

**NARBHA Continued Stay Level I Inpatient Hospitalization/Subacute
Prior Authorization form 3.14.6**

Instructions: This form is completed by RA staff prior to end of previous authorization and faxed to NARBHA UM (928) 214-1166

Member Name: _____ **Member ID:** _____

AHCCCS ID: _____ **Responsible Agency:** _____

Facility Name: _____ **Number of Days Requested:** _____

Date of Admission: _____ **Estimated Total Length of Stay (days):** _____

Name of physician to contact for more information: _____ **MD phone/pager #:** _____

A person must meet ALL criteria in Sections A and E, at least ONE of the criteria in each of Sections B, C and must meet Section D for continued stay in a psychiatric acute hospital or subacute facility.

A. DIAGNOSIS: Axis I _____ Axis II _____ Axis III _____

(A specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.)

B. BEHAVIOR AND FUNCTIONING (must meet one)

1. Emergence or continued evidence of symptoms, which reflect imminent risk of danger to self or others as a result of a behavioral health condition, as evidenced by:

Current suicidal ideation, behavior or intent; **OR**

Current homicidal or significant assaultive ideation, behavior or intent; **OR**

Ongoing physiologic jeopardy; or

2. Continued disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation; **OR**

3. Significant regression of the person's condition is anticipated without continuity of this type of service.

EXPLANATION: _____

C. INTENSITY OF SERVICE (must meet one)

There is documented evidence that the person requires at least one of the following:

Continued planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. This may be as a result of a change in diagnosis, treatment failure, or newly-discovered aspect of the person's case necessitating a significant change in the treatment plan; **OR**

Close, continuous, 24 hour skilled medical/nursing supervision of the person's behaviors, which are due to a behavioral health condition, in order to prevent injury to the person or others; **OR**

Pharmacotherapy which requires continuous, skilled medical/nursing supervision for safe, effective use; **OR**

Skilled nursing observation and care in the management of disturbances of mood, thought or behavior which cannot be provided by non-medical personnel; **OR**

Repeated use of physical restraint; **OR**

Psychiatric acute hospital or sub-acute facility services may be continued if the person no longer requires the type of service provided in a psychiatric acute hospital or subacute facility but there is not an available lower intensity of services suitable to the behavioral health needs of the person or the person cannot return to the person's residence because of a risk of harm to self or others.

EXPLANATION: _____

D. EXPECTED RESPONSE

There is documented evidence that: (must meet)

Active treatment is provided that is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; **OR**

There has been a re-evaluation and subsequent change in the treatment plan.

----- **AND**-----

There is still an expectation that continued treatment in this type of service can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed; **OR**

There is no less restrictive type of service available to safely meet the person's behavioral health needs.

F. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment. **(Please attach treatment plan)** _____

Other: _____

Provider Signature: _____ **Date** _____