

HealthSystems of Mississippi
Instructions for Completing the Medicaid Continued Stay 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 part 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. 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.
4. **Lead Clinician Medicaid #** - Enter the lead clinician's Mississippi Medicaid provider number. Please do not list the facility Medicaid number in this section.
5. **Lead Clinician License #** - (*Optional only* when the lead clinician does not have a Mississippi Medicaid number.) List the lead clinician's 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** – The first and last name of the person completing this request form. This may be different from the clinician who signs the attestation statement.
3. **Requestor Phone #** - Phone number that is the quickest way to reach the person who completed this form in the event HSM has a question or can not locate necessary information in order to proceed with sending the request to a clinician for review and generation of a Treatment Authorization Number (TAN). A TAN is necessary in order to receive reimbursement for services provided to Medicaid beneficiaries.

Section V Continued Stay Information

1. **Admit Date** – List the date services began for the admission for which continued services are requested and for which a treatment authorization number (TAN) was previously issued.
2. **Treatment Authorization Number** – This is the TAN number provided to you during the initial precertification review.
3. **Discharge Date** – If the *beneficiary has been discharged*, list the discharge date in this area.

Section VI Medical Information

1. **New ICD-9-CM Codes/Diagnoses/Date Identified/GAF Score** - Enter the ICD-9-CM code and 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.

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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. Enter the start date for each CPT® code for which continued services are requested with an end date of up to 90 days from the start of the service “From” date. To request new services for the same TAN, enter the “from” and “thru” dates for no more than a 90 day period. If the request is for maintenance medication management in which the requested service end date can be up to 1 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.
5. **Performed by (Psychiatrist/Nurse/Other)** – Check the discipline of the provider who will be providing the service to the beneficiary.
6. **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 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 IX 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 X 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 XI 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 XII 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 XIII 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 XIV 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.

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Section XV 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 XVI Current Living Arrangement

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

Section XVII 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.

Section XIX 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. Example: Beneficiary did not attend any sessions and therefore no services were rendered beyond the initial 90801 and a 90804 on January 5, 2009. Available options are listed below.

- Successfully met all goals and objectives
- Partially met goals and objectives
- Minimally met goals and objectives
- No progress evident

Section XX 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.

Section XXI 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.

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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.

Section XXII Clinician Attestation, Signature and Date

1. ***Signature of Clinician*** –When submitting by Web, the attestation statement is assumed. When submitting certification requests by fax or mail a psychiatrist, psychiatric nurse practitioner, licensed certified social worker or psychologist must sign this form. Although the form can be completed by any hospital staff responsible for supporting certifications for proposed services to Medicaid beneficiaries, one of the four licensed disciplines must validate that the information documented on this form is correct to the best of their knowledge and that the information to be submitted to HSM is medically necessary.
2. ***Check One*** –Select one of the four options listed. The selection must match the discipline of the clinician that signed the attestation statement.