arkansas total care

# Residential Treatment Center Review Form (RTC Level of Care)

## Initial Review Section

| Member Demographics & Authorization Details | |
|---|---|
| Member name/Medicaid number: | Admission date: |
| Submission date: | Attending physician name, credentials: |
| UR name/phone and fax numbers: | Facility name/state: |
| RTC prior authorization form for initial request attached (OP referral form)? ☐ Yes ☐ No<br>If no, provide reason: | |
| **Clinical Information** | |
| Primary diagnoses (BH, medical, comorbidities): | |
| Primary reason for admission: | |
| Ongoing symptoms, behaviors, functioning information, and risk factors to member requiring need for residential treatment (please note if any symptoms or behaviors have been persistent for six months or more): | |
| **Personal and Social Context** | |
| Living arrangements prior to admission: | |
| Education history (IEP, 504, homeschooled, low IQ, etc.): | |
| Legal issues: | |


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**Planned Treatment Interventions Acknowledgment Checklist**

Please acknowledge Yes or No for each of the following treatment interventions:

Clinical assessment completed daily

☐ Yes ☐ No

Individual and/or family education

☐ Yes ☐ No

Therapies by LMHP (including one individual therapy session weekly, two family therapy sessions monthly, total of five therapy sessions weekly)

☐ Yes ☐ No

Psychiatric evaluation once a week by a Licensed Clinical Practitioner

☐ Yes ☐ No

A current and updated treatment plan

☐ Yes ☐ No

Participation in a school or vocational program

☐ Yes ☐ No

| **Substance Use History** |
| --- |
| Current or historical substance use concerns: |
| **Treatment History/Current OP Providers** |
| Inpatient/outpatient treatment history: |
| **Medications** |
| Current medications (name, dosage, frequency): |
| **Discharge Plan** |
| Discharge planner name/phone number: |
| Discharge barriers: |
| Tentative discharge plan (please provide as much detail as possible): |

## Concurrent Review Section

| **Authorization Details** | |
|---|---|
| Last covered day: | Submission date: |
| Attending physician name, credentials: | UR name/phone and fax numbers: |
| **Clinical Information** | |
| Updated diagnoses (BH, medical, comorbidities): | |
| Current unit precautions: | |
| MD/RN/therapy/staff notes (please be sure to include group therapy dates and individual therapy note(s) in last week, and family therapy note(s) since last review): | |
| Treatment plan, objectives, and update on progress (please attach most recent treatment plan/update): | |
| Dates of passes completed in the previous review period: | |
| Additional issues to be addressed in treatment: | |
| **Substance Use History** | |
| Updates to substance use concerns: | |
| **Medications** | |
| Current medications including PRNs (name, dosage, frequency, start date, end date): | |
| Vitals (include height, weight, BMI): | |
| **Labs Since Last Review** ☐ **Yes** ☐ **No** | |
| If yes, please provide: | |
| **Discharge Plan** | |
| Discharge planner name/phone number: | |
| Discharge barriers: | |
| Member’s primary support: | |
| Updated discharge plan (provide as much detail as possible including, planned DC location, and follow-up appointments): | |