

HealthSystems of Mississippi
Instructions for Completing the Medicaid Admission Review Plan of Care Form:
Hospital Outpatient Mental Health

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. Enter in months if less than two (2) years of age.
6. **Beneficiary Account Number** - Enter the beneficiary's hospital account number. *(Optional field for hospital use only)*

Section II Provider Information – (This is not the Billing Provider, but the lead clinician for services for the billing provider)

1. **Lead Clinician Name** - This is the clinician who is the point person for clinical coordination and care of this beneficiary when more than one treating provider within or outside the hospital setting provides services or care. If there is only one clinician who will be providing services to this beneficiary, then list that clinician in this section.
2. **Lead Clinician Address** - The lead clinician is in charge of the hospital outpatient service. List the hospital address or address in which this clinician can receive timely written notifications when necessary.
3. **Lead Clinician Telephone #** - The quickest and most direct phone number to reach the lead clinician in the event HSM has a question or the HSM Medical Director or HSM physician reviewer must speak immediately to the lead clinician concerning the beneficiary.
4. **Lead Clinician Medicaid #** - Enter the lead clinician's Mississippi Medicaid provider number. Please do not list the facility Medicaid number in this section. If the lead clinician does not have a Mississippi Medicaid provider number, write "none" in the space provided and provide the Lead Clinician's license number.
5. **Lead Clinician License #** - *(Optional only* when the lead clinician does not have a Mississippi Medicaid number.) List the lead clinician's Mississippi license number.

Section III Hospital Information – Billing Provider

1. **Hospital #** - Enter the hospital's Mississippi Medicaid provider number.
2. **Hospital Name** - Enter the hospital name associated with the above Medicaid provider number.

Section IV Requestor's Information

1. **Request Date** - Enter the date that you submit your request.
2. **Requestor Name** - Enter the name of the individual requesting the review.
3. **Requestor Phone #** - Enter the telephone number of the requester including area code and extension number.

Section V Service Dates

1. **Actual Admit/Service Start Date - Include the date the evaluation occurred on as the start date.**
2. **Proposed Discharge Date** - List the proposed discharge date. Remember discharge planning occurs at the start of treatment and is discussed with the beneficiary as part of the agreement and planning for care. If the beneficiary has been discharged, record the actual discharge date.

Section VI 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.

Section VII Requested Services

1. **Beneficiary Name** - When using the web, the beneficiaries name automatically populates. However, when submitting the form it is very important to list the beneficiaries first and last name at the top of every page when submitting your request to HSM for certification.
2. **Medicaid #** - When using the web the beneficiaries Medicaid number will automatically populate. However, when submitting the form via fax or mail, it is very important to list the Medicaid number at the top of every page.
3. **CPT® Code, Description and Dates of Service (From/Thru)** – Codes listed in this are used on the UB04 when submitting a claim to the fiscal agent for reimbursement. These are the only codes for which certification is sought from HSM following the completion of the 90801. Select the 90801 and enter the start date and end date. This will be the same date. For other CPT® codes the end date will be up to 90 days from the start of the service ("From" date), unless the request is for maintenance medication management in which the request service end date can be up to one year. If you bill for these services on any other type of claim you do not require precertification by HSM.
4. **Total Units Requested** - Number of total sessions per code(s) for up to a 90 day period or, for maintenance medication management up to four units per year may be requested.

HealthSystems of Mississippi
Instructions for Completing the Medicaid Admission Review Plan of Care Form:
Hospital Outpatient Mental Health

5. **Performed by (Psychiatrist/Nurse/Other)** - Check the discipline of the provider who will be providing the service to the beneficiary. Complete this section for each requested CPT[®] Code (Physician Name/Medicaid #/License #) – List clinician’s first and last name and their Medicaid provider number. If the treating clinician for the specific service code/CPT[®] code does not have a Mississippi Medicaid number, list the clinicians Mississippi license number and specify that the number provided is their license number.

Section VIII Treatment History

1. **Past Treatments:**
- A. **Were outpatient mental health services provided by this hospital at the time of initial evaluation and/or prior to submission of this review request?** Indicate whether outpatient mental services were provided at the time of initial evaluation or prior to submission of this review request. If **yes**, indicate why immediate intervention was required and therefore services could not be precertified.
 - B. **Did the beneficiary receive outpatient mental health services from this hospital prior to submission of this review request?** Indicate whether the beneficiary was in your care prior to submission of this review request care, e.g., the beneficiary was in care six months prior to initiation of Medicaid’s requirement for precertification. If the response is **yes**, provide the service start date.
 - C. **Did the beneficiary receive other related health care services prior to initial evaluation?** - Indicate whether the beneficiary received other health care services related to the current primary diagnosis prior to this admission. If yes, complete the **Treatment History** section.
2. **Treatment History:**
- A. **Psychiatric Inpatient Admits/Latest Discharge Date**– 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/Latest 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.

Section IX 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 X 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 XI 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 XII 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 XIII 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 XIV 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 XV