



## INSTRUCTIONS

### COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)

**Please note:** To ensure timely processing of your Inpatient Treatment Report, please complete all sections for submission to ValueOptions. TYPE or PRINT LEGIBLY. Check/Circle responses where applicable.

Information requested	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 covered day for continued stay authorization.
Level of Care	Please see your Provider Relations Handbook for Level of Care definitions ( Or see www.valueoptions.com)
Tx Unit/Program	If the patient is on a specialty unit please indicate.( e.g., Eating Disorder Unit)

Type of Review Option	Definition
Prospective	The patient has not yet started the program or was admitted on an emergent basis without preauthorization within the prior 72 hours.
Concurrent	The patient is currently enrolled in the program.
Discharge	The patient is being/has been released from the program.
Retrospective	The patient has already been admitted to and released from the program prior to submission of an ITR/request for authorization.

Information requested	How to complete this section
Type of Care	Circle the appropriate type of service. If treatment is for dual diagnosis, circle the primary focus.
Precipitating Event	What has happened to cause the patient to be admitted now?
Member's Current location	Where is the member at this time?

#### Demographics:

Information requested	How to complete this section
Member/Policyholder ID #	This is usually the ID # from the member's benefit card. However, for some plans it is still the policy holder's SSN or Alternate ID #.
Insured's Employer/Benefit Plan	This is either the policy holder's employer's name or the Health Plan the member belongs to, depending on who holds the contract with ValueOptions.
Fac. ID#	The ValueOptions Facility ID#
Attending Provider & Phone #	This is the provider who will follow the member throughout the admission.
UR Name and UR Phone #	This is the contact at the facility for clinical reviews / additional information

Information requested	How to complete this section
DSM-IV Diagnosis	All five Axes required. List primary; add secondary as appropriate. See DSM IV-TR for further instructions.

#### Current Risks:

Information requested	How to complete this section
Risk to self (SI)	Indicate member's level of, or absence of, suicidality by circling the appropriate value, and checking all boxes that apply. <b>This must be completed</b>
Risk to others (HI)	Indicate member's potential for, or absence of, violence and/or abuse by circling the appropriate value, and checking all boxes that apply. <b>This must be completed</b>
Current Serious attempts	Has a serious attempt occurred very recently (i.e., immediately prior to this request)? If yes circle SI and/or HI as appropriate
Prior Serious attempts	Have serious attempts occurred in the past? If yes circle SI and/or HI as appropriate
Prior Serious gestures	Have serious gestures occurred in the past? If yes circle SI and/or HI as appropriate

#### Current Impairments: (please select/circle one value for each type of impairment – this must be completed)

Rating	Definition
0 = none	No evidence of impairment
1 = mild	Occasional impairment or difficulties, but no interference with normal daily activities
2 = Moderate	Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks
3 = Severe	Currently experiencing severe symptoms, potential risk for harm to self/others, severe distress and/r disruption in daily activities
N/A = not assessed	Impairment was not assessed – <b>Please note use of N/A may result in additional calls from ValueOptions to ascertain this information.</b>

#### Mental Health/Psychiatric Treatment History: (If none or unknown please check none or unknown. If known complete the following section)

Information requested	How to complete this section
Treatment Compliance (non-med)	Compliant with aspects of their treatment that do not include medications. <ul style="list-style-type: none"> <li>• Poor -- Member complies with few (Less than 50%) of the recommendations in his/her treatment plan.</li> <li>• Fair -- Member complies with some (More than 50% but less than 75%) of the recommendations in his/her treatment plan.</li> <li>• Good -- Member complies with most (At least 75%) of the recommendations in his/her treatment plan</li> </ul>
Number of psychiatric hospitalizations in the past 12 months	The total number of "24 hour psychiatric admissions" in the past 12 months. These include inpatient hospitalization, residential treatment, group home, etc. An estimate is acceptable.
Number of psychiatric hospitalizations in lifetime	The total number of "24 hour psychiatric admissions" in his/her lifetime. These include inpatient hospitalization, residential treatment, group home, etc. An estimate is acceptable.



**INSTRUCTIONS**  
**COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)**

**Substance Use/Abuse:** If yes, please complete below

Information requested	How to complete this section
Substance, Total Yrs Use, Length current use, amount, frequency chart	An estimate is acceptable.
Withdrawal Symptoms	If this is a Substance Abuse admission this needs to be complete
Relapse Date	What is the most recent Relapse date?

**ASAM Dimensions:**

Information requested	How to complete this section
Intoxicated/Withdrawal Potential	<ul style="list-style-type: none"> <li>Low – Not under the influence; no withdrawal potential</li> <li>Medium – Recent use; moderate withdrawal potential requiring 24 hour monitoring</li> <li>High – Severe withdrawal history; presenting with severe withdrawal; history or current seizure activity</li> </ul>
Biomedical Conditions	<ul style="list-style-type: none"> <li>Low – No current medical problems or complications</li> <li>Medium – Diagnosed medical condition requiring monitoring but not intensive treatment.</li> <li>High – History of, or identified medical condition that requires 24 hour medical/nursing monitoring and/or intensive treatment,</li> </ul>
Emotional/Behavioral/Cognitive Conditions	<ul style="list-style-type: none"> <li>Low – No current cognitive/emotional/behavioral conditions</li> <li>Medium – Impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs.</li> <li>High – Active suicidal/homicidal ideations; acutely psychotic/delusional/labile; impacting ability to engage in treatment; symptoms require 24 hour psychiatric care.</li> </ul>
Readiness to Change	<ul style="list-style-type: none"> <li>Low – Ready for/Accepting need for treatment; attending, participating, and can ID future goals, plans</li> <li>Medium – Ambivalent about treatment; seeking help to appease others; avoiding consequences; variable to poor engagement.</li> <li>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.</li> </ul>
Relapse Potential	<ul style="list-style-type: none"> <li>Low – Recognizes onset signs; uses coping skills with CD or psychiatric problems</li> <li>Medium – Awareness of relapse triggers or onset signs for MH/SA issues but requires close monitoring.</li> <li>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.</li> </ul>
Recovery Environment	<ul style="list-style-type: none"> <li>Low – Supportive recovery environment for MH/SA issues.</li> <li>Medium – Moderately supportive environment/resources for MH/SA issues.</li> <li>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.</li> </ul>

**Treatment Request:**

Information requested	How to complete this section
Admit Date	Date of this admission

**Discharge Plan:**

Information requested	How to complete this section
Estimated Return to work date	This is N/A for children and adolescents.
Planned D/C level of care	This should be completed for both admission and continued stay requests.

**Discharge Information: To be completed upon discharge**

Information requested	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 GAF:	GAF score 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. <b>This must be completed</b>
Total # Days/Sessions used	The total number of days/sessions used during this course of treatment
Discharge plans in place?	<b>This must be completed</b>
AfterCare Behavioral Health Provider	If arranged, enter provider's name, telephone #, scheduled appointment date and type of appointment
Prescribing Physician	If arranged, enter the physician's name, telephone #, check what type of physician it is and appointment date