

**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 |  |
|  |  |  |  |
| **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 |
|  |  |  |  |
| **Member Last Name:** | Enter Last Name | **Member First Name:** | Enter First Name |
| **Member Medi-Cal ID:** | Enter Medi-Cal ID | **Member DOB:** | Enter DOB |
|  |  |  |  |  |  |  |
| **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 hospitalizedPlease 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 [ ]  NoDate of first contact: 1st contact dateDescribe the results of that contact (who, when, outcome): Discuss resultsDate of second contact: 2nd contact dateDescribe the results of that contact (who, when, outcome): Discuss resultsDate of third contact: 3rd contact dateDescribe the results of that contact (who, when, outcome): Discuss resultsDate of forth contact: 4th contact dateDescribe the results of that contact (who, when, outcome): Discuss resultsDate of fifth contact: 5th contact dateDescribe 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 [ ]  NoIF 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 |