

HealthSystems of Mississippi

Instructions for Completing the Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Section I Beneficiary Information

1. **Beneficiary/Youth's Name** - Enter the youth's last and first name. If the youth has an active Medicaid number record the name as it appears on the Mississippi Medicaid ID card.
2. **MS Medicaid #** - Enter the youth's MS Medicaid number that appears on the MS Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the youth's birth.
4. **Sex** - Indicate the sex of the youth.
5. **Age** - Enter the age of the youth at the time service is to be rendered.
6. **Beneficiary/Youth's Account #**: - Enter the facilities internal identification or medical record number for the youth.

Section II Provider Information

1. **Facility MS Medicaid Number** - Enter the facilities Medicaid provider number.
2. **Facility Name** - Enter the name of the facility.
3. **Physician Name** - Enter the first and last name of the attending physician.
4. **Physician MS Medicaid #** - Enter the Physician MS Medicaid ID number of the attending physician.
5. **Requested By** - Indicate whether the facility or the physician made the request.
6. **Requester's Name** - Enter the first and last name of the individual who is primary contact for this case.
7. **Phone # and Ext.** - Enter the requester's telephone number, including area code and extension, if applicable.

Section III Admission Information

1. **Request Date** - Enter the date of submission of the request in month, day, and year format.

Section IV Service Dates

1. **Planned date of Admission** - Enter the month, date and year of the planned admission.
2. **Number of Days requested** - Enter the number of days requested for this review period
3. **Can the patient be managed in outpatient or alternative level of care (if available)?** Select either yes or no.
4. **IQ** - Enter the youth's IQ score.

Section V 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 VI Treatment History

1. **Past Treatments:**
 - A. **Did the youth receive other related health care services prior to being recommended for PRTF services?** - Indicate whether the beneficiary received other health care services related to the current primary diagnosis prior recommendation for 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 VII 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 VIII 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.

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Section IX 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 X 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 XI 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 XII 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 XIII 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 XIV 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 XV Current Living Arrangement

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

Section XVI 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 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 Family Therapy

List the county, state and approximate distance family will be traveling to facility for family sessions.

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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.
2. **Anticipated Discharge Date** – Record the anticipated discharge date.
3. **Anticipated discharge to:** - Indicate the anticipated discharge location or care arrangement. If the beneficiary is transferred to an 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.
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.

Section XXII Clinician Attestation, Signature and Date

1. **Signature of MYPAC Medical Director and Date** - When submitting certification requests by fax or mail the MYPAC Waiver provider's medical director must sign this form. Although the form can be completed by any MYPAC staff responsible for supporting certifications for proposed services to Medicaid beneficiaries, the medical director 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.

Note: A copy of an independent evaluation completed by a psychiatrist or psychologist, which indicates the need for psychiatric residential treatment and the potential for benefit from psychiatric residential treatment, must be attached to this form. This evaluation must be performed within the last 60 days prior to the proposed admission date.