

HealthSystems of Mississippi

Instructions for Completing the MYPAC Continued Stay/Recertification Request Form

Section I Beneficiary Information

1. **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 #** - If the youth has an active MS Medicaid number, enter the number that appears on the MS **Medicaid** ID card. If the youth does not have an active number, LEAVE BLANK.
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. **Guardian/Representative Name** - Enter the name of the youth's legal guardian/representative.
7. **Guardian/Representative Address** - Enter the mailing address of the guardian/representative.

Section II Provider Information

1. **MYPAC MS Medicaid Number** - Enter the MYPAC Waiver Medicaid provider number.
2. **MYPAC Provider Name** - Enter the name of the MYPAC Waiver provider.
3. **Request Date** - Enter the date of the request in month, day, and year format.
4. **Requester's Name** - Enter the name of the individual who is primary contact for this case.
5. **Phone # and Ext.** - Enter the requester's telephone number, including area code and extension, if applicable.

Section III Physician Information

1. **Medical Director Name** - Enter the name of MYPAC Waiver provider's medical director.
2. **Medical Director MS Medicaid #** - Enter the MS Medicaid ID number of the medical director.
3. **Medical Director Phone #** - Enter the phone number of the MYPAC Waiver provider's medical director.

Section IV Medical Information

1. **Date of Admission** - 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.

Section V New Diagnoses Since Last Review

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 Requested Services

1. **The following information must be submitted for each type of service requested. Please note that once a Treatment Authorization Number has been issued by HSM, request for respite services must be submitted via the Web.**
 - **Dates of Service** - Indicate date service will start and the date thru which the service is requested.
 - **Units** - Record the total number of units requested. Please do not exceed the maximum units allowed.
2. **Specifically, why does the beneficiary need continued MYPAC services? Please describe what will be the focus of continued MYPAC services.** Record a response in the space provided.

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.

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.

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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 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 XV 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 XVI 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 XVII 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.

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

Section XVIII 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.

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Section XIX 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.

Section XX 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:

Include a copy of the following:

- A current ISP indicating the necessity of continuing the current level of care. The ISP must be dated no more than 30 days prior to this request.
- Current CANS – MH, dated no more than 60 days prior to the date of this request.
- WRAP meeting notes for the past two meetings, one of which must be within the last 30 days.