BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

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Inpatient Provider Application

Identifying Information (Please type or print)	
Name of Psychiatric Facility or Unit	If Unit, Name of Hospital

Address Information (Please list all locations and group affiliations. Use an additional attachment if needed.)

Physical Address		
Street Address		
Suite #	City	
State	Zip	County
Phone	Fax	Emergency/After Hours
Federal Tax ID Number	Type of Facility ☐Freestanding ☐Hospital Unit	
Normal Business Hours	Admission Hours	
Name of Administrator		
Name of Medical Director	Specialty	

Mailing Address *SAME AS PHYSICAL ADDRESS* ☐		
Street Address		Suite
City	State	Zip
Attention		
Email Address		

Claims Payment Address *SAME AS PHYSICAL ADDRESS* ☐		
Street Address		Suite
City	State	Zip

Please Describe Your Facility's Ownership Structure

☐	For-Profit	☐	Publicly Held	☐	System Affiliate (Describe)
☐	Non-Profit	☐	Privately Held	☐	Other (Describe)

How long have you operated under your current structure?
Please describe the physical characteristics of your psychiatric facility/unit in terms of size, age, design, condition, etc.
Are any of your psychiatric units under external contracted management? If yes, please list name of provider and initial contract date.
If management is externally contracted, please describe the working relationship which exists between hospital and unit management, including hospital board participation, staffing, lines of authority, etc.

Licensure/Affiliations

State of License			Type of Licensure
Accreditations:	☐ JCAHO	☐ CARF	☐ Other

Have you lost any accreditations in the last ten years? ☐ Yes ☐ No (If yes, please attach explanation)

Has your eligibility as a Medicare/Medicaid provider ever been revoked? ☐ Yes ☐ No (If yes, please attach explanation)

Can you treat patients with medical problems? ☐ Yes ☐ No

What affiliations does your facility/unit have with other:

Psychiatric Hospitals	
General Medical Hospitals	
Satellites	

What transportation arrangements do you make available to your patients?

How do you work with HIV-positive patients?

Can you treat disabled patients?

Do you have a dietary consultant?

Financial/Insurance

What is your overall payor mix (in percent of gross revenue)

Medicare	Blue Cross	Other Private Payor
Medicaid	Charity Care	Other

How would you describe your facility's financial condition? ☐ Poor ☐ Fair ☐ Strong ☐ Very Strong

Do you accept: ☐ Court Referrals ☐ Indigent Patients If not, where do you refer such patients?

Levels of professional and comprehensive general liability coverage: Professional General

Liability history within past 10 years? ☐ Yes ☐ No

Has your facility had a revoked, suspended, limited, or probationary license within the past 10 years? ☐ Yes ☐ No

Does your facility have any actions or formal complaints pending or currently under investigation by any ethical standards committee, licensing board, or other board of inquiry or authority? ☐ Yes ☐ No

Has your facility been denied or refused renewal of liability insurance, or had liability insurance voluntarily terminated, within the past 10 years? ☐ Yes ☐ No

Has your facility entered into a consent agreement, entered into a plea of guilty, or been found guilty of fraud or abuse involving payment of health care claims by any health care payor or health care claims or professional review organization, governmental entity, or agency, within the past 10 years, or is any such action pending? ☐ Yes ☐ No

PLEASE ATTACH AN EXPLANATION OF ANY "YES" RESPONSES.

Medical Staff

Is your medical staff ☐ Open ☐ Closed

Number of Salaried Physicians	Number of Salaried Psychiatrists	Number of Psychiatrists with Attending Physician Status

Do any non-physician medical staff have admitting privileges? ☐ Yes ☐ No Please Explain:

Have any of your medical staff had malpractice judgements entered against them or been involved in litigation? ☐ Yes ☐ No (If yes, please attach list of names and outcomes.)

Do you report information on non-physician medical staff to the National Practitioner Data Bank? ☐ Yes ☐ No

Categories of Care

Total Number of Psychiatric Care Beds			Current Census	

What are your areas of specialization? (Check all that apply)

	# Beds	Designated Unit			# Beds	Designated Unit
☐ General Adult		☐ Yes ☐ No		☐ Sleep Disorders		☐ Yes ☐ No
☐ Substance Abuse		☐ Yes ☐ No		☐ Eating Disorders		☐ Yes ☐ No
☐ Child		☐ Yes ☐ No		☐ Elderly		☐ Yes ☐ No
☐ Adolescent		☐ Yes ☐ No		☐ Other		☐ Yes ☐ No

If more than one unit, how is placement determined for a dual psychiatric diagnosis?

How is placement handled for a dual psychiatric/medical diagnosis?

If a free-standing facility, how do your patients access a full range of medical services?

Presenting Problems: Rank the following, indicating which disorders you treat most frequently, with #1 being the most common. Also include average length of stay.

	Rank	ALOS			Rank	ALOS
Developmental Disorder				Disruptive Behavior Disorder		
Eating Disorder				Organic Mental Disorder		
Substance Use Disorder				Psychoses		
Mood Disorder				Anxiety Disorder		
Sexual Disorder				Sleep Disorder		
Adjustment Disorder				Personality Disorder		

What percent of your patients are discharged within (indicate overall average):

1 – 5 days: %	6 - 10 days: %	11 – 15 days: %	16 – 20 days: %	21 – 30 days: %	31^{+} days: %

Please describe any related program expansion plans currently in process:

Outcome/Quality of Care
Please describe your facility's quality assurance process.
Please describe your internal utilization review program. Do you have a designated UR department?
How do you interact with/involve external utilization review/case management companies in this UR process? Do you allow on-site reviews?
How do you measure treatment outcomes?
How do you handle patient complaints? (review process, etc.)

PLEASE SUBMIT COPIES OF THE FOLLOWING WITH THIS APPLICATION

- Current state licensure
- Current accreditation (e.g., JCAHO, CARF)
- Current professional and general liability coverage. If self-funded, please provide a statement of reserves.
- Vitaes of the Medical Director and Program Director(s).
- Brochures/literature regarding your program.

PLEASE REVIEW AND SIGN THE CERTIFICATION AND AUTHORIZATION

PLEASE COMPLETE THE SECTION FOLLOWING THE CERTIFICATION AND AUTHORIZATION FOR EACH SPECIALIZED PROGRAM OR UNIT WITHIN YOUR FACILITY

INPATIENT PROVIDER QUALIFICATIONS

1. Appropriate licensure/JCAHO and other appropriate accreditation;
2. Maintain a demonstrated level of satisfactory financial stability and insurance liability protection;
3. Cooperate in an external assessment/review/case management process;
4. Provide a program of care supervised by a Board-certified psychiatrist, or by a physician in the case of substance abuse residential treatment facilities;
5. Provide access to medical care either directly or through contractual arrangement;
6. Provide 24 hour nursing and medical staff coverage;
7. Employee or contract staff to include:
    a. Psychiatrist(s), or addictionologist(s) in the case of substance abuse treatment providers;
    b. Primary care physician(s);
    c. Psychologist(s);
    d. Social Worker(s);
    e. Psychiatric nurses, or registered nurses in the case of substance abuse treatment providers;
    f. Occupational/recreational/physical therapists;
8. Adhere to specific admission criteria;
9. Provide a thorough assessment, individualized treatment plan and discharge plan including discharge summary for each patient (preliminary treatment plan completed within 24 hours, master treatment plan completed within 72 hours and reassessed at specified times and when major clinical changes occur);
10. Provide an organized program for psychiatric services and individualized treatment in response to identified patient needs. Program components should include:
    a. Individual therapy;
    b. Group therapy;
    c. Marriage/family therapy;
    d. Coping skills training (i.e., leisure skills training, relaxation training, assertiveness training, recreation/exercise);
    e. Educational/teaching groups;
    f. Access to consultation as needed for vocational, spiritual, nutritional and financial counseling;
    g. Aftercare;
11. Provide post-discharge monitoring process;
12. Actively engage in a formal quality assurance/utilization review process.

Inpatient substance abuse treatment providers must meet the following qualifications in addition to those specified above:

1. Employee or contract staff to include counselors with specialty in substance abuse;
2. Program components to include alcohol and drug education groups, and support groups;
3. Provide medically supervised detoxification when necessary;
4. Provide individualized treatment and length of stay planning as an alternative to the traditional 28-day program;
5. Provide directly or by referral alternative/step-down levels of care (i.e., structured outpatient, day treatment);
6. Provide drug screening services;
7. Provide staff facilitated group aftercare meetings at least weekly for two years post-discharge;
8. Monitor recovery (i.e., attendance at aftercare groups, support groups, results of drug screens).

Certification, Authorization and Attestation

I acknowledge and agree that Behavioral Health Systems, Inc. (BHS) has a valid interest in obtaining and verifying information concerning the facility, in determining whether to enter into an agreement with the facility for the provision of services to members. I understand that any material misstatement, error, or omission in this application shall constitute cause for denial of this application and of the facility's participation in the network. Accordingly:

i. I represent and certify to BHS that the information contained in this Application is true and complete to the best of my knowledge and belief, that I meet the BHS Criteria set forth above and, if applicable, the Assessment/Case Manager Criteria, for those specialties I have indicated on the Application, and I agree to inform BHS promptly if any material change in such information occurs, whether before or after acceptance by BHS of my Application for affiliation with BHS' provider network; and

ii. I understand and agree that I have the burden of producing adequate information for proper evaluation of the facility's qualifications and for resolving any reasonable questions regarding such qualifications, and that BHS has no responsibility to consider this application until all necessary information is received by BHS, and

iii. I authorize BHS to consult with the facility's administrators, members of facility's staff, malpractice carriers and other persons to obtain and verify information concerning the facility's qualifications, and I release BHS and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating this application; and

iv. I consent to the release by any person to BHS of all information that may reasonably be relevant to an evaluation of the facility's qualifications, hereby release any such person providing such information from any and all liability for doing so; and

v. I represent and certify to BHS that I have full authority to sign this application on behalf of the facility.

Printed Name: ______________________________

Title: ______________________________

Facility: ______________________________

Signature: ______________________________

THE FOLLOWING SECTION PERTAINS SPECIFICALLY TO INDIVIDUAL PROGRAMS OR UNITS WITHIN YOUR FACILITY. EACH PROGRAM OR UNIT SHOULD COMPLETE THE FOLLOWING SECTION.

Unit/Program Name:	Category of Care:

Administrative Structure:		Weekly Time Commitment (in Hours)	
		Administrative	Clinical
Unit/Program Coordinator Name:	☐ Salaried ☐ Contract		
Medical Director Name:	☐ Salaried ☐ Contract		
Clinical Director Name:	☐ Salaried ☐ Contract		
Nursing Supervisor Name:	☐ Salaried ☐ Contract		

Is your unit/program physically or functionally distinct within a hospital? ☐ Yes ☐ No Freestanding? ☐ Yes ☐ No Other?
Physical location within the facility?
Is this a locked unit? ☐ Yes ☐ No
Is your unit/program JCAHO accredited? ☐ Yes ☐ No Other certifications?
Total number of dedicated beds: # Private # Semi-Private # Other

Medical & Clinical Staff		
Is there 24-hour nursing and medical staff coverage? ☐ Yes ☐ No		
Names of active MDs on your unit and estimated annual admissions:		
Name	Specialty	# Admits

How many of the following professionals are on staff in your unit? (In FTE's)		
Psychiatrists		
General MDs		
Psychologists (Ph.D.)		
Psychologists (MA/MS)		
Social Workers (MSW)		
Counselors (ED.D, LPC)		
Psych Nurses (RNC, RNCS)		
Other Therapists (OT, PT, RT)		
Education Specialists (MA/MS, ED.D.)		

What percentage of staff are recovering?

What is your patient to clinical staff ratio?

What is your staff turnover rate?

Who would be our referral contact on your unit? Name/Title
Phone

Admissions Criteria

What is your intake/admission process?

Please summarize your admission criteria for this program/unit, including age limitations.

What percent admissions are direct (physician) vs. general (facility) admissions? **% / %**

What is your current census?

How do you handle waiting lists?
Frequency?

Is a case manager assigned to each patient throughout the stay? ☐ Yes ☐ No

Briefly describe the diagnostic/treatment planning process a new patient typically undergoes:

What is your program or unit's practice regarding Friday admissions and Monday discharges?

What is your policy on re-admissions?

What is your program or unit's re-admission rate?

Program Description

What are the top 5 DSM codes treated in this unit/program?

Is the program co-educational? ☐ Yes ☐ No Are men/women in separate areas? ☐ Yes ☐ No

What treatment model do you follow?

Do you utilize an interdisciplinary team approach? ☐ Yes ☐ No

If yes, how often are team conferences scheduled?

When does the first one occur?

Please describe the formal structured components of your treatment process.

What group therapies are used in your program?

Average number of patients in a group?

Please estimate the average number of daily (direct care) individual vs. group counseling hours each patient receives.

Individual + Group = Total

Are passes permitted? ☐ Yes ☐ No When?

Please describe your family programs/involvement.

Please describe a typical patient day (structure, program activities schedule).

How do you handle medical complications?

What physical fitness facilities does the patient have access to?

The Following 10 Questions Pertain to Substance Abuse Units Only:

Do you provide detoxification only for those patients for whom inpatient rehab is not necessary or is not covered as a benefit?
☐ Yes ☐ No

Do you have a separate detox unit? ☐ Yes ☐ No

How long is your average detox phase?

Do you offer individualized treatment and length of stay planning as an alternative to the traditional 28-day program?
☐ Yes ☐ No If yes, please describe treatment review process.

Do you ever maintain patients on medication after detox? ☐ Yes ☐ No

Do you treat patients maintained on methadone? ☐ Yes ☐ No

Do you have a separate track for cocaine dependence? ☐ Yes ☐ No

Do you combine substance abuse and eating disorders within same unit/program? ☐ Yes ☐ No

Do you have a separate relapse prevention track? ☐ Yes ☐ No

Do you have AA, NA or other 12-step group meetings in-house? ☐ Yes ☐ No

Continuing Care

Do you provide alternative/step-down levels of care for this program (i.e., structured outpatient, day treatment, aftercare)?
☐ Yes ☐ No

If yes, please describe:

If no, where do you refer patients appropriate for a less intense level of care?

Is an aftercare program included in the program cost? ☐ Yes ☐ No If yes, please describe length and nature of program.

Do you have satellites available to provide continuing care to patients outside your area? ☐ Yes ☐ No

Other arrangements?

Outcome/Quality Assurance

How do you measure outcomes?

If a formal system is used, what model?

Please describe post-discharge patient follow-up/monitoring process.

How do you handle patient complaints?

When does your discharge planning process begin?

Who performs?

What is the process?

What internal utilization review process do you use? (Do you have a separate department/individual assigned for this function?)
Do you cooperate with external case manager? (Allow on-site visits, share reports, etc.)
What is the procedure for on-site patient access by an external case manager?
What is your protocol for providing feedback to the referral source?
Briefly describe your quality assurance process.