

HealthSystems of Mississippi
Instructions for Completing the Medicaid Continued Stay 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 physician or hospital made the request.
6. **Requester Name** - Enter the name of the individual requesting the review.
7. **Requester Tel #** - Enter the telephone number of the requester including area code and extension number.

Section III Continued Stay Information

1. **Request Date** - Enter the date of submission of the request.
2. **Admit Date** - Enter the actual inpatient admission date.
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 Day 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.

Section IV Medical Information

1. **New ICD-9-CM Codes/Diagnoses/Date Identified/GAF Score** - Enter the ICD-9-CM code and the narrative description for any new diagnoses identified since the previous review for Axis I, Axis II, Axis III, and Axis IV. Record the date that the new diagnosis was first noted in the medical record. For Axis V, record the beneficiary's baseline and current Global Assessment of Functioning (GAF) scores
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. If any of the procedures were cancelled, check the box to inform HSM that the procedure was not performed at all or not performed as planned.

Section V 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 VI Behavioral/Evidence

The behavior/evidence section includes presence of ideations and/or intentional, 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 VII 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 VIII 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 IX 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.

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Section X 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 XI 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 XII 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 XIII 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, adjustments to routine medications.

Section XIV Response to Treatment Plan for Previous Review Period

Please evaluate and provide the percentage of completion of the overall treatment plan as a whole in which treatment interventions were requested during the previous review period. Example: If all goals and objectives were met during the previous review period select option

1. If no progress was made and option 4 was selected, provide an explanation. Available options are listed below.
 - A. Successfully met all goals and objectives.
 - B. Partially met goals and objectives.
 - C. Minimally met goals and objectives.
 - D. No progress evident.

Section XIV Current 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. Include information to explain why the beneficiary needs continued inpatient level of care.

Section XVII 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 for the beneficiary.