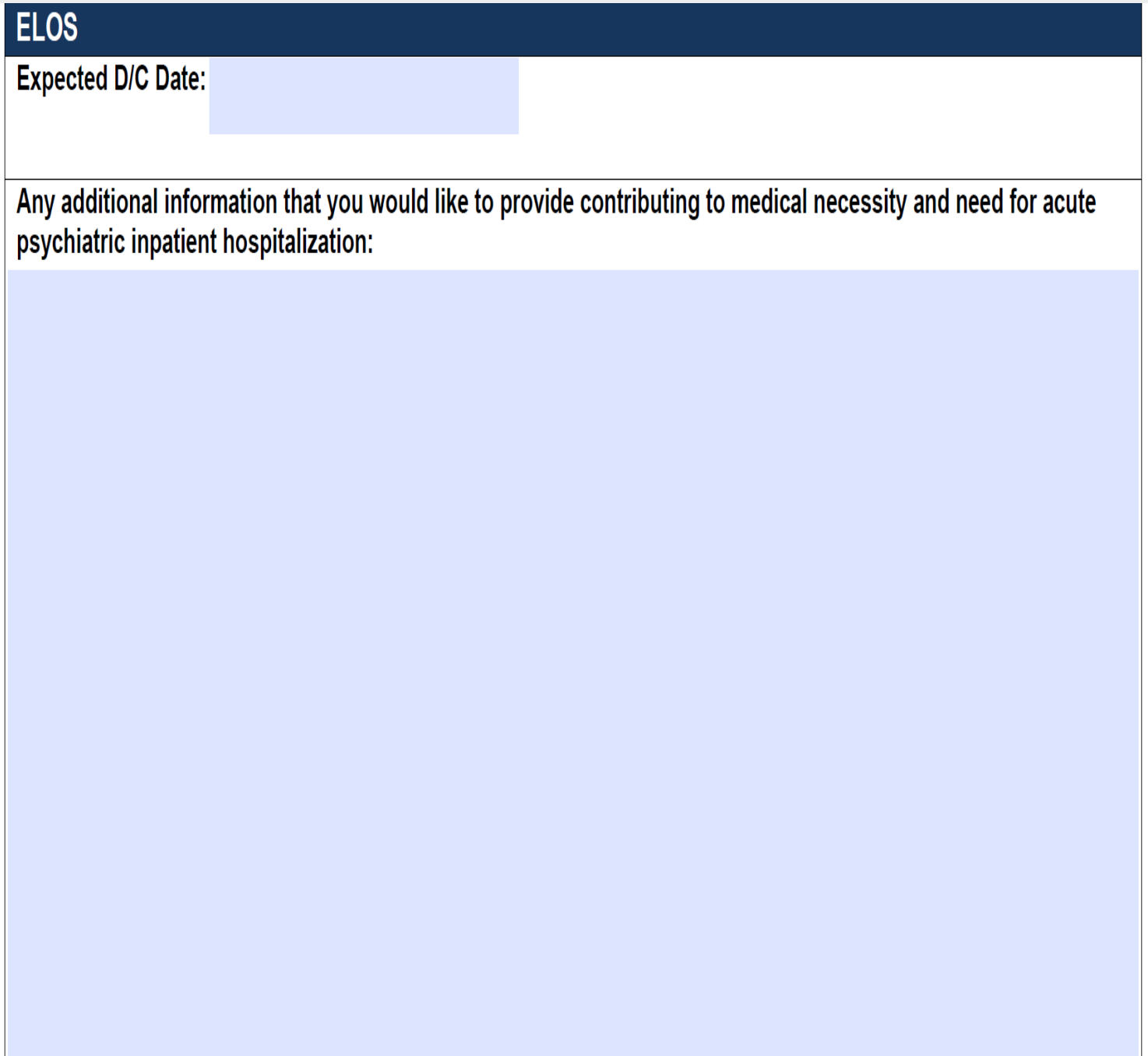
Initial Form Continued

- This space is for you to provide any additional information that can help us determine if a member meets medical necessity criteria.
- You can provide new information not given elsewhere in the form or provide additional explanation to information documented on the form.



Concurrent Review Form

Concurrent Review Form

- We are interested in the member's progression:
  - The treatment
  - The member's presentation/response to treatment

Type of Admission: Behavioral, Detox or Both	SELECT ONE
BH Diagnosis update if it has changed:	
Lab results (including medication related):	
If not provided at previous review, please indicate:	
• Blood Alcohol Level:	
• UA/UDS/Utox Results:	
If detox is being provided, update with current information:	
• Msas/CIWA Score:	
• COWS/CINA Score:	

Vitals:	
Temperature:	
Heart Rate:	
Respiratory Rate:	

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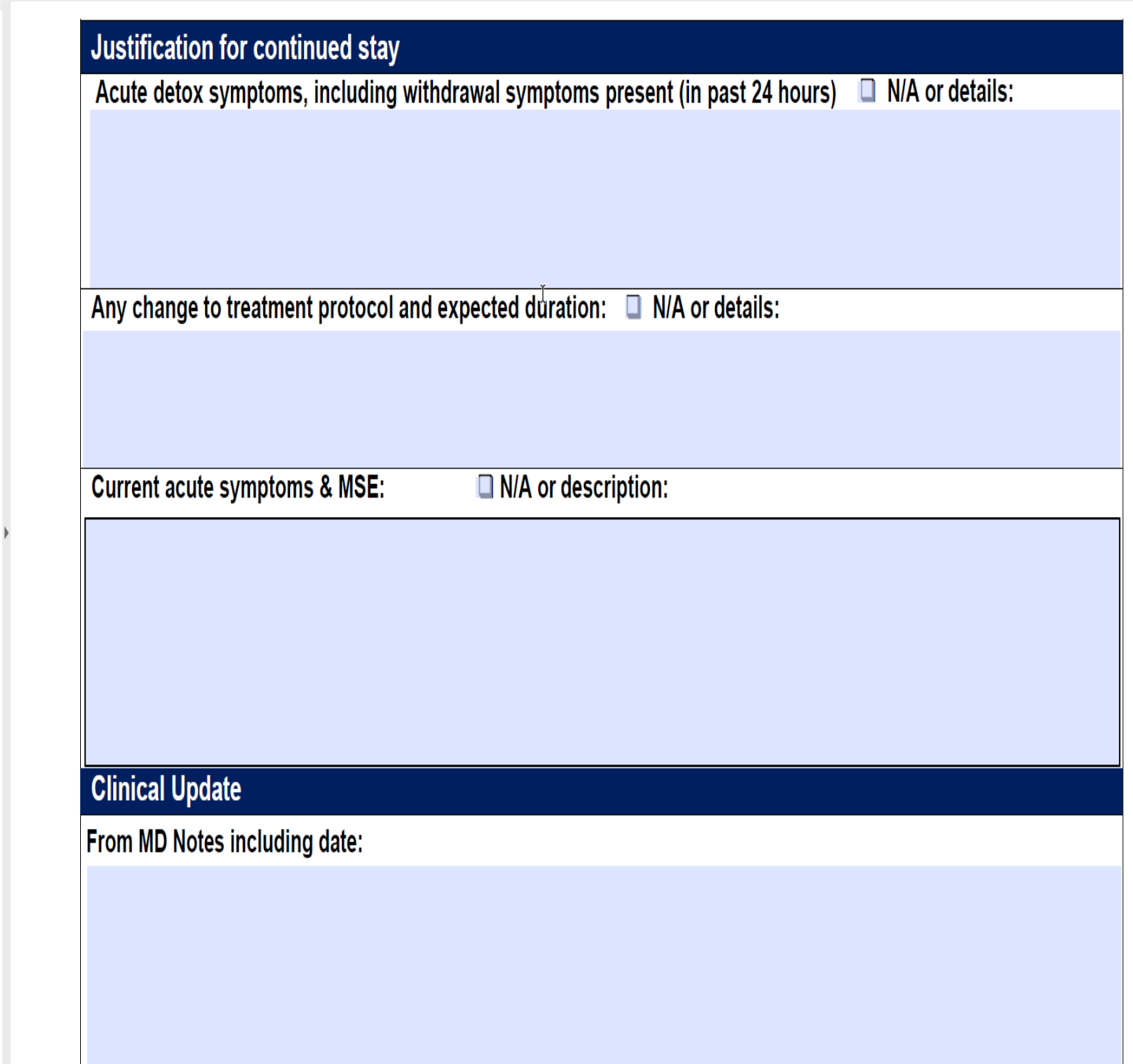
Concurrent Review Form Continued

- If a member is progressing along in their detox without issue, we would expect a clear discharge plan without issue as soon as the protocol is complete.
- For all treatment, we need an updated clinical picture showing the patient's response to treatment.



Justification for continued stay

Acute detox symptoms, including withdrawal symptoms present (in past 24 hours) ☐ N/A or details:

Any change to treatment protocol and expected duration: ☐ N/A or details:

Current acute symptoms & MSE: ☐ N/A or description:

Clinical Update

From MD Notes including date:

Concurrent Review Form Continued

- Please provide specific information as to how the patient has improved or deteriorated since the last review.

Changes/improvements since last review (be specific):

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Concurrent Inpatient Review Form

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AHCCCS Number:	Member Name:	Review Date:

Current Medications

Medication/Dose/Frequency/Compliant: Please note if medication is PRN.

Medications	Dose	Frequency	Compliant	PRN (Y or N)	Note Date of Changes	Increase, Decrease or Discontinued

Concurrent Review Form Continued

- We need to know the dates of all medication changes.
- We need to know if medication is a standing order or a prn.

Concurrent Inpatient Review Form

This form is to be TYPED.

Cc: A copy of the form to your current health plan re viewer

AHCCCS Number:	Member Name:	Review Date:

Current Medications

Medication/Dose/Frequency/Compliant: Please note if medication is PRN.

Medications	Dose	Frequency	Compliant	PRN (Y or N)	Note Date of Changes	Increase, Decrease or Discontinued
1.	1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.	2.
3.	3.	3.	3.	3.	3.	3.
4.	4.	4.	4.	4.	4.	4.
5.	5.	5.	5.	5.	5.	5.

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Concurrent Review Form Continued

- The discharge information must ALWAYS be provided.
- We need to know the status and steps you are taking to prevent delays to discharge.
- If you need assistance from our discharge coordinators, let us know.

AHCCCS number:	Member name:	Review date:

Discharge Plan

1.

2.

3.

Barriers to Discharge:

How are the barriers being addressed:

Do you need assistance with discharge coordination? ☐ yes ☐ no

If yes, please provide the name/title/email/phone number of the person our discharge coordinator can contact:

Concurrent Review Form Continued

- Part of active discharge planning is coordination with outpatient clinical teams if there is one.
- If there is no outpatient provider, then urgent engagements are important.
- Many readmissions are driven by the members not being connected to outpatient providers.

ELOS:	Expected D/C date:
Date the most recent discharge planning/ART/CFT meeting was held?	
Who was present for the discharge meeting:	

What discharge follow up appointments have been made:

	Service:	Provider:	Date of Appointment:
1.			
2.			
3.			

If plan is to step down to an out of home level of care, What facilities have been contacted, When were they contacted, and What was the outcome?

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Concurrent Review Form Continued

- It is important to know if the hospital is making a report to DCS or APS.
- Our reviewers are mentioning that the last part of the concurrent form where we place questions is being missed.

AHCCCS number:	Member name:	Review date:

If DCS/APS concerns have been identified, date and time of report:

If DCS/APS report has not been made, please identify the rationale:

For Concurrent Review, please answer any questions or address recommendations from the Banner reviewer that are below this line.

Banner Health

Any questions?

Thank you for attending the inpatient forms training.

Lynda Crooms and Beth Pfile

Lynda.Crooms@bannerhealth.com and Beth.pfile@bannerhealth.com