

HealthSystems of Mississippi
Instructions for Completing the Medicaid Admission Review Form: Psychiatric 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.
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
4. **Sex** - Indicate the sex of the beneficiary.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.
6. **Beneficiary Account Number** - Enter the beneficiary's hospital account number. (*Optional field for hospital use only.*)

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 Mississippi 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. **Care Setting: Check if Gero-Psych** - Check this box if the services are will be provided in a Geropsychiatric Unit. *Please remember that Medicaid does not cover services in Gero-Psych units.*
3. **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.
4. **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.
5. **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.
6. **Actual/ Proposed Admit Date** - Enter the actual or proposed admission date.
7. **Proposed Discharge Date** - Enter the planned (anticipated) discharge date.
8. **Actual Discharge Date** - If the patient has been discharged, enter the actual discharge date.
9. **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.

Section IV Medical Information

1. **ICD-9-CM Codes/Diagnoses/GAF Score** - Enter the ICD-9-CM code and narrative description for the beneficiary's diagnoses for Axis I, Axis II, Axis III, and Axis IV. For Axis V, record the beneficiary's baseline and current Global Assessment of Functioning (GAF) scores.
2. **Date/ICD-9-CM Code/Procedure** - Enter date of planned/actual procedure(s), the ICD-9-CM code and procedure narrative description.

Section V Treatment History

1. **Past Treatments:**
 - A. **Is/was this an urgent or emergent Admission** - Indicate whether the admission was determined to be an urgent admission or an emergency admission based on definitions provided within HSM's Inpatient Acute Care Provider Manual. If yes, supply the rationale for the determination.
 - B. **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.
 - C. **Did the patient 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**, complete the **Treatment History** section.
2. **Treatment History:**
 - A. **Psychiatric Inpatient Admits** - Indicate the number of psychiatric inpatient hospitalizations within the last year. Record the discharge date for the most recent psychiatric inpatient hospitalization.
 - B. **Other Care/Institution/Discharge Date** - Indicate whether the beneficiary received other care and type of institution, if applicable. Record the date of most recent discharge from that care, if applicable.
 - C. **Other Treatment and Settings: Community Mental Health Center, Outpatient Hospital Provider, Private Practice and Discharge Date** - Complete the grid, indicating all types of care and applicable setting in which the beneficiary received care within the last year. Indicate the discharge date or leave the date blank if the beneficiary is receiving active care.

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Section VI Current Symptoms/Behavior

Complete the grid by indicating the beneficiary's current symptoms/behavior regarding danger to him or herself and/or to others. Select a valid value (0-5) for each listed area.

Section VII Behavioral/Evidence

The behavior/evidence section includes presence of ideations and/or intentions, previous attempts/gestures, presence of plan, access to and lethality of intended means, ability to contract for safety and other social supports such as family.

Complete the grid by indicating the behavior or evidence demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

Section VIII Current Psychological Stressors/Events

Complete the grid by indicating all applicable current psychological stressors/events. If none of the listed options are selected, check "other" and specify the stressors/events in the space provided.

Section IX Current Functioning

Current physical/cognitive function and verbal interactions are recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

Section X Current Communication

Current ability to communicate with others is recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-2) for each listed area.

Section XI Current Drug Use

Current drug use is recorded in this section. Complete the grid by indicating the whether the beneficiary is currently using illegal drugs and whether use occurred within the past 24 hours or within the past 30 days. Select a valid value (0-3) for each drug listed.

Section XII Current Skill/Ability Assessment

Complete the grid by indicating the results of the beneficiary's current skills and ability assessment. Select a valid value (0-4) for each listed area.

Section XIII Current Work/School Schedule

1. **Employment/School Hours per Week** – Indicate whether the beneficiary is employed or in school and the numbers of hours per week. Check only one option.
2. **Employment Type** – Indicate whether the beneficiary is in school or the employment type. Check only one option.
3. **Date of Last Employment and Occupation**– If the patient is no longer employed; indicate the date of last employment and the beneficiary's occupation.

Section XIV Current Living Arrangement

Complete the grid by indicating the beneficiary's current living arrangements. Select only one option.

Section XV Resource/Needs Assessment

Complete the grid by indicating the results of the beneficiary's resource/needs assessment. Select a valid value (0-4) for each listed area.

Section XVII 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.

Section XVIII Medications

1. **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 of the review request, record the date of discontinuation. Include oral "stat" medications and adjustments to routine medications.
2. **Is the beneficiary compliant with home medications?** Indicate whether the beneficiary has been compliant with home medications.
 - A. If **yes**, this section is complete.
 - B. If **no**, indicate the length of time of the non-compliance.

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Section XIX Treatment Plan/Frequency

List all planned treatment beginning with those related to the current diagnosis/diagnoses. Include up to five of the most urgent goals that will address specifically the diagnosis/diagnoses and specific reason for this service level.

Section XX 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.