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Description automatically generated with medium confidence

**Inpatient Submission Form** - **Confidential**

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| **Select Type of Review:** | | | | | | | | |  | | | | |  | |
|  | **Concurrent Review – New** | | | | | | | |  | | | | |  | |
|  | **Concurrent Review – Continued Stay Review ---** | | | | | | | | **Previous Case #:** | | | | Case ID | | |
|  | **Retrospective Review** | | | | | | | |  | | | | |  | |
|  | **Administrative Days** | | | | | | | |  | | | | |  | |
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| **Date of Request (MMDDYYYY)** | | | | | | Enter Date of Request | | | |  | | | | | | |
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| **Admission Date:** | | | Enter Admission Date | | | |  | | | | | | | | | |
| **Admission Source:**  Voluntary  Involuntary | | | | | | | | | | | | | | | | |
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| **Hospital Name:** | | | | | | Enter Hospital Name | | | | | | | | | | |
| **Hospital NPI:** | | | | | | Enter Hospital NPI | | | | | | | | | | |
| **County Health Plan Name:** | | | | | | Enter County Health Plan Name | | | | | | | | | | |
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| **Member Last Name:** | | | | Enter Last Name | | | **Member First Name:** | | | | | Enter First Name | | | | |
| **Member Medi-Cal ID:** | | | | Enter Medi-Cal ID | | | **Member DOB:** | | | | | Enter DOB | | | | |
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| **Start Date:** | | Start Date | | | |  | **End Date:** | | | | End Date | | | |  | |
| **Number of Days Requested:** | | | | | Enter Total Days | | |  | | | |  | | | | |
| Service Lengths:   * Concurrent Review = Up to 3 days * Administrative Days Review = Up to 7 days * Retrospective Review = No limit (ie start to end of treatment) | | | | | | | | | | | | | | | | |

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**Primary Diagnosis codes and Descriptions:**

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| **Diagnosis Code** | **Description** |
| Enter Dx Code | Enter Dx Description |
| Enter Dx Code | Enter Dx Description |
| Enter Dx Code | Enter Dx Description |
| Enter Dx Code | Enter Dx Description |
| Enter Dx Code | Enter Dx Description |

**ADMISSION QUESTIONNAIRE:** *\*Completed on initial submission*

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| **Date of Admission:** | Enter Admission Date |  |  |
| **Reason for Admission:** | Danger to self  Danger to others  Immediately unable to provider for, or utilize, food, shelter, or clothing  Grave Disabled due to a mental disorder  Other Click or tap here to enter text. | | |
| **Explain:** | Click or tap here to enter text. |  |  |
| **Legal Status:** | Voluntary  Welfare and Institution Code (WIC) 5150 (adults)/5585 (children)  WIC 5250 – 14-day hold  WIC 5300 – At the expiration of the 14-day period of intensive treatment, a person may be confined for further treatment for an additional period, not to exceed 180 days  Temporary Conservatorship  Conservatorship  Foster Care  Penal Code 1370 – Restoration of Competency  Parole  Probation  AB109 Post-Release Community Supervision (Probation) | | |
| **Insurance:** | Medi-Cal  Medi-Medi  Medical/Private  Kaiser Medi-Cal  Indigent  Other Explain: Click or tap here to enter text. | | |

**CONTINUED STAY REVIEW QUESTIONNAIRE:** *\*Completed on days 4+*

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| **Clinical Impression** |
| **Please discuss the beneficiary’s current presentation, symptoms, and behaviors (frequency, intensity, and duration) that support an inpatient level of care:**  Click or tap here to enter text. |
| **Please discuss any co-occurring factors that are contributing to the beneficiary’s psychiatric condition (e.g., chronic medical conditions and/or substance use disorders):**  Click or tap here to enter text. |
| **Could the beneficiary be safely treated at a lower level of care with crisis residential treatment services or psychiatric health facility services for this acute psychiatric episode?**  Yes  No  **IF YES -** Provide justification for the beneficiary not being treated at a lower level of care (example: no bed availability, referral pending, etc.):  Click or tap here to enter text. |
| **Does the beneficiary require psychiatric hospital services as the result of their mental disorder (check all that apply):**  Symptoms or behaviors represents a current danger to self or others, or significant property destruction  Symptoms or behaviors prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter  Symptoms or behaviors present a severe risk to the beneficiary’s physical health  Symptoms or behaviors represent a recent, significant deterioration in ability to function  Requires admission for further psychiatric evaluation  Requires admission for medication treatment  Requires admission for other treatment that can reasonably be provided only if the patient is hospitalized  Please describe: Click or tap here to enter text. |
| **Each day of treatment must meet medical necessity and/or continued stay criteria. Continued stay services in a hospital shall only be reimbursed when the beneficiary experiences one of the following:**  Continued presence of indications that meet medical necessity criteria  Serious adverse reaction to psychiatric medications, procedures, or therapies requiring continued inpatient hospitalization  Presence of new indications that meet medical necessity criteria  Need for continued psychiatric evaluation or treatment that can only be provided if the beneficiary remains in an inpatient hospital setting |
| **Coordination of Discharge and Aftercare Plan** |
| **Based on the hospitals assessment, what is the proposed discharge date:** Enter Admission Date |
| **Please discuss the discharge plan:**  Discharge plan |
| **Please discuss any community/family/friend/supports that the beneficiary has in place or is pending:**  Discuss supports |
| **Anticipated discharge disposition:**  Transitioned to lower level of care such a board and care or supported housing  Transitioned to a residential treatment facility  Transitioned to Full-Service Partnership Program  Transitioned to Assisted Outpatient Treat Program  Transitioned to Intensive Outpatient Program or Partial Hospitalization Program  Transitioned to Outpatient Services  Beneficiary declined any further mental health services  Unknown at this time |

**ADMINISTRATIVE DAYS QUESTIONNAIRE:** *\*Completed only when requesting admin days*

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| **Clinical Impression** |
| **Are you requesting administrative days for the beneficiary?**  Yes  No  Date beneficiary was placed on Administrate Days: Admin days date |
| **Has the hospital made at least one contact to a non-acute residential treatment facility per day (except for weekends and holidays) starting with the day the beneficiary is placed on Administrative Day status?**  Yes  No |
| **Has the hospital made and documented 5 contacts, any days within the seven-consecutive-day period from the day the beneficiary is placed on Administrate days?**  Yes  No  Date of first contact: 1st contact date  Describe the results of that contact (who, when, outcome): Discuss results  Date of second contact: 2nd contact date  Describe the results of that contact (who, when, outcome): Discuss results  Date of third contact: 3rd contact date  Describe the results of that contact (who, when, outcome): Discuss results  Date of forth contact: 4th contact date  Describe the results of that contact (who, when, outcome): Discuss results  Date of fifth contact: 5th contact date  Describe the results of that contact (who, when, outcome): Discuss results |
| **Are there fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary**  Yes  No  IF YES – Please describe:  The beneficiary’s packet is under review  An interview with the beneficiary has been schedule for Date  No bed is available at the non-acute treatment facility Name of facility  The beneficiary has been put on a wait list at Name of facility  The beneficiary has been accepted and will be discharge to Name of facility on Date  The beneficiary has been rejected from a Name of facility due to Reason  A conservator deems the facility to be inappropriate for placement |