

HealthSystems



HealthSystems
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the main title text.

Outpatient Hospital Mental Health Provider Manual

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Of Mississippi

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I. Introduction

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform precertification and quality review for outpatient hospital mental health services rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Our review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers who bill for hospital outpatient mental health services on a UB-04, in successfully navigating through HSM's review requirements and process.

II. Getting Started - Helpful Tips

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884-3222 or 601-206-3000. The above contact information is also used if you have a billing question.

Providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov/manuals.aspx>.

Verify that the revenue and CPT[®] code that you plan to bill on your UB-04 requires precertification by HSM. Our website address can be located at www.hsom.org.

Requests for precertification are submitted to HSM following:

- Completion of the clinical evaluation.
- Discussion between the assessing clinician and beneficiary regarding the clinical evaluation findings.
- Agreement between the provider and beneficiary regarding services.

Request for precertification should contain only those CPT[®] codes listed in section V of this manual, Outpatient Hospital Mental Health CPT[®] Codes Requiring Precertification.

III. Information You Need to Know

The majority of providers submit review requests and receive HSM certification responses via the Web. HSM's HIPAA secure Web-based system provides 24 hour a day 7 days a week access to real-time electronic submission of:

- Review requests.
- Additional information for specific reviews when requested by HSM (when the original review was submitted by Web).
- Helpline inquiries.

One of the benefits to providers who are enrolled to use the electronic Web submission is that you can check the status of your reviews at any time. The reporting module is provider-specific and available 24 hours a day 7 days a week.

If you do not have a HSM logon, contact HSM's Education Department at education@hsom.org or by phone at (601)-360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

In addition to Internet access, minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers
- Color monitor
- 28.8K modem connection or higher (phone line quality will determine speed of connection)
- Internet Explorer Version 4.0 or higher

In the event a provider cannot submit via the Web, a dedicated fax number is provided to assist with certification needs. Although we can accept mailed requests, fax submission provides a faster response to your request. When submitting review request by fax or mail the required forms and instructions are included in this manual and can be downloaded from the HSM Web site at www.hsom.org.

The table below list fax and phone numbers and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
Precertification Review Request Submission	Used by providers to submit review request and additional information requested by HSM.	<p>Web reviews: www.hsom.org click on "Submit Review Requests" link.</p> <p>Hours: 24 hours, 7-days a week.</p> <p>Faxes received after 5:00 p.m. or over the weekend or holidays are considered received the next working day.</p> <p>FAX: 1- 866-740-2292</p> <p>Mail: Attn: HSM – OPMH 175 East Capitol Street Suite 250, Lock Box 13 Jackson, Ms 39201</p>
Helpline	Used by providers for questions regarding the certification process and to request assistance.	<p>Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)</p> <p>Local: 601-360-4949</p> <p>Toll Free: 1-866-740-2221</p>

Purpose	Description	Hours of Operation and Number(s)
Hot Line	Used by beneficiaries and providers to report quality concerns and/or complaints	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Toll Free: 1-888-204-0221

IV. Hospital Outpatient Mental Health Review Exclusions

Medicaid policy exempts certain services from HSM review. Providers should not submit reviews for these situations. The following are reasons for review exclusion:

Reason	Description
No Medicaid Eligibility	No HSM review is required if the beneficiary does not have current Medicaid eligibility. If the patient has applied for Medicaid and the <u>eligibility determination is pending</u> , HSM cannot perform review. Once eligibility has been determined, HSM performs review based on the eligibility begin date.
Medicare Eligibility	No HSM review is required if the beneficiary has Medicare Part A <u>and</u> Part B coverage for the outpatient hospital mental health service requested.
Family Planning Waiver	No HSM review is required if the beneficiary's Medicaid eligibility is only for the family planning waiver.
Psychological Testing	Psychological testing <u>is not</u> precertified <u>through HSM</u> .
CPT [®] codes 90817 through 90829	Codes in the 90817 through 90829 range will receive a review not performed message from HSM. The above codes are for services not covered by Medicaid in an outpatient hospital setting.

Notes:

Certification should be obtained from HSM when the beneficiary:

- Has Medicare Part A and Part B and benefits are exhausted and the beneficiary has private insurance.
- Has Medicaid eligibility and third party insurance.

V. Hospital Outpatient Mental Health CPT® Codes Requiring Precertification

Outpatient hospital mental health services coded to the following CPT® Codes and **billed on a UB-04** require precertification by HSM beginning January 1, 2009. Following completion of your initial evaluation (90801), select from the below list the code, or codes, needed to address the beneficiary's treatment needs for the next 90 days.

CPT® Code	Units/Service	Notes	Service Provider Limitations
90801	Does not require precertification, however, must be included in your review request for services.	If outcome of the evaluation is that the beneficiary will not receive services from your hospital, submit a review request for only the 90801.	
90804	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90805	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.
90806	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90807	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.
90808	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90809	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.
90810	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90811	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.
90812	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90813	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.

CPT® Code	Units/Service	Notes	Service Provider Limitations
90814	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90815	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.
90846	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90847	No Service limit when certified by HSM.	Available to children, adolescent, and adult	
90849	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90853	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90857	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	
90862	No Service limit when certified by HSM.	Available to children, adolescent, and adult.	Service can only be provided and billed for when provided by a psychiatrist or psychiatric nurse practitioner.
90870	No Service limit when certified by HSM.	Available to children, adolescent, and adult. Helpful Tip: When a beneficiary begins ECT in an inpatient setting and it is anticipated that the cycle will be completed after discharge in an hospital outpatient setting, the review request may be submitted to HSM prior to discharge from the inpatient setting with an anticipated start date.	Service can only be requested by a psychiatrist, anesthesiologist, or nurse anesthetist.

*Please refer to <http://www.ama-assn.org> for CPT® code descriptions.

VI. Precertification Review Process

A. Requests for Certification Review

Providers submit request for review directly to HSM through the Web. In the event your organization does not have Web capabilities, fax or mail is available. Forms can be downloaded from the HSM Web site at www.hsom.org.

A review for initiation of a service(s) is referred to as an admission review. Subsequent reviews are performed to determine if continuation of services is medically indicated and appropriate. These are continued stay reviews. If a retroactive determination of Medicaid eligibility is made while a beneficiary is receiving services, a request for admission review is submitted. Retrospective review occurs when the beneficiary received services, was discharged from care, was not eligible for Medicaid, and DOM provides retroactive Medicaid eligibility.

The following table describes the types of review, timeframes for submission, and required documentation for each type of review. Required forms and instructions are included in the *Forms and Instructions* section of this manual for providers without web technology.

Review Type	Timeframe	Required Documentation
Admission Precertification	At least three business days prior to initiation of services and after the evaluation.	<ul style="list-style-type: none"> Enter information required by HSM's Web system.
Admission Precertification for providers with NO Web availability	At least three business days prior to initiation of services and after the evaluation.	<ul style="list-style-type: none"> Fax or mail a copy of the approved Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health to HSM.
Continued Stay Request	At least two business days prior to end of current authorized service period.	<ul style="list-style-type: none"> Enter information required by HSM's Web system. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> Fax or mail completed Medicaid Continued Stay Review Plan of Care Form: Hospital Outpatient Mental Health to HSM.
Crisis Session	Within one working day of clinical evaluation (90801) and the crisis session.	<ul style="list-style-type: none"> Enter information required by HSM's Web system. Fax or mail a copy of the approved Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health to HSM.
Retrospective Review (Retroactive Medicaid Only)	Within one year of eligibility determination. [When the beneficiary was not eligible at the time of admission but has received a retroactive eligibility status after services were discontinued (after discharge).]	<ul style="list-style-type: none"> Fax or mail a copy of the approved Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health. Submit a cover letter explaining why the requested services were not precertified. Submit a copy of the entire medical record for the service period in which the beneficiary received services and became Medicaid eligible.

B. Processing of Review Request

HSM's Web-based review is the most efficient method by which precertification is obtained. HSM has a diverse group of professionals that assist at various stages of the review process such as our Intake staff, who handle administrative functions. Our clinical staff is composed of registered nurses and psychiatrists. These highly qualified professionals make precertification review determinations for hospital outpatient mental health services. In addition, HSM employs social workers and other specialized disciplines that may provide consultation to first and second level reviewers. The following table describes our staff's functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> Screen request for completeness. May request additional non-clinical information. Perform verbal notification of review determination, as appropriate. Support all review functions.
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> Apply DOM policy. Apply DOM approved medical necessity clinical guidelines Apply quality of care triggers and screens. May request additional information. Approve services based on policy or guidelines. Refer requests that cannot be approved to a physician.
Second level reviewers (Physicians)	<ul style="list-style-type: none"> Make certification, denial or reconsideration determinations. The determination is: <ul style="list-style-type: none"> - Based on documentation that supports medical necessity and appropriateness of setting.* - Patient-centered and takes into consideration the unique factors associated with each patient care episode. - Sensitive to the local healthcare delivery system infrastructure - Based on his or her clinical experience, judgment and generally accepted standards of healthcare. May request additional information. <p>*The physician reviewer may request additional information and attempt to contact the hospital outpatient medical director or clinical director to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p>Note: See the <i>Reconsideration Process</i> section of this manual for information on the reconsideration process.</p>

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframes for the submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review cannot proceed because ...	Then	Review Type	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	All review types.	One business day.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.	Precertification, Planned or Elective Admission	Three business days.
		Crisis Session	One business day.
		Continued Stay	One business day.
		Retrospective	Ten business days.

C. Notification of Review Outcome

HSM provides written notification of review results to providers and to beneficiaries or the beneficiary's or youths legal guardian or representative/responsible party when services are not approved as requested. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Providers also receive verbal notice of denials.

The hospital outpatient provider, the clinical director/medical director, the beneficiary or youth's legal guardian, or representative/responsible party may request a reconsideration of a denial determination. A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the beneficiary or youth/guardian, or representative/responsible party may appeal the decision directly to the Division of Medicaid. See the *Reconsideration Process* section of this manual for additional information.

The following table contains the details of the notification process based on review outcome.

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> Written notification of approval review results is sent to the provider and treating clinician. Verbal notification will only occur if the provider is unable to receive written auto-fax notification.
Denial	<ul style="list-style-type: none"> If HSM determines that services are not medically necessary and appropriate for any part of the request, a denial letter will be issued and reconsideration rights will apply. Written notification of denial determination is sent to the provider, the treating clinician and the beneficiary or youth's legal guardian, or representative/responsible The beneficiary/representative/responsible party's notice does not contain the medical basis for the denial. Verbal notice is given to the provider for all review types except retrospective review.
Suspended	<ul style="list-style-type: none"> HSM will notify the requester (verbally and in writing) when additional information is required and the review will be pended. If the requested information is not submitted by the due date HSM issues a written notice of Review Suspended.

Review determination and notification timeframes are displayed in the following table.

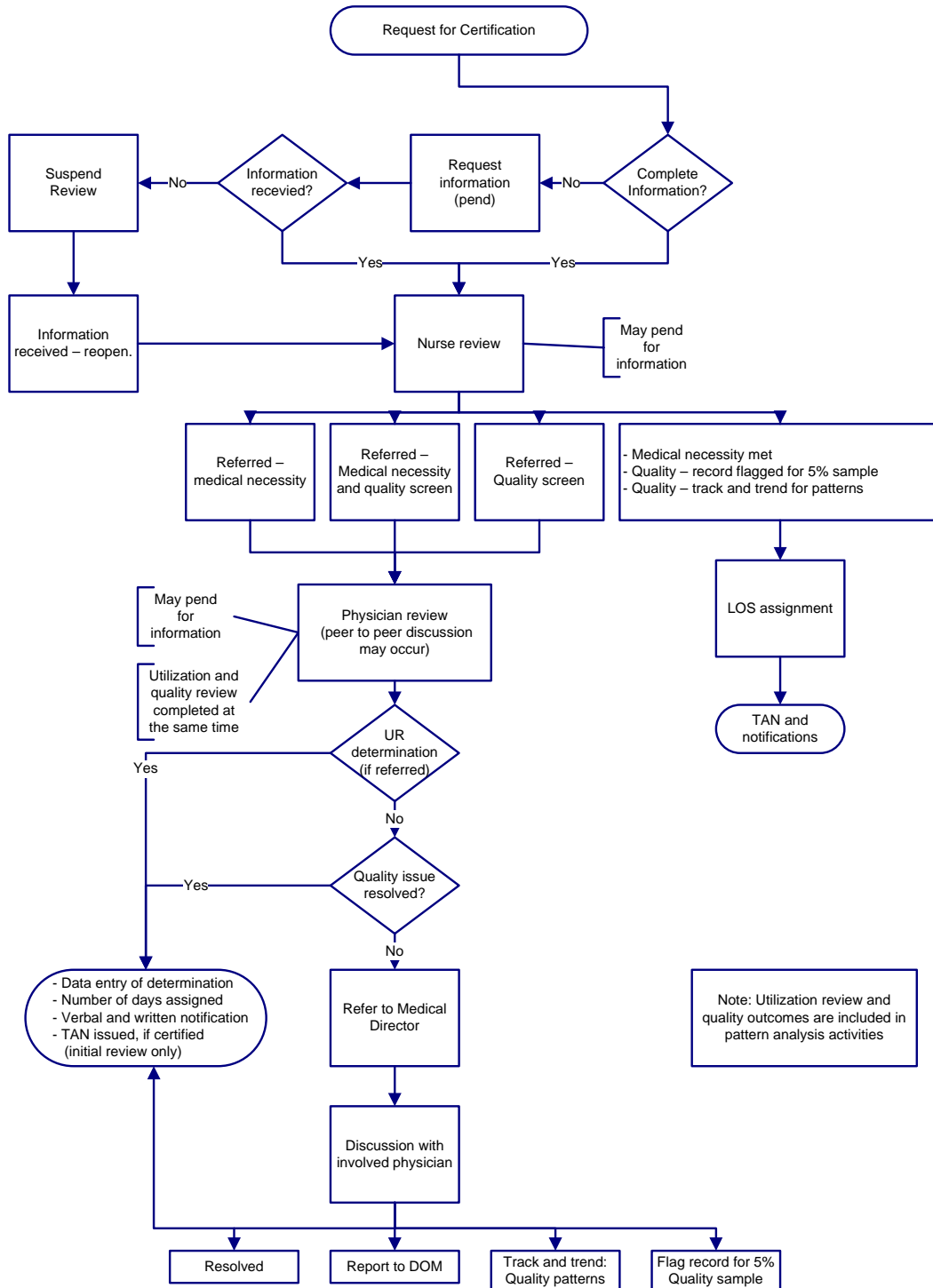
Review Type	Review Determination and Verbal Notification	Written Notification
<ul style="list-style-type: none"> Admission Continued Stay 	Within two business days of receipt of review request and necessary information.	Within one business day of review determination.
<ul style="list-style-type: none"> Retrospective 	Verbal notification is not given for this review.	Within 20 business days of receipt of review request and necessary information.

Written notifications of review certification (approval) and determinations involving denials are sent to the various parties as noted above.

Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Admission	Continued Stay/Recertification
Certification (Approval)	Date of notice	√	√
	Brief statement of HSM's authority and responsibility for review	√	√
	Reason for determination	√	√
	Date(s) of service being approved	√	√
	Type service certified	√	√
	Number of units/days certified	√	√
	Total number & type services certified to date	√	√
	Total time span approved to date	√	√
	Treatment Authorization Number (TAN)	√	√
Denial	Date of notice.	√	√
	Brief statement of HSM's authority and responsibility for review.	√	√
	Principal and clinical reason for denial.	√	√
	Type of services, number of units, and dates of services being denied.	√	√
	Total number and time span for previously certified procedures or services.		√
	Process for submitting a reconsideration request.	√	√
	Reconsideration timeframes.	√	√

D. Notification of Review Outcome



VI. Reconsideration Review

If any of the following parties disagree with the determination made by HSM, a request for reconsideration may be requested.

- Beneficiary/representative/responsible party.
- Hospital outpatient provider (facility).
- Treating clinician.

A second HSM physician, one not involved in the initial decision, will review the reconsideration request and make a determination. If the decision to deny is upheld or modified, the beneficiary/representative/responsible party may appeal the decision directly to the Division of Medicaid.

Please see the ***Reconsideration Manual*** for additional details.

VII. Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving hospital outpatient mental health services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by HSM. HSM identifies aberrant patterns and/or trends by provider.

Please see the ***Quality Review Process Manual*** for additional details.

***VIII. Utilization Analysis, Focused Studies, Outcome Reports,
and Proposals for Improving Health Care Delivery System***

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

VX. Forms and Instructions

- Admission Review Request Form - Outpatient Hospital Mental Health Services
- Continued Stay Review Request Form - Outpatient Hospital Mental Health Services
- Additional Information Form

HealthSystems of Mississippi
Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Information		Provider Information	
Beneficiary Name: _____		Lead Clinician:	
Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Name: _____	
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Address: _____	
Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>		Address _____	
Beneficiary Account #: _____ <i>(if applicable)</i>		City/State _____	
		Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		License #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Hospital Information		NOTE: Attestation Statement on last page of form must be signed and dated by the psychiatrist, psychiatric nurse practitioner, psychologist, or licensed certified social worker.	
Hospital #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Hospital Name: _____			
Requester's Information			
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Name: _____	
		Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
SERVICE DATES:			
Actual Admit/Service Start Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Proposed Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
MEDICAL INFORMATION - DIAGNOSIS AND PROCEDURES			
Axis I (ICD-9-CM Codes)	Narrative Description (Primary diagnosis cannot be substance abuse diagnosis.)		
1. Primary DX.:			
2.			
3.			
Axis II (ICD-9-CM Codes)	Narrative Descriptions		
1.			
2.			
3.			
Axis III (ICD-9-CM Codes)	Narrative Descriptions		
1.			
2.			
3.			
Axis IV (ICD-9-CM Codes)	Narrative Descriptions		
1.			
2.			
3.			
Axis V	Baseline GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>	Current GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>	

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Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

REQUESTED SERVICES								
CPT® Code	Dates of Service		Total Unit(s) Requested	Performed by			Complete this section for each requested CPT® Code.	
	From	Thru		Psychiatrist / Nurse Practitioner	Anesthesiologist / Nurse Anesthetist	Other	For each code requested, list the last and first name of the clinician who will be providing the service.	Provider Medicaid # or License #
90801	<input type="text"/>	<input type="text"/>						
90804	<input type="text"/>	<input type="text"/>						
90805	<input type="text"/>	<input type="text"/>						
90806	<input type="text"/>	<input type="text"/>						
90807	<input type="text"/>	<input type="text"/>						
90808	<input type="text"/>	<input type="text"/>						
90809	<input type="text"/>	<input type="text"/>						
90810	<input type="text"/>	<input type="text"/>						
90811	<input type="text"/>	<input type="text"/>						
90812	<input type="text"/>	<input type="text"/>						
90813	<input type="text"/>	<input type="text"/>						
90814	<input type="text"/>	<input type="text"/>						
90815	<input type="text"/>	<input type="text"/>						
90846	<input type="text"/>	<input type="text"/>						
90847	<input type="text"/>	<input type="text"/>						
90849	<input type="text"/>	<input type="text"/>						
90853	<input type="text"/>	<input type="text"/>						

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

REQUESTED SERVICES								
CPT® Code	Dates of Service		Total Unit(s) Requested	Performed by			Complete this section for each requested CPT® Code.	
	From	Thru		Psychiatrist / Nurse Practitioner	Anesthesiologist / Nurse Anesthetist	Other	For each code requested, list the last and first name of the clinician who will be providing the service.	Provider Medicaid # or License #
90857	□□/□□/□□	□□/□□/□□						
90862	□□/□□/□□	□□/□□/□□						
90870	□□/□□/□□	□□/□□/□□						

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

PAST TREATMENTS

Were outpatient mental health services provided by this hospital at the time of initial evaluation and/or prior to submission of this review request? Yes No *If yes, indicate why immediate intervention was required and therefore services could not be precertified.*

Did the beneficiary receive outpatient mental health services from this hospital prior to submission of this review request?

Yes No *If yes, provide the date on which those services were initiated.* //

Did the beneficiary receive other related health care services prior to initial evaluation? Yes No Unknown

If yes, complete the following Treatment History section.

Treatment History (Check all that apply within last year):

Psychiatric Inpatient Admits None 1 2 3-5 6 or more Latest Discharge Date
//

Other care/Institution None NF ICF/MR PRTF //

	Community Mental Health Center	Outpatient Hospital Provider	Private Practice	Discharge Date <i>(Leave blank if active care)</i>
<input type="checkbox"/> Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Case Management Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Psychosocial Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Group Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Outpatient Substance Use Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> NA or AA Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> NAMI or Other Mental Health Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Other (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Current Symptoms/Behavior		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Danger to Self/Others	Suicidal Thought / Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Current plan to kill / injure self, requiring medical Tx.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Homicidal Thought / Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Recent attempt to kill or seriously injure another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Aggressiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uncontrolled Impulsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral/Evidence <i>(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.)</i>							
		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Psychosis	Command auditory hallucinations to kill / injure self, requiring medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hallucinations – Non-Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Disorganized/Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood	Gross psychomotor retardation from depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crying / Tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	Anxiety / Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Binging / Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Property Destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Behavioral/Evidence, Continued		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Behavior, con't.	Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lying / Manipulative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction	Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Alcohol Use / Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other Drug Use / Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uncontrolled Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Psychological Stressors/Events (Check all that apply)

<input type="checkbox"/> Recent Death	<input type="checkbox"/> Separation / Divorce	<input type="checkbox"/> Financial Difficulties
<input type="checkbox"/> Physical / Sexual / Emotional Abuse	<input type="checkbox"/> Relapse / Decompensation	<input type="checkbox"/> Change in Living Situation
<input type="checkbox"/> Recent Hospitalization	<input type="checkbox"/> Work / School Problems	<input type="checkbox"/> Current Living Arrangement is Unstable
<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Custody / Placement	<input type="checkbox"/> Beneficiary is Unable to Return to Current Living Arrangement

Other: (Describe) _____

Current Functioning		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Care
Physical/ Cognitive	Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Change in Energy Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor Self-Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Verbal Interaction	Argumentative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rapid / Pressured Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Slurred / Incoherent Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Current Communication	0 Unable to Assess	1 Yes	2 No
Verbal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses Communication Device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Make Needs Known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Drug Use	0 Unable to Assess	1 None	2 Within Past 24 Hours	3 Within Past 30 Days
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Skill/Ability Assessment	0 Unable to Assess	1 Independent or N/A	2 Minimal Assistance	3 Moderate Assistance	4 Significant Assistance
Literacy / Basic Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coping Skills / Emotional Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical / Medication Mgmt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social / Family Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare / Parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking / Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household Tasks / Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Mobility within Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure / Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Current Work/School Schedule		
Employment/School Hours Per Week <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> 1-9 hours <input type="checkbox"/> 10-19 hours <input type="checkbox"/> 20-39 hours <input type="checkbox"/> 40 or more hours	Employment Type <input type="checkbox"/> School <input type="checkbox"/> Employed by Company <input type="checkbox"/> Self Employed <input type="checkbox"/> Sheltered Workshop <input type="checkbox"/> Supported Employment <input type="checkbox"/> Volunteering <input type="checkbox"/> Unemployed	Date of Last Employment: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Occupation: _____ _____ _____

Current Living Arrangement <i>(Select only one)</i>		
<input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Parent / Guardian	<input type="checkbox"/> Foster Home <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Group Residential Facility	<input type="checkbox"/> Shelter <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Other: <i>(Specify.)</i> _____

Resource/Needs Assessment	0 Unknown	1 Has Resource	2 Has Resource that Needs Enhancement	3 Needs Assistance to Obtain and Use	4 Resource Not Available
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Social Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Individual Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Annual History and Physical Exam	
Date of last physical exam: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Next exam due: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

Studies/labs/x-rays <i>(List any diagnostic studies and tests and findings that are associated with the primary diagnosis)</i>		
Date	Study/Lab/X-Ray	Results/Findings
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

HealthSystems of Mississippi

Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

DISCHARGE PLANS

Will/can the beneficiary return to current living arrangement? Yes No

Anticipated Discharge Date: / /

Anticipated Discharge to: *(Check one)*

- Acute Care Facility: _____
- Custody DHS County: _____
- Custody DYS
- Home with family
- Group home
- Foster home
- Shelter
- Independent living
- Left AMA
- Other: *(Specify.)*

Anticipated Follow-Up Care: *(Check all that apply)*

- Case Management
- Day Treatment - CMHC
- DME
- Family Therapy
- Follow-Up w/PCP /Specialist
- Follow-Up w/Pharmacy
- Group Therapy
- Home Health
- Individual Therapy
- Other: *(Specify.)*
- Med Management
- PDN
- OT/PT/ST Outpatient Therapy
- SNF/NH
- Substance Abuse Counseling
- Vocational Rehab

Clinician Attestation, Signature and Date

A psychiatrist, psychiatric nurse practitioner, psychologist, or licensed certified social worker who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to monetary penalties and/or fines. I hereby approve the information submitted on behalf of the beneficiary listed on this Plan of Care form for outpatient mental health services and I deem this request medically necessary. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Signature:

**Psychiatrist, psychiatric nurse practitioner, psychologist, or
 licensed certified social worker**

Date

Check One:

- Psychiatrist Psychiatric Nurse Practitioner
- Psychologist Licensed Certified Social Worker

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

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

HealthSystems of Mississippi

Medicaid Continued Stay Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Information		Provider Information	
Beneficiary Name: _____ Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> <input type="text"/> Beneficiary Account #: _____ <i>(if applicable)</i>		Lead Clinician: Name: _____ Address: _____ Address: _____ City/State: _____ Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> License #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Hospital Information		NOTE: Attestation Statement on last page of form must be signed and dated by the psychiatrist, psychiatric nurse practitioner, psychologist, or licensed certified social worker.	
Hospital #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Hospital Name: _____			
Requester's Information			
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Name: _____ Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Continued Stay Information			
Admit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
Treatment Authorization Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
NEW DIAGNOSIS SINCE LAST REVIEW			
New Axis I (ICD-9-CM Codes)	New Narrative Description		
1. Primary DX.:			
2.			
3.			
New Axis II (ICD-9-CM Codes)	New Narrative Description		
1.			
2.			
3.			
New Axis III (ICD-9-CM Codes)	New Narrative Description		
1.			
2.			
3.			
New Axis IV (ICD-9-CM Codes)	New Narrative Description		
1.			
2.			
3.			
Axis V	Baseline GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>		Current GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>

HealthSystems of Mississippi

Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____

Medicaid #: _____

REQUESTED SERVICES								
CPT [®] Code	Dates of Service		Total Unit(s) Requested	Performed by (Check as applicable.)			Complete this section for each requested CPT [®] Code	
	From	Thru		Psychiatrist/Nurse Practitioner	Anesthesiologist / Nurse Anesthetist	Other	For each code requested, list the last and first name of the clinician who will be providing the service.	Provider Medicaid # or License #
90801	<input type="text"/>	<input type="text"/>						
90804	<input type="text"/>	<input type="text"/>						
90805	<input type="text"/>	<input type="text"/>						
90806	<input type="text"/>	<input type="text"/>						
90807	<input type="text"/>	<input type="text"/>						
90808	<input type="text"/>	<input type="text"/>						
90809	<input type="text"/>	<input type="text"/>						
90810	<input type="text"/>	<input type="text"/>						
90811	<input type="text"/>	<input type="text"/>						
90812	<input type="text"/>	<input type="text"/>						
90813	<input type="text"/>	<input type="text"/>						
90814	<input type="text"/>	<input type="text"/>						
90815	<input type="text"/>	<input type="text"/>						
90846	<input type="text"/>	<input type="text"/>						

HealthSystems of Mississippi

Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ **Medicaid #:** _____

REQUESTED SERVICES								
CPT [®] Code	Dates of Service		Total Unit(s) Requested	Performed by (Check as applicable.)			Complete this section for each requested CPT [®] Code	
	From	Thru		Psychiatrist/Nurse Practitioner	Anesthesiologist / Nurse Anesthetist	Other	For each code requested, list the last and first name of the clinician who will be providing the service.	Provider Medicaid # or License #
90847	□□/□□/□□	□□/□□/□□						
90849	□□/□□/□□	□□/□□/□□						
90853	□□/□□/□□	□□/□□/□□						
90857	□□/□□/□□	□□/□□/□□						
90862	□□/□□/□□	□□/□□/□□						
90870	□□/□□/□□	□□/□□/□□						

HealthSystems of Mississippi
Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Current Symptoms/Behavior		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Danger to Self/Others	Suicidal Thought/Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Current plan to kill / injure self, requiring medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Homicidal Thought / Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Recent attempt to kill or seriously injure another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Aggressiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uncontrolled Impulsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral/Evidence <i>(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.)</i>							
		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Psychosis	Command auditory hallucinations to kill / injure self, requiring medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hallucinations – Non-Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Disorganized/Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood	Gross psychomotor retardation from depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crying / Tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	Anxiety / Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Obsessions / Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HealthSystems of Mississippi

Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Behavioral/Evidence, Continued		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Behavior	Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Binging / Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Property Destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lying / Manipulative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction	Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Alcohol Use / Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other Drug Use / Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uncontrolled Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Psychological Stressors/Events (Check all that apply)

<input type="checkbox"/> Recent Death	<input type="checkbox"/> Separation/Divorce	<input type="checkbox"/> Financial Difficulties
<input type="checkbox"/> Physical/Sexual/Emotional Abuse	<input type="checkbox"/> Relapse/Decompensation	<input type="checkbox"/> Change in Living Situation
<input type="checkbox"/> Recent Hospitalization	<input type="checkbox"/> Work/School Problems	<input type="checkbox"/> Current Living Arrangement is Unstable
<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Custody/Placement	<input type="checkbox"/> Beneficiary is Unable to Return to Current Living Arrangement

Other: (Describe)

Current Functioning		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Care
Physical / Cognitive	Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Change in Energy Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor Self-Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HealthSystems of Mississippi
Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Current Functioning, cont.		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Care
Verbal Interaction	Argumentative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rapid / Pressured Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Slurred / Incoherent Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Communication		0 Unable to Assess	1 Yes	2 No
Verbal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression Difficulty		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sign Language		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses Communication Device		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestures		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Make Needs Known		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Drug Use		0 Unable to Assess	1 None	2 Within Past 24 Hours	3 Within Past 30 Days
Alcohol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crank		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Skill/Ability Assessment		0 Unable to Assess	1 Independent or N/A	2 Minimal Assistance	3 Moderate Assistance	4 Significant Assistance
Literacy / Basic Math		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coping Skills / Emotional Mgmt.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Safety		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical / Medication Mgmt		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social / Family Relations		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Hygiene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare / Parenting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking / Nutrition		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household Tasks / Chores		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Mobility within Community		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure / Recreational		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial Management		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HealthSystems of Mississippi

Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

Current Work/School Schedule		
Employment/School Hours Per Week <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> 1-9 hours <input type="checkbox"/> 10-19 hours <input type="checkbox"/> 20-39 hours <input type="checkbox"/> 40 or more hours	Employment Type <input type="checkbox"/> School <input type="checkbox"/> Employed by Company <input type="checkbox"/> Self Employed <input type="checkbox"/> Sheltered Workshop <input type="checkbox"/> Supported Employment <input type="checkbox"/> Volunteering <input type="checkbox"/> Unemployed	Date of Last Employment: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Occupation: _____ _____ _____

Current Living Arrangement <i>(Select only one)</i>		
<input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Parent / Guardian	<input type="checkbox"/> Foster Home <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Group Residential Facility	<input type="checkbox"/> Shelter <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Other: <i>(Specify.)</i> _____ _____

Resource/Needs Assessment	0 Unknown	1 Has Resource	2 Has Resource that Needs Enhancement	3 Needs Assistance to Obtain and Use	4 Resource Not Available
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Social Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Individual Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Studies/labs/x-rays <i>(List any diagnostic studies and tests and findings that are associated with the primary diagnosis)</i>		
Date	Study/Lab/X-Ray	Results/Findings
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

MEDICATIONS		
Date Ordered	Medication, Dosage, Frequency & Route	Date Discontinued <i>(if applicable)</i>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

HealthSystems of Mississippi

Medicaid Continued Stay Review Form: Hospital Outpatient Mental Health

Beneficiary Name: _____ Medicaid #: _____

DISCHARGE PLANS

Will/can the beneficiary return to current living arrangement? Yes No

Anticipated Discharge Date: / /

Anticipated Discharge to: *(Check one)*

- Acute Care
- Custody DHS
- Custody DYS
- Home with family
- Group home
- Foster home
- Shelter
- Independent living
- Left AMA
- Other: *(Specify.)*

Facility: _____
County: _____

Anticipated Follow-Up Care: *(Check all that apply)*

- Case Management
- Day Treatment - CMHC
- DME
- Family Therapy
- Follow-Up w/PCP /Specialist
- Follow-Up w/Pharmacy
- Group Therapy
- Home Health
- Individual Therapy
- Other: *(Specify.)*
- Med Management
- PDN
- OT/PT/ST Outpatient Therapy
- SNF/NH
- Substance Abuse Counseling
- Vocational Rehab

Clinician Attestation, Signature and Date

A psychiatrist, psychiatric nurse practitioner, psychologist, or licensed certified social worker who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to monetary penalties and/or fines. I hereby approve the information submitted on behalf of the beneficiary listed on this Plan of Care form for outpatient mental health services and I deem this request medically necessary. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Signature:

**Psychiatrist, psychiatric nurse practitioner, psychologist,
or licensed certified social worker**

Date

Check One:

- Psychiatrist Psychiatric Nurse Practitioner
- Psychologist Licensed Certified Social Worker

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

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.

