



Mississippi Youth Programs Around the Clock (MYPAC) Waiver Services

Provider Manual

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175 East Capitol Street

Suite 250

Lock Box 13

Jackson, Ms 39201

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Introduction

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform precertification for Mississippi Youth Programs Around the Clock (MYPAC) waiver services rendered to Mississippi applicants. We perform precertification review activities for case management, wraparound and respite services.

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.
- Private duty nursing.
- Swing beds.
- Psychiatric residential treatment facilities.
- Home health.
- Durable medical equipment, supplies, orthotics and prosthetics.
- Outpatient physical, occupational and speech therapy.
- MYPAC

HSM is committed to providing the highest level of service to DOM, Medicaid beneficiaries, physicians and providers throughout the state.

Mission Statement

To improve the quality of health and health care by using information and collaborative relationships to enable change.

About HSM

Our office is located in downtown Jackson, Mississippi at the following address:

175 East Capitol Street
Suite 250, Lockbox 13
Jackson, MS, 39201

Our business hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays. Our direct business office phone number and primary fax number are:

Phone: (601) 352-6353
Fax: (601) 352-6358

Note: Request for precertification review should not be faxed to our business fax. Please see grid below for MYPAC fax numbers.

Other Important Numbers

Dedicated phone numbers are provided to assist you with your certification needs. These numbers and hours of operation are listed in the following table.

Purpose	Description	Hours of Operation and Number(s)
MYPAC Precertification Review Request Submission	Used by providers to submit review request and additional information requested by HSM.	Hours: 24 hours, 7-days a week. Faxes received after 5:00 p.m. or over the weekend or holidays are considered received the next working day. FAX: 1-888-204-0504
Helpline	Used by providers for questions regarding the: <ul style="list-style-type: none"> • Precertification process. • Status of review. 	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Local: 601-360-4949 Toll Free: 1-866-740-2221
Hot Line	Number to use 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

MYPAC Review Process

Providers submit request for review directly to HSM. 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 called continued stay reviews. If a retroactive determination of Medicaid eligibility is made while a youth is receiving services, a request for admission review is submitted.

Requests for precertification review are processed by our intake staff. Our intake staff is experienced and work collaboratively with our clinical staff to provide quality services to our customers. Our clinical staff is composed of registered nurses, physicians and physician consultants. These highly qualified professionals make precertification review determinations for MYPAC waiver services. 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.
Registered Nurses (RN)	<ul style="list-style-type: none"> • Apply DOM policy. • Apply explicit DOM approved medical review criteria. • May request additional information. • Approves services based on policy or criteria. • Refer requests that cannot be approved for physician determination.
Physician Advisors (Reviewers)	<ul style="list-style-type: none"> • Make certification, denial or reconsideration determinations. That decision 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 attempts to contact the MYPAC Waiver Provider's medical director to obtain additional information when the documentation submitted does not clearly support medical necessity.</p>

Written notification of approval review results is sent to providers. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Written notification of denial determinations are sent to the youth/representative/responsible party and to the MYPAC Waiver Provider.

The MYPAC Waiver Provider, the attending physician, or the youth/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, the youth/representative/responsible party may appeal the decision directly to the Division of Medicaid. See the *Reconsideration Process* section of this manual for additional information.

- MYPAC Waiver providers must precertify services through HSM. Service codes, narrative description and maximum units/days are listed in the following table.

HCPSC Codes	Descriptions	Units/Days	Notes
T2022	Case Management	12 months per fiscal year	One year must be requested when youth initially admitted to program.
H2022	Community Based Wraparound	365 days	One year must be requested when youth initially admitted to program.
H0045	Respite	Up to 29 days at a time	The beneficiary must be discharged from MYPAC if 29 consecutive days of respite have been used and the beneficiary cannot be safely discharged. Notify DOM of the discharge. No more than 45 days total certified per DOM fiscal year.

Case Management and community based wrap-around services are reviewed for medical necessity and appropriateness. Respite services are reported to HSM; this service must be entered via HSM's Web Utility when an HSM Treatment Authorization Number has previously been issued.

- Providers submit via faxed or mail request for review in accordance with specific timeframes based on the review type.
- 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 this manual.

Notes:

- Faxes received after 5:00 p.m. are considered received the next working day.
- Respite services are reported to HSM; this service must be entered via HSM's Web utility when an HSM Treatment Authorization Number has previously been issued.

Review Type	Timeframe	Required Documentation
Admission Certification:	At least 3 business days prior to initiation of MYPAC waiver services.	Fax or mail the following to HSM: <ul style="list-style-type: none"> • Completed HealthSystems of Mississippi MYPAC Admission Certification Request Form. • A completed and signed freedom of choice form. • A copy of an independent evaluation performed within 60 days prior to proposed admission date. The psychiatric evaluation must be performed by a psychiatrist or a licensed psychologist. • If the evaluation is greater than 60 days, HSM will accept the evaluation with an update or addendum. The addendum must include the clinical summation and recommendation for the care. <p style="text-align: center;">OR</p> A pre-discharge recommendation in lieu of the independent evaluation if the youth is in an acute care setting prior to placement in the MYPAC Waiver.

Review Type	Timeframe	Required Documentation
Once the beneficiary has been admitted:	At least 30 business days post admission to MYPAC waiver services.	Fax or mail the following to HSM: A copy of the Individualized Service Plan (ISP).
Continued Stay/Recertification request:	At least 30 days prior to the last date certified by HSM.	Fax or mail the following to HSM: <ul style="list-style-type: none"> Completed HealthSystems of Mississippi MYPAC Continued Stay/Recertification Request Form. A copy of the most current Individualized Service Plan indicating the necessity of continuing the current level of care. Plan should be dated no more than 30 days from the date of the request. A copy the most current CANS – MH, dated no more than 60 days from the date of the request. A copy of the WRAP meeting notes for the past two meetings, one of which must be within the last 30 days.

- HSM will verbally notify the requester if the maximum number of participants has been reached in the MYPAC program. The review will be stopped.
- If a youth is not Medicaid eligible when the review is initiated:
 - HSM will assign a pseudo number (Temporary ID).
 - The pseudo number will be used on all forms/documents/correspondence submitted to HSM until an active Medicaid number is assigned.
 - If HSM determines that services are medically necessary and appropriate, the Division of Medicaid will determine whether the youth meets Medicaid financial eligibility requirements. This may take up to 45 days.

If the youth is	Then
Determined to be financially eligible	<ul style="list-style-type: none"> DOM will notify HSM of the youth’s active Medicaid number. HSM will update the pseudo number with the youth’s active Medicaid number on all correspondence. HSM will notify the MYPAC waiver provider of the medical necessity review certification (approval).
Determined not to be financially eligible	<ul style="list-style-type: none"> DOM will notify the provider. HSM will end the review process.

- If HSM determines that services are not medically necessary and appropriate we will issue a denial letter. Reconsideration rights will apply.
- HSM will notify the requester (verbally and in writing) when additional information is required and the review is pended. One business day is allowed for submission of the requested information. There are three types of situations that may cause a review to be pended. Each is described in the following table.

If the review cannot proceed because	Then	Timeframe for submission	If information is submitted then	If information is not submitted then
Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	One business day.	HSM continues the review process.	HSM issues a written Notice of Review Suspended.

If the review cannot proceed because	Then	Timeframe for submission	If information is submitted then	If information is not submitted then
Clinical information is needed by the: <ul style="list-style-type: none"> • RN reviewer • Physician reviewer 	Clinical information required to complete the review is requested.			Notice is issued by close of business on due date.

Written notification of approval review results is sent to providers. The written notice contains the Treatment Authorization Number (TAN) which is used on the bill. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Written notification of denial determinations are sent to the youth/representative/responsible party and to the MYPAC Waiver Provider.

Notification timeframes are displayed in the following table.

Notification Type	Review Type	
	Admission Certification	Continued Stay/Recertification
Verbal (if no auto-fax)	Within three business days of receipt of review request and when all necessary information has been received.	Within three business days of receipt of review request and all necessary information.
Written notification.	Within one business day of review determination.	Within one business day of review determination.

Please see *Content of Written Notices of Review Outcome* in this manual for additional information.

Content of Written Notices of Review Outcome

Written notifications of review certification (approval) determinations are sent to the MYPAC Waiver provider.

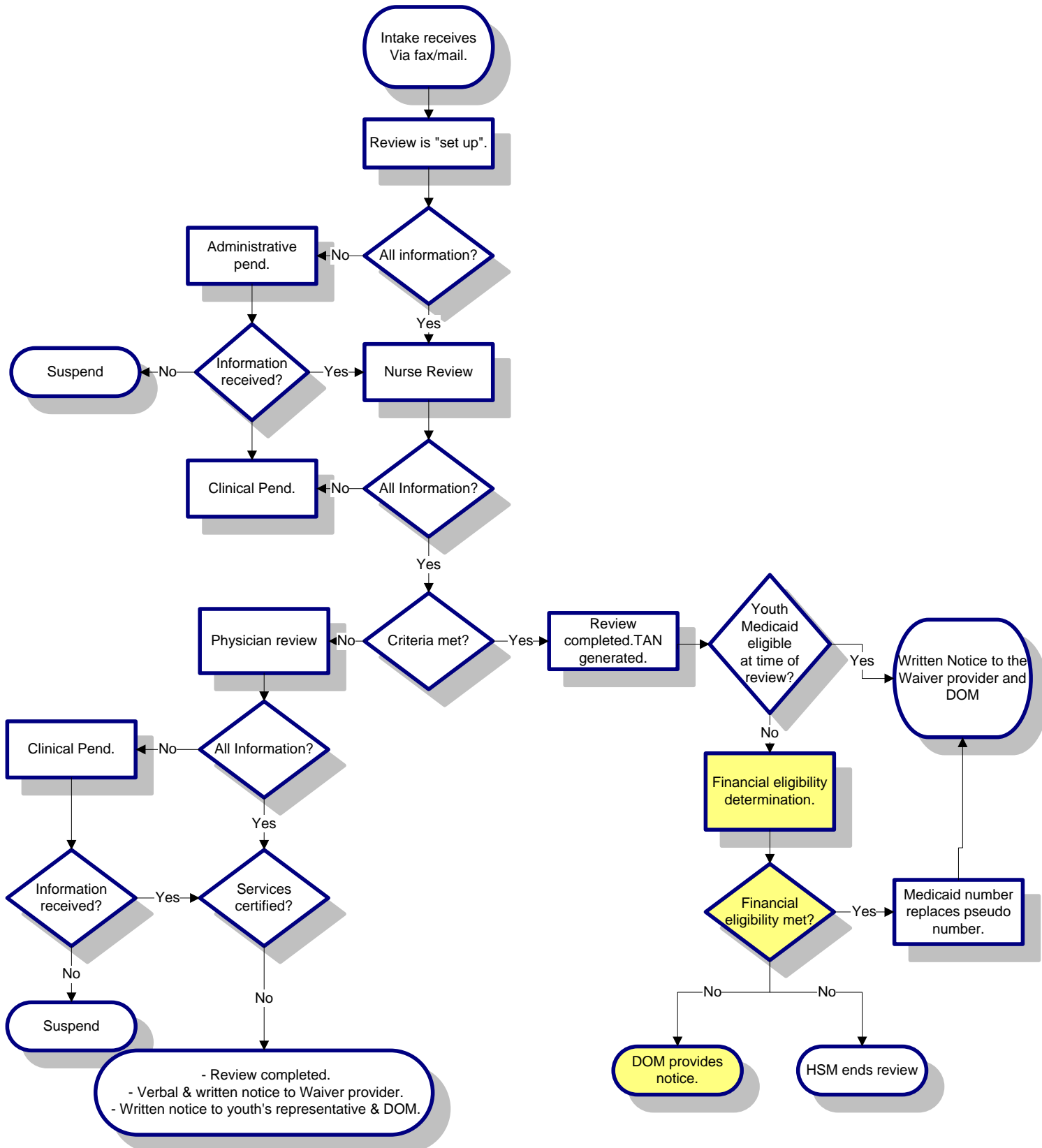
Review determinations involving denials are sent to the youth/representative/responsible party and MYPAC Waiver provider. The youth/representative/responsible party's notice does not contain the medical basis for the denial.

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.	√	√

Review Process Flow Chart

Key: Black by HSM
Yellow by DOM



Reconsideration Review

If any of the following parties disagrees with the determination made by HSM, they can request a reconsideration of the initial decision.

Applicant/parent/responsible party

- MYPAC Waiver Provider
- MYPAC Medical Director

Submission of Reconsideration Request

A request for reconsideration may be submitted to HSM by fax, mail or telephone at (601) 360-4875. There are two types of reconsideration request available. Additional information to substantiate the need for services may be submitted with the request for reconsideration.

The following table provides the types of reconsideration available, submission and completion timeframes.

Type of Review Denied	Request for Reconsideration must be received	Type of Reconsideration	HSM's Timeframe for Completion
Admission	Within 15 calendar days of denial notice.	Standard	Within 15 calendar days of receipt of request.
	Within three calendar days of denial notice.	Expedited	Within one business day of receipt of request.
Continued Stay/Recertification	Within 30 calendar days of denial notice.	Standard	Within 20 business days of receipt of request.
	Within three calendar days of denial notice.	Expedited	Within one business day of receipt of request.

Reconsideration Review Determinations

There are two types of reconsideration review determinations. The table below describes each decision and its impact on the original service request.

The original denial is...	Description	Impact to Services
Reversed	The decision is changed from denial to approval (certification).	Services are approved as originally requested.
Upheld	The reviewing physician agrees with the original denial determination.	Services remain denied.

The reconsideration review is completed by a second physician reviewer.

Written notification of the reconsideration determination will be sent to the youth/legal representative/responsible party and the MYPAC Waiver Provider. Verbal notice is provided to the MYPAC Waiver Provider.

If there is still a disagreement with HSM's reconsideration determination and the denial was upheld, the youth/legal representative/responsible party has the right to request an administrative appeal (hearing) from DOM within thirty (30) days of the reconsideration denial.

The written request for appeal is sent to:

Division of Medicaid
Executive Director
550 High Street, Suite 1000
Jackson, MS 39201
1-800-421-2408

Obtaining Help with the Review Process

HSM's helpline coordinators are available to assist you with questions related to the review process or the status of a review request. Please see *About HSM* for helpline hours and contact information.

Please refer all billing questions to DOM's fiscal Agent.

Glossary

Appeal: A process for resolving disputes. A youth/representative may request and obtain a DOM Administrative Appeal of an HSM denial determination that was upheld or modified through HSM'S reconsideration process.

Beneficiary: An individual eligible for medical assistance in accordance with the state's Medicaid Program and who has been certified as eligible by the appropriate agency and has received services.

Certification: Authorization of services by HSM for Medicaid covered services.

Continued Stay/Recertification: Prior services have been certified by HSM and precertification of additional services is needed.

Criteria: Predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of medical necessity, and appropriateness of a health care service may be compared.

Denial Determination: A decision by a professional review organization, regarding the medical necessity or appropriateness of health care services furnished, or proposed to be furnished.

Pend: Status assigned to a review request by HSM when additional information necessary to complete the review process is required. HSM informs the provider of the need for the information and allows a specific timeframe for submission.

Precertification: Authorization of services by HSM prior to the date and or time the services are to begin or continue.

Provider: Person, entity, or facility enrolled in the Medicaid program and renders services to Medicaid beneficiaries and bills Medicaid for services. The MYPAC Waiver Provider.

Reconsideration: The rereview of a denial determination previously rendered by HSM, requested by the provider or youth/representative/responsible party.

Review Suspend: Act of discontinuation of certification review of a request for services because additional information was not received by HSM in timeframe allocated.

Treatment Authorization Number (TAN): approval number that the provider uses to seek payment from the fiscal agent.

HealthSystems of Mississippi

MYPAC ADMISSION CERTIFICATION REQUEST FORM

YOUTH'S INFORMATION	PROVIDER INFORMATION
Youth's Name: <i>(Please print)</i> _____ MS 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"/>	MYPAC 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"/>
Check if no active Medicaid #: <input type="checkbox"/> Enter Soc. Sec. # below: <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"/>	MYPAC Provider Name: <i>(Please print)</i> _____
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Request Date: <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"/>	Requester's Name: <i>(Please print)</i> _____
Guardian/Representative Name: <i>(Please print)</i> _____	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"/>
Guardian/Representative Address: <i>(Please print)</i> _____ _____	Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

PHYSICIAN INFORMATION	
Medical Director Name: <i>(Please print)</i> _____	Medical Director MS 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"/>
Medical Director Address: (only if no MS Medicaid #) <i>(Please print)</i> _____ _____	Medical Director 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"/>

MEDICAL INFORMATION	
Planned Date of Admission: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	IQ: <input type="text"/> <input type="text"/> <input type="text"/>
Diagnosis/Five Parts of Multi-Axial <i>(Please print)</i>	ICD-9-CM Codes
I.	
II.	
III.	
IV.	
V.	

REQUESTED SERVICES				
HCPCS Code	Description	Dates of Service		Total Unit (s) Requested
		From	Thru	
H2022	Wrap around	<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"/>	Days: <i>(Maximum = 365)</i>
T2022	Case Management	<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"/>	Months: <i>(Maximum = 12)</i>
H0045	Respite	<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"/>	Days: <i>(Maximum = 29 at initial cert)</i>

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST FORM

Beneficiary Name: _____ MS Medicaid #:

CLINICAL INFORMATION

Psychiatric History. *List a brief history of the youth's psychiatric care.*

Current Behavior. *Please provide a detailed explanation why the beneficiary requires this intensity of services:*

List any previous admissions (to any provider) in the past 3 months. *(Please include shelters, group or foster homes, detention center, training schools or outpatient therapy.)*

List any discharge plans.

Physician Attestation, Signature and Date

A physician who attests to prescribed MYPAC Waiver 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 civil monetary penalties and/or fines. I hereby certify that I am the ordering physician identified on this form and I deem the service medically necessary for the patient listed as the beneficiary. I certify that the medical necessity information on this form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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

MYPAC Waiver Medical Director's Signature

Date

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.

Instructions for Completing the HealthSystems of Mississippi MYPAC Waiver Admission Request Form

YOUTH'S INFORMATION

Youth's Name - Enter the youth's last and first name. If the youth has an active Medicaid number record the name as it appears on the Mississippi Medicaid ID card.

MS Medicaid # - If the youth has an active MS Medicaid number, enter the number that appears on the MS Medicaid ID card. If the youth does not have an active number, LEAVE BLANK.

Check If no active Medicaid # - Check the box if the youth does not have an active Mississippi Medicaid ID.

Soc. Sec. # - If Mississippi Medicaid has been applied for, enter the youth's social security number.

Date of Birth - Enter the month, date, and year of the youth's birth.

Sex - Indicate the sex of the youth.

Age - Enter the age of the youth at the time service is to be rendered.

Guardian/Representative Name - Enter the name of the youth's legal guardian/representative.

Guardian/Representative Address - Enter the mailing address of the guardian/representative.

PROVIDER INFORMATION

MYPAC MS Medicaid Number - Enter the MYPAC Waiver Medicaid provider number.

MYPAC Provider Name - Enter the name of the MYPAC Waiver provider.

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

Requester's Name - Enter the name of the individual who is primary contact for this case.

Phone # - Enter the requester's telephone number, including area code and extension, if applicable.

PHYSICIAN INFORMATION

Medical Director Name - Enter the name of MYPAC Waiver provider's Medical director.

Medical Director Address - Enter this information only if the MYPAC Waiver provider's Medical Director's Ms Medicaid ID number is unavailable.

Medical Director MS Medicaid# - Enter the MS Medicaid ID number of the Medical Director.

Medical Director Phone # - Enter the phone number of the MYPAC Waiver provider's Medical director.

Medical Information

Planned date of Admission - Enter the month, date and year of the planned admission.

IQ - Enter the youth's IQ score.

Diagnosis Axis - Enter the youth's current diagnoses (five parts of multi-axial).

ICD - 9-CM Codes - Enter the ICD-9-CM codes that correspond with each of the listed diagnosis.

REQUESTED SERVICES

The following information must be submitted for each type of service requested. Please note that once a Treatment Authorization Number has been issued by HSM, request for respite services must be submitted via the web.

Dates of Service - Indicate date service will start and the date thru which the service is requested.

Units - Record the total number of units requested. Please do not exceed the maximum units allowed.

CLINICAL INFORMATION

Psychiatric History - List a brief history of the youth's psychiatric care.

Current Behavior - List a detailed explanation why the youth requires this intensity of services.

Previous Admission - List all admissions within the last three months for psychiatric treatment. Include shelters, group or foster homes, detention centers, training schools or outpatient therapy.

Discharge Plans - List any discharge plans.

Location and Distance - List the county and state the youth resides, and the approximate distance the family member must travel to the facility for family sessions.

NOTES:

- A copy of an independent evaluation completed by a psychiatrist or psychologist, which indicates the need for psychiatric residential treatment and the potential for benefit from psychiatric residential treatment, must be attached to this form. This evaluation must be performed within the last 60 days prior to the proposed admission date.
- The MYPAC Waiver's Medical Director must attest to the clinical information in the request, that a copy of an independent evaluation is attached to the request, and sign and date page two of request form (space provided).

Instructions for Completing the HealthSystems of Mississippi MYPAC Additional Medical Information Form

NOTE: The Additional Medical Information Form serves two purposes as noted below.

1. Serves as an **attachment** to the MYPAC Admission Certification Request Form or to the MYPAC Continued Care Certification Request Form when additional space is needed.
2. Serves as a form to submit additional information requested by HSM and required to complete the review process.

NOTE: Please do not resubmit the MYPAC Admission Certification Request Form or MYPAC Continued Care Certification Request Form when additional information is requested by HSM.

Section I Beneficiary Information

1. **Youth's Name** - Enter the youth's last and first name. If the youth has an active MS Medicaid number record the name as it appears on the Mississippi Medicaid ID card.
2. **MS Medicaid #** - If the youth has an active MS Medicaid number, enter the number that appears on the MS Medicaid ID card. If the youth does not have an active number, LEAVE BLANK.
3. **Check if Medicaid applied for** - Check the box if the youth does not have an active Mississippi Medicaid ID.
4. **Enter HSM Pseudo #** - Enter the temporary number assigned by HSM in this space.
5. **Date of Birth** - Enter the month, date, and year of the youth's birth.
6. **Sex** - Indicate the sex of the youth.
7. **Age** - Enter the age of the youth at the time service is to be rendered.
8. **Admit Date** - Enter the actual admission date.
9. **Date This Information Submitted** - Enter the date in which you submit additional information.

Section II Provider Information

1. **MYPAC MS Medicaid Number** - Enter the MYPAC Waiver Medicaid provider number.
2. **MYPAC Provider Name** - Enter the name of the MYPAC Waiver provider.
3. **Requester's Name** - Enter the name of the individual who is primary contact for this case.
4. **Phone #** - Enter the requester's telephone number, including area code and extension, if applicable.

Section III Additional Medical Information

1. **Information Requested by** - Enter the name or number of the HSM reviewer that requested the additional information (if applicable).
2. **Additional Medical Information** - Enter all information requested and any additional supporting documentation to support the medical necessity for certification.

HealthSystems of Mississippi
MYPAC CONTINUED STAY/RECERTIFICATION REQUEST FORM

Beneficiary Name: _____ MS Medicaid #:

CLINICAL INFORMATION

Current Behavior: *Please provide a detailed explanation why the beneficiary continues to require this intensity of services:*

Treatment Plans and response to treatment for past review period *(please check one and indicate percentage):*

- Successfully met all goals and objectives for this treatment intervention and care setting. _____ % (80 – 100)
- Partially met goals and objectives for this treatment intervention and care setting. _____ % (51 – 79)
- Minimally met goals and objectives for this treatment intervention and care setting. _____ % (11 - 50)
- No progress evident. _____ % (0 - 10)

Explain: _____

Specifically, why does the beneficiary need continued MYPAC services? Please describe what will be the focus of continued MYPAC services. _____

Anticipated Discharge Date: <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"/>	
Anticipated Discharge To: <i>(Please check one)</i>	Follow Up/Step Down Care <i>(Check all that apply)</i>
<input type="checkbox"/> Acute Care Specify Facility: _____	<input type="checkbox"/> Case Management <input type="checkbox"/> Family Therapy
<input type="checkbox"/> Custody DHS Specify County: _____	<input type="checkbox"/> Day Treatment - CMHC <input type="checkbox"/> Group Therapy
<input type="checkbox"/> Custody DYS <input type="checkbox"/> Shelter	<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Med Management
<input type="checkbox"/> Home with Family <input type="checkbox"/> Independent Living	<input type="checkbox"/> Vocational Rehab <input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Group Home <input type="checkbox"/> Left AMA	
<input type="checkbox"/> Foster Home	

Please attach copies of the following with this form:

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

Comments:

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.

Instructions for Completing the HealthSystems of Mississippi MYPAC Waiver Continued Stay/Recertification Request Form

YOUTH'S INFORMATION

Youth's Name - Enter the youth's last and first name. If the youth has an active Medicaid number record the name as it appears on the Mississippi Medicaid ID card.

MS Medicaid # - If the youth has an active MS Medicaid number, enter the number that appears on the MS Medicaid ID card. If the youth does not have an active number, LEAVE BLANK.

Check If no active Medicaid # - Check the box if the youth does not have an active Mississippi Medicaid ID.

Soc. Sec. # - If Mississippi Medicaid has been applied for, enter the youth's social security number.

Date of Birth - Enter the month, date, and year of the youth's birth.

Sex - Indicate the sex of the youth.

Age - Enter the age of the youth at the time service is to be rendered.

Guardian/Representative Name - Enter the name of the youth's legal guardian/representative.

Guardian/Representative Address - Enter the mailing address of the guardian/representative.

PROVIDER INFORMATION

MYPAC MS Medicaid Number - Enter the MYPAC Waiver Medicaid provider number.

MYPAC Provider Name - Enter the name of the MYPAC Waiver provider.

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

Requester's Name - Enter the name of the individual who is primary contact for this case.

Phone # - Enter the requester's telephone number, including area code and extension, if applicable.

PHYSICIAN INFORMATION

Medical Director Name - Enter the name of MYPAC Waiver provider's Medical director.

Medical Director Address - Enter this information only if the MYPAC Waiver provider's Medical Director's Ms Medicaid ID number is unavailable.

Medical Director MS Medicaid# - Enter the MS Medicaid ID number of the Medical Director.

Medical Director Phone # - Enter the phone number of the MYPAC Waiver provider's Medical director.

Medical Information

Date of Admission - Enter the month, date and year of the planned admission.

Last Date Certified - Enter the thru date of the Treatment Authorization Number for the admission.

Treatment Authorization Number - Enter the Treatment Authorization Number given for the admission.

Diagnosis/Multi-Axis - Enter the youth's current diagnoses (five parts of multi-axial).

ICD - 9-CM Codes - Enter the ICD-9-CM codes that correspond with each of the listed diagnosis.

REQUESTED SERVICES

The following information must be submitted for each type of service requested. Please note that once a Treatment Authorization Number has been issued by HSM, request for respite services must be submitted via the Web.

Dates of Service - Indicate date service will start and the date thru which the service is requested.

Units - Record the total number of units requested. Please do not exceed the maximum units allowed.

CLINICAL INFORMATION

Current Behavior - List a detailed explanation why the youth continues to require this intensity of services.

Treatment Plans and response to treatment - List the treatment plans and response to treatment from admission to present. Check the appropriate level of goals met; successfully is 80% - 100%; partially 51% - 79%; minimally 50% or less; none 10% or less.

Reason for continued services - List the specific goals to be met.

Anticipated Discharge Date - List the anticipated discharge date.

Anticipated Discharge Plans -

- Discharge To: List the place of discharge - Select one.
- Follow Up/Step Down Care: Check the box(es) that apply to what has been agreed upon with family and facility for the beneficiary.

Attachments - Include current ISP indicating the necessity of continuing the current level of care, dated no more than 30 days from the date of this request; current CANS - MH, dated no more than 60 days from the date of this request; WRAP meeting notes for the past two meetings, one of which must be within the last 30 days.

Comments - Any additional information HSM should know, that has not been previously provided.

HealthSystems of Mississippi MYPAC Reconsideration Request Form

YOUTH'S INFORMATION	PROVIDER INFORMATION
<p>Youth's Name: <i>(Please Print)</i></p> <p>_____</p> <p>MS 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"/><input type="text"/></p> <p>Check if Medicaid # applied for: <input type="checkbox"/> Enter HSM Pseudo #:</p> <p>HSM Pseudo #: <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"/></p> <p>Date of Birth: <input type="text"/><input type="text"/>/<input type="text"/><input type="text"/>/<input type="text"/><input type="text"/></p> <p>Sex: <input type="checkbox"/> Age: <input type="text"/><input type="text"/></p>	<p>MYPAC MS Medicaid #:</p> <p><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"/></p> <p>MYPAC Provider Name: <i>(Please Print)</i></p> <p>_____</p> <div style="border: 1px solid black; padding: 5px;"> <p><i>For HSM Use Only:</i> <input type="checkbox"/> Telephone Request</p> <p>Time of Request: <input type="text"/><input type="text"/>:<input type="text"/><input type="text"/> <input type="text"/> a.m. <input type="text"/> p.m.</p> </div>

REQUEST INFORMATION		
<p>Request Date:</p> <p><input type="text"/><input type="text"/>/<input type="text"/><input type="text"/>/<input type="text"/><input type="text"/></p>	<p>Requester's Information: <i>(Please Print)</i></p>	<p>Attending Physician Information: <i>(Please Print)</i></p>
<p>Method:</p> <p><input type="checkbox"/> Fax</p> <p><input type="checkbox"/> Mail</p>	<p>Name: <i>(First, Last)</i></p>	<p>Name: <i>(First, Last)</i></p>
<p>Requested By:</p> <p><input type="checkbox"/> MYPAC Provider</p> <p><input type="checkbox"/> Beneficiary/Representative</p>	<p>Telephone Number:</p> <p>(_____) _____ - _____</p> <p>Ext. _____</p>	<p>MS Medicaid #:</p>

RECONSIDERATION INFORMATION	
<p>Date of denial notification: <input type="text"/><input type="text"/>/<input type="text"/><input type="text"/>/<input type="text"/><input type="text"/></p>	<p>Date of Admission: <input type="text"/><input type="text"/>/<input type="text"/><input type="text"/>/<input type="text"/><input type="text"/></p>
<p>Rationale/medical reason for disagreement: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>Is additional information being submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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.

Instructions for Completing the HealthSystems of Mississippi MYPAC Reconsideration Request Form

Section I Youth's Information

1. **Youth's Name** - Enter the youth's last and first name. If the youth has an active MS Medicaid number record the name as it appears on the Mississippi Medicaid ID card.
2. **MS Medicaid #** - If the youth has an active MS Medicaid number, enter the number that appears on the MS Medicaid ID card. If the youth does not have an active number, LEAVE BLANK.
3. **Check if Medicaid applied for** – Check the box if the youth does not have an active Mississippi Medicaid ID.
4. **Enter HSM Pseudo** - Enter the temporary number assigned by HSM in this space.
5. **Date of Birth** – Enter the month, date, and year of the youth's birth.
6. **Sex** - Indicate the sex of the youth.
7. **Age** - Enter the age of the youth at the time service is to be rendered.

Section II Provider Information

1. **MYPAC MS Medicaid Number** - Enter the MYPAC Waiver Medicaid provider number.
2. **MYPAC Provider Name** - Enter the name of the MYPAC Waiver provider.

DO NOT COMPLETE THE “*For HSM Use Only*” section.

Section III Request Information

1. **Request Date** - Record the date of the request in month, day, and year format.
2. **Method** – Indicate whether request is submitted by fax or mail.
3. **Requested By** - Indicate whether the MYPAC Waiver provider or beneficiary/representative made the request for reconsideration.
4. **Requester's Name** - Enter the name of the individual requesting the review.
5. **Requester's Telephone Number** - Enter the telephone number of the requester including area code and extension, if applicable.
6. **Attending Physician's Name** - Enter the name of the attending physician..
7. **Attending Physician's MS Medicaid #** - Enter the attending physician's Mississippi Medicaid provider number.

Section IV Reconsideration Information

1. **Date of Denial Notification** - Enter the date of denial as printed on the letter.
2. **Date of Admission** - Enter the date the patient was admitted to the MYPAC Waiver provider, i.e., the first “from date”.
3. **Rationale for Request** - Enter the medical basis/rationale for disagreement with the denial determination.
4. **Additional information submitted** - Indicate whether additional information was submitted with the request for reconsideration.