HealthSystems of Mississippi

Instructions for Completing the Psychiatric Residential Treatment Facility Continued Stay 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 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 Continued Stay Information

1. ***Request Date*** – Enter the date of the request in month, day, and year format.
2. ***Date of Admit*** – 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.
3. ***Treatment Authorization Number*** –This is the TAN number provided to you during the initial precertification review.
4. ***Last Day Certified*** – Enter the last date that was certified for the previous review.
5. ***Additional Days requested*** – Enter the number of additional days for which certification is requested for this hospitalization.

Section IV Medical Information

1. ***ICD-9-CM Codes/Diagnoses/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.
2. ***Date of Procedure*** – Enter the date of any procedure required by the beneficiary during the prior review period and any scheduled to occur. List the ICD-9-CM code and description of the procedure. Please attach an additional information form if more space is needed.
3. ***Specifically, why does the beneficiary need continued PRTF services? Please describe what will be the focus of continued PRTF services***. Record a response in the space provided.

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 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 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 and 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 XV Family Therapy

Please list the date(s) family therapy occurred during the prior review period. Check either face to face, phone, or waiver for each date listed.

Section XVI Current Treatment Plan/Frequency

Include up to five of the most urgent goals that can only be addressed while in a PRTF setting. Goals and objectives must specifically relate to the reason for why the beneficiary/youth was admitted to PRTF services and requires ongoing PRTF services for their diagnosis/diagnoses.

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.
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 XVIII Clinician Attestation, Signature and Date

Signature of PRTF Attending Physician and Date **-** When submitting certification requests by fax or mail the attending physician must sign this form. Although the form can be completed by any PRTF staff responsible for supporting certifications for proposed services to Medicaid beneficiaries, the attending physician 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 with in the last 60 days prior to the proposed admission date.