Connecticut BHP
Supporting Health and Recovery

INSTRUCTIONS FOR COMPLETING THE HIGHER LEVEL OF CARE TEMPLATE

Treatment Information *(required)*	How to complete this section
Requested Start Date for this Authorization	For a new request, this is the date of admission. For a continuing stay request, this is the first uncovered day for continued stay authorization.
Admit Date	The date the member was admitted to your facility.
Has the member been admitted to the facility?	Select No if the member has not been admitted to your facility and if this is an initial precertification. Select Yes if the member has already been admitted to your facility and this is a concurrent review request.
Type of Service	Select the appropriate check box for mental health or substance use depending on the member's primary behavioral health diagnosis.
Type of Care	Select the appropriate check box for the type of care being provided.
Type of Review	Initial Precertification – The member has not been admitted or received HLOC services from your facility and an authorization for services has not been received yet. Concurrent Review – The member has already received an initial authorization for HLOC services from your facility. You are completing another review to receive additional day/units for this member.

Demographic Information Requested *(required)*	How to complete this section
Member Name:	This is the member's name as it appears on their HUSKY benefit card.
Member Medicaid ID	This is the Member ID# from the member's gray HUSKY benefit card.
Member DOB	This is the member's date of birth.
Member Follow-Up Contact Information	Enter the member's phone number or email address so we can contact them for follow-up communications. If this information is not available, enter N/A and the reason why it's not available.
Preparer Name and Phone #	Write the name of the individual who is completing the template and their phone number in case our clinical team needs to contact this person with additional questions.
Facility Name	This is the name of your facility.
Facility ID #	This is your facility's Medicaid ID #. If this is not available, use your facility's NPI #.
Name of Facility/Institution Referring Member to You	Write the name of the facility or institution who referred the member to you.

Diagnostic Information						
Symptomatology *(required)*	**Behavioral Diagnoses *(required)***	**Medical Diagnoses *(required)***		**Social Elements Impacting Diagnosis *(required)***	**Functional Assessment *(optional)***	**Add. Medical Information *(optional)***
"Why now" 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.	Minimum requirement of primary behavioral diagnosis. Add additional diagnoses as appropriate. When multiple diagnoses will be listed, please list the most important diagnosis in the first available primary diagnosis field. Please list appropriate ICD code and description. Please see DSM-5 for further instructions.	Options include: •Infectious & Parasitic - Other •Infectious & Parasitic - HIV •Cancer & Neoplasms •Blood, blood-forming organs, & immunological •Endocrine, nutritional & metabolic - Thyroid •Endocrine, nutritional & metabolic - Diabetes •Endocrine, nutritional & metabolic - Other •Endocrine, nutritional & metabolic - Overweight •Mental, Behavioral, Neurodevelopmental •Nervous system - Other •Nervous system - Parkinson's, EPS •Nervous system - Multiple Sclerosis •Nervous system - Migraine, Epilepsy, Stroke •Nervous system - Chronic pain, other •Eye - Other •Eye - Blindness •Circulatory system - Other	•Circulatory system - Hypertension •Circulatory system - Heart •Respiratory system - Other •Respiratory system - COPD, Asthma, Emphysema •Digestive system - Other •Digestive system - Liver •Skin & subcutaneous tissue •Musculoskeletal system & connective tissue •Genitourinary system - Kidney •Genitourinary system - Other •Pregnancy, childbirth •Perinatal period •Congenital malformation, deformation, & chromosome abnormality •None •Unknown	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 & environmental problems (list details) •Unknown	May enter functional assessment from following list and score: •WHO_DAS •GAF •SF12 •SF36 •FAST •CDC HRQOL •OMFAQ •Other	Information concerning the individual's comorbid medical conditions as well as information concerning the individual's body mass index & potential impact on overall health may be entered for this section.

Current Risks: *(required)*	How to complete this section
Risk to self (SI)	Indicate individual's level of, or absence of, suicidality by circling the appropriate value.
Risk to others (HI)	Indicate individual's potential for, or absence of, violence and/or abuse by circling the appropriate value.
Substance Use	Indicate individual's level of, or absence of, substance use by circling the appropriate value.
Legal	Indicate the individual's level of involvement with the legal system.

Primary Behavioral Diagnosis/ Risk Assessment (*Required if primary behavioral health/medical diagnosis relates to any of the complex categories below. Also required if current risks (above) relating to the complex category is scored as a 2 or 3.)*

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:

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:

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:

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:

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)?
- Describe plan for medication compliance (including supports to assist prn):
- Treatment History:
- ICM needs (including Community, VO, CM, DM, etc):

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:
- Please include Vital Signs: Blood Pressure, Temperature, Pulse (Heart Rate), and Respiratory Rate
- Please describe withdrawal symptoms. If a COWS/CIWA score is indicated, please explain why that score was given.
- Please describe co-morbid medical conditions and their impact on the member's substance use and/or behavioral health diagnosis.

Child/ Adolescent Behavior Symptom Complex:	**Mood Disorder 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:	• 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:

Urine Drug Screen *(only required if primary diagnosis is Substance Use)*	**How to complete this section**
UDS completed?	Enter date for most current UDS evaluation.
Outcome of UDS	Note details of urine drug screen, whether results were positive, negative, or pending.
Positive For	Check off all checkboxes pertaining to positive results from the UDS.

ASAM Dimensions (Required if request is Substance Use related)	**How to complete this section**
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. • 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.

Psychotropic Medications *(not required)*	**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 (i.e., involuntary medication).

Additional Information *(required)*	**How to complete this section**
Recovery and Resiliency Environment	To be completed on each review and updated as the recovery & resiliency plan is further developed.
Best Practice Endorsement	Best practice guidelines can be found for reference at http://valueoptions.com/providers/Handbook/treatment_guidelines.htm
Care Planning Team Includes	Check all parties who are involved in the member's care planning.
Is there a child or adult in member's household in need of any support or service?	If you select Yes, indicate the category of support/service needed from the drop down, then provide more details in the text box below.
Is service requested for HLOC because appropriate LLOC is not available?	If you select Yes, complete the following 2 questions for which LLOC is not available and the reason it is not available at this time.

Discharge Information *(required for initial pre-certifications and concurrent reviews only)*	**How to complete this section**
Planned D/C level of care	This should be completed for both admission and continued stay requests.
Planned Discharge Residence	This should be completed for both admission and continued stay requests.
Expected Discharge Date	This is not required on initial pre-certifications, but should be completed on all concurrent reviews.

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