

HealthSystems of Mississippi
Instructions for Completing the Medicaid Admission Review Form:
Inpatient Medical/Surgical Services

Section I Beneficiary Information

1. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card. *If the request is for a K-Baby, the mother's name should be recorded in this area.*
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card. *If the request is for a K-Baby, the mother's Medicaid number should be recorded in this area.*
3. **K-Baby Name** – If the request is for a K-Baby, enter the name of the baby born to the Medicaid eligible mother. “Baby boy” or “Baby Girl” in not acceptable.
4. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. *If the request is for a K-Baby enter the mother's date of birth. This information is used by HSM to verify that the correct Medicaid number was reported for the mother.*
5. **Sex** - Indicate the sex of the beneficiary. *If the request is for a K-Baby, enter the baby's sex and age.*
6. **Age** - Enter the age of the beneficiary at the time service is to be rendered. Enter in months if less than two (2) years of age. *If the request is for a K-Baby, enter the baby's age.*
7. **Beneficiary Account Number** –Enter the beneficiary's hospital account number. *(This is an optional field.)*

Section II Provider Information

1. **Facility Medicaid #** - Enter the hospital's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the hospital associated with the MS Medicaid provider number.
3. **Physician Name** - Enter the name of the attending physician, first and last name.
4. **Physician MS Medicaid #** - Enter the attending physician's MS Medicaid provider number.
5. **Requested By** - Indicate whether the hospital or physician made the request.
6. **Requester Name** - Enter the name of the individual requesting the review.
7. **Requester Tel # and Ext.** - Enter the telephone number of the requester including area code and extension number.

Section III Admission Information

1. **Request Date** - Enter the date of submission of the request.
2. **Outpatient Services Date** - Enter the date of hospital outpatient services *if* the beneficiary received hospital outpatient services (of any type) and was admitted as an inpatient without ever leaving the hospital.
3. **Emergency Department Services Date** - Enter the date the beneficiary received emergency department services *if* the beneficiary was treated in the emergency department and was admitted as an inpatient without ever leaving the hospital.
4. **Observation Admit Date**- Enter the date the beneficiary received services in the outpatient observation setting *if* the beneficiary was admitted as an inpatient without ever leaving the hospital.
5. **Actual/ Proposed Admit Date** - Enter the actual or proposed inpatient admission date. *For newborn birth admissions, enter the baby's date of birth in this area.*
6. **Proposed Discharge Date** - Enter the planned (anticipated) discharge date.
7. **Actual Discharge Date** – If the patient has been discharged, enter the actual discharge date.
8. **Number of Days Requested** - Enter the number of days for which certification is requested. Requested days must include the earliest service date i.e. outpatient services, emergency department service or outpatient observation admit date, if applicable.
9. **OB: Delivered during stay** – **APPLIES ONLY WHEN CERTIFICATION IS REQUIRED.** Enter the date of delivery and time of delivery as noted in the maternity beneficiary's medical record.
10. **NEWBORN:**
 - A. **Baby Birth Date** - Enter the date of birth of the baby *only if* the review is for the birth admission of a newborn baby.
 - B. **(Baby) Transfer Date to Any Setting Other Than Well-Baby** - Enter a date *only if* a newborn baby was born in the hospital requesting this review and was transferred within the hospital to any other setting other than well-baby nursery.
 - C. **Mom's Discharge Date** - Enter a date *only if* a newborn baby was born in the hospital requesting this review and the mother was discharged before the baby.
 - D. **Gram weight at Birth** –Submit the baby's gram weight at birth. *This information is required for newborns born in the hospital requesting this review or if the request is for a neonate that was transferred to the hospital requesting the review.*

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- E. **Gram Weight at time of review request** - Submit the baby’s gram weight at the time review request is submitted to HSM. *This information is required for newborns born in the hospital requesting this review or if the request is for a neonate that was transferred to the hospital requesting the review.*
- F. **Nursery Level** –Indicate the current nursery level setting for newborn or neonate. *This information is required for newborns born in the hospital requesting this review or if the request is for a neonate that was transferred to the hospital requesting the review.*

For the purposes of completing HSM’s review request forms, guidelines for assignment of nursery level are provided below.

Nursery Level	Guideline
I	A Level I nursery is essentially a healthy newborn nursery, providing basic neonatal care. Neonates (infants in the first 28 days of life) in this nursery level may have a few minor, common complications. This nursery can also used to stabilize ill newborns until transfer to a facility that provides intensive care. Note: Some hospitals may no longer have this level of nursery because mothers and babies often share the same room.
II	Level II is an intermediate care or specialty care nursery where the infant does not have life-threatening conditions at the moment. Infants in this level are moderately ill with problems that are expected to resolve rapidly. Level II nurseries often receive patients from Level III (NICU) who are stable but are not ready for discharge. Neonates in this level may have been born prematurely or may be suffering from an illness; these patients may need supplemental oxygen, intravenous therapy, specialized feedings, or more time to mature before discharge.
III	The Level III neonatal intensive care unit (NICU) admits all neonates (during the first 28 days of life) who are the most critical patients and who cannot be treated in either of the other two nursery levels. These patients may be small for their age, premature or sick term infants who require high technology care, such as ventilators, special equipment or incubators, or surgery. The Level III nurseries may be in a large general hospital or part of a children’s hospital.
IV	Level IV nurseries are found in a limited number of states, usually in regional academic medical centers. These nurseries provide the most complex level of neonatal care.
Other	Select this level if none of the above levels apply.

Section IV Medical Information

1. **ICD-9-CM Code/Diagnoses** - Enter the ICD-9-CM code and narrative description for the beneficiary’s primary diagnosis and any secondary diagnoses. ***Complete Section VI, Primary Diagnosis-Specific Information when additional information is required based on the beneficiary’s primary diagnosis in section VI of the form. Be sure to provide complete responses for all requested information. HSM considers the information when rendering medical necessity review determinations; therefore, incomplete requests will be pended and review may be delayed until the information is submitted.***
2. **Date/ICD-9-CM Code/Procedure** - Enter date of planned/actual procedure(s), the ICD-9-CM code and procedure narrative description.
3. **Treatment History:**
 - A. **Did the beneficiary receive related health care services prior to admit?** - Indicate whether the beneficiary received health care services related to the primary diagnosis prior to this admission. If yes, indicate date and list the treatments in the space provided.
 - B. **Is/was this an urgent or emergent admission?** – Indicate whether the admission is an urgent admission or an emergent admission based on definitions provided within HSM’s Inpatient Acute Care Provider Manual. If yes, supply the rationale for the determination.
 - C. **Can the Beneficiary be managed in an outpatient or alternative level of care?** – Indicate whether the beneficiary’s clinical condition is manageable in a setting other than inpatient acute care.

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4. **Clinical Signs and Symptoms** - List the clinical signs and symptoms to support the need for inpatient level of care.
5. **Studies/labs/x-rays** - Record the date, name and results/findings of diagnostic studies, lab and x-ray tests that are associated with the primary diagnoses. Be sure to include pertinent abnormal results.
6. **Treatment Plan** - List all planned treatment beginning with those related to the primary diagnosis.
7. **Medication List** – Complete the medication grid by recording the date of order, the medication’s name, dosage, frequency, and route. If the medication was discontinued prior to submission the review request, record the date of discontinuation. Include oral “stat” medications and adjustments to cardiac medications. *If the admission is for chemotherapy, include the number of days to be administered.*
8. **If the beneficiary admitted for surgery, provide the reason/medical indication for the surgery** - Indicate the medical indications for each planned surgical procedure.

Section V Discharge Plans

1. **Will/can the beneficiary return to current living arrangements?** Indicate whether the beneficiary will/can return to his or her current living arrangements. If the beneficiary was discharged prior to submission of the review request, indicate whether the beneficiary returned to his or her living arrangement in place at the time of inpatient admission.
2. **Anticipated Discharge Date** – Record the anticipated discharge date. If the patient has been discharged, record the actual discharge date.
3. **Anticipated discharge to:** - Indicate the anticipated discharge location or care arrangement. If the beneficiary is transferred to a different acute care hospital, record the hospital’s name in the space provided. If the beneficiary is released to custody of DHS or DYS, record the county. If none of the listed options are appropriate, check “Other” and specify the location in the space provided. If the beneficiary was discharged prior to submission of the review request, indicate the actual discharge location or care arrangement for the beneficiary.
4. **Anticipated Follow-Up Care** - Indicate the anticipated follow-up care for the beneficiary. If none of the listed options are selected, check “Other” and specify the anticipated follow-up plans in the space provided. If the beneficiary was discharged prior to submission of the review request, indicate the actual follow-up plans.

Section VI Primary Diagnosis-Specific Information

Complete the following sections of the form when the beneficiary’s primary diagnosis is one of those listed below. Be sure to provide complete responses for all requested information. HSM considers the information when rendering medical necessity review determinations; therefore, incomplete requests will be pended and review may be delayed until the information is submitted.

Alcohol Withdrawal/Detoxification

1. **Is the beneficiary being admitted for medical stabilization for alcohol withdrawal/alcohol withdrawal syndrome?**
 - A. If **no**, this section is complete.
 - B. If **yes**, complete the remaining form fields in this section.
 - I. *Record the **Beneficiary’s current blood alcohol level.***
 - II. Indicate whether ***the beneficiary has received detoxification within the last 30 days.***
 - III. Indicate whether ***the beneficiary has any of the conditions listed.*** More than one option may be checked.

Asthma

1. **Did maximum outpatient/ ED treatment fail?** – Select “yes” or “no” as appropriate.
 - A. If **yes**, **explain.** Record the treatments provided and the beneficiary’s response to those treatments.
 - B. If **no**, proceed to the next question in this section.
2. **Is the beneficiary compliant with medications?** Indicate whether the beneficiary has been compliant with medications.
 - A. If **yes**, this section is complete.
 - B. If **no**, indicate the length of time of the non-compliance.

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Burns

1. *% of total body surface area with 3rd degree burns* – Record the percentage of total body surface area with 3rd degree burns.
2. *% of total body surface area with burns* - Record the percentage of total body burns.

Sickle Cell Crisis

1. *Did maximum outpatient/ED treatment fail?*
 - A. If *no*, this section is complete.
 - B. If *yes*, complete the remaining form fields in this section.