HealthSystems of Mississippi
Instructions for Completing the Medicaid Continued Stay 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 Continued Stay Review Information

1. ***Request Date*** **-** Enter the date of submission of the request.
2. ***Admit Date*** - Enter the actual inpatient admission date. *For newborn birth admissions, enter the baby's date of birth in this are.*
3. ***Treatment Authorization Number (TAN)*** - Enter the certification number assigned by HSM for this admission.
4. ***Discharge Date*** **–** If the patient has been discharged, enter the actual discharge date. Leave this field blank if the patient has not been discharged.
5. ***Last Date Certified*** - Enter the last date that was certified from the previous review.
6. ***Additional Days Requested*** **–** Enter the number of additional days for which certification is requested for this hospitalization.
7. ***NEWBORN:***
   A. ***Current Gram Weight*** **-** Submit the baby's gram weight at the time review request is submitted to HSM. *This informaiton 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.*
   B. ***Nursery Level*** **–**Indicate the current nursery level setting for newborn or neonate**.** *This informaiton 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.

Nursery Level	Guideline
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. ***New ICD-9-CM Code/Diagnoses/Date Identified*** - Enter the ICD-9-CM code and narrative description for any new diagnoses identified since the previous review. Record the date that the new diagnosis was first noted in the medical record.
2. ***Date/ICD-9-CM Code/Procedure/Check if cancelled*** - Enter date of planned/actual procedure(s), the ICD-9-CM code and procedure narrative description. Report all surgical procedures. If any of the surgical procedures were cancelled, check the box to inform HSM that the procedure was not performed at all or not performed as planned.
3. ***Clinical Signs and Symptoms that support continued stay*** - List the clinical signs and symptoms to support the need for continued inpatient level of care. Include progression or regression of admitting signs and symptoms as well signs and symptoms related to new diagnoses.
4. ***Studies/labs/x-rays*** **-** Record the date, name and results/findings of diagnostic studies, lab and x-ray tests and findings since last review. Be sure to include pertinent abnormal results.
5. ***Treatment Plan*** - List all planned treatment related to the primary diagnosis and new diagnoses. Include information to explain why the beneficiary needs continued inpatient level of care. Also describe what will be the focus of continued inpatient services.
6. ***Medication List (List medications that are given by the IV/IM/SQ route*** – Complete the medication gird 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" medication and medication adjustments to previously reported medications.

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.