

HealthSystems



HealthSystems
OF MISSISSIPPI

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

Psychiatric Residential Treatment Facility 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 Psychiatric Residential Treatment Facilities (PRTF) 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 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>.

Psychiatric Residential Treatment Facility (PRTF) services are available for Mississippi Medicaid beneficiaries under the age of 21.

PRTF admissions are not considered emergent in nature and must be precertified with HSM.

Request for precertification are submitted to HSM following:

- Completion of an independent evaluation performed within 60 days prior to the proposed admission date. The psychiatric evaluation must be performed by a psychiatrist or a licensed psychologist and must include IQ testing, or
- Addendum of an independent evaluation that is greater than 60 days prior to the proposed admission date. The addendum must include a clinical summation and recommendations for care, or
- A pre-discharge recommendation if the beneficiary is in an acute care setting prior to request for placement in the PRTF facility, and
- Discussion between the assessing clinician and the youth's legal guardian, or representative/responsible party, and
- Agreement between the attending physician, the PRTF provider and the youth's legal guardian, or representative/responsible party regarding the services.
- The proposed admission date should be in the future and should allow HSM three business days to process. The review request should be no more than two weeks from the proposed admission date.

III. Information You Need to Know

Required forms and instructions are included in this manual and can be downloaded from the HSM Web site at www.hsom.org.

A dedicated PRTF fax number is provided to assist with certification needs. Although we can accept mailed requests, fax submission provides the most expedient response to your request. The table below lists fax and phone numbers, and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
PRTF 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 business day. Fax: 1-888-204-0504 Mail: Attn: HSM – PRTF 175 East Capitol Street Suite 250, Lock Box 13 Jackson, MS 39201
Helpline	Used by providers for questions regarding the precertification process and to obtain assistance.	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	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
Retrospective Review Request Submission	Used by providers to submit retrospective review requests.	Attn: HSM – PRTF Retrospective Review 175 East Capitol Street Suite 250, Lockbox 13 Jackson, MS, 39201

Electronic Helpline Inquiries

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries and to check the status of reviews at any time. One of the benefits to providers who are enrolled to use the electronic Web system 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.

IV. PRTF Review Exclusions

Medicaid policy exempts certain encounters from HSM review and the provider should not submit review requests for these situations. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

Reason	Description
No Medicaid Eligibility	No HSM review is allowed if the beneficiary does not have Medicaid eligibility for the encounter timeframe.
Medicare Eligibility	No HSM review is allowed if the beneficiary has Medicare Part A and Part B coverage for the encounter timeframe and the Medicare benefits are not exhausted.
Adult Beneficiaries	No HSM review is required for beneficiaries who have attained age 21. PRTF services are not available for age 21 and over.
Family Planning Waiver	No HSM review is required if the beneficiary's Medicaid eligibility is only for the family planning waiver.

V. Precertification Review Process

A. Requests for Precertification Review

Providers submit requests for review directly to HSM. Reviews may be submitted by fax or mail. Please refer to Forms and Instructions section of this manual for the approved forms or the forms may be downloaded from the HSM Web site at www.hsom.org.

PRTFs must also submit a monthly census report to HSM no later than the last day of the month. The report must list current patients, new admissions (including date of admission) and discharges (including discharge date). The census report can be downloaded from our 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 called 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. If a retroactive determination of Medicaid eligibility is made after the beneficiary was admitted and discharged, a request for retrospective review is submitted to HSM.

It is the responsibility of the PRTF to request continued stay review at least five business days prior to the next review point (Last Day Certified). As a reminder, HSM provides all facilities with a daily list of beneficiaries whose certification expires within five calendar days. The PRTF should:

- Verify or correct the admit date for each beneficiary listed.
- Access HSM's Web system's reports module and enter the discharge date for each beneficiary that has been discharged or fax the list to HSM within one working day.

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 for providers without Web technology.

Review Type	Timeframe	Required Documentation
Preadmission Review	At least three business days prior to PRTF admission.	<ul style="list-style-type: none"> • Completed HSM Medicaid Admission Review Form: PRTF. • A copy of an independent evaluation performed within 60 days prior to the 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 a current update or addendum. The addendum must include the clinical summation and recommendation for the care. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • A pre-discharge recommendation in lieu of the independent evaluation will be accepted if the beneficiary is in an acute care setting prior to placement in the PRTF facility.

Review Type	Timeframe	Required Documentation
Continued Stay Review	At least five business days prior to the last date certified by HSM.	<ul style="list-style-type: none"> • Completed HSM Medicaid Continued Stay Review Form: PRTF. • Date and length of each therapy session. • Notation of the child's current clinical status as evidenced by his/her signs and symptoms. • Content of each therapy session. • Statement summarizing the therapeutic intervention used during each therapy session, along with the child's response to the intervention, outcome of each session, and response to family/legal representative and others. • Statement summarizing the child's progress toward meeting treatment goals and objectives. • Progress toward meeting the discharge plan established in the initial treatment plan. • Family therapy notes which include participants, topics covered and location/type of therapy. • Updated discharge plan or discharge planning documentation. <p>For a request of continued stay beyond 180 days documentation must be in the clinical record that:</p> <ul style="list-style-type: none"> • Active treatment has taken place for the past 180 days and substantial progress has been made according to the plan of treatment and reason for admission. • The progress made is insufficient due to the complexity of the illness for the child to be discharged to a less restrictive level of care and clinical evidence supports that a longer period of PRTF services is beneficial. • Specific evidence is provided to explain the factors which interfered with treatment progress during the 180 days of PRTF care. • The request includes specific timeframes and a specific plan of treatment which will lead to discharge.
Retrospective Review	Within one year of DOM's retroactive Medicaid eligibility determination.	<ul style="list-style-type: none"> • Completed HSM Medicaid Admission Review Form: PRTF. • Statement indicating why the hospitalization was not precertified. • Copy of the complete medical record.

B. Processing of Review Request

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, physicians and physician consultants. These highly qualified professionals make certification review determinations for psychiatric residential treatment facility services. The following table describes our staff's functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> • Screen requests 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 screens. • May request additional information. • Approve services based on policy and criteria. • Refer requests that cannot be approved to a physician.
Second level Reviewers (Physician)	<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 attending physician 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 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 can not 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:	Clinical information required to complete the review is requested.	• Preadmission	One business day.
2. First level reviewer.		• Continued Stay	
3. Second level reviewer.		• Retrospective	Ten business days.

C. Notification of Review Outcome

HSM provides written notification of review results to providers and to the youth's legal guardian or representative/responsible party when services are denied. 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 PRTF provider, the attending physician, and the youth's legal guardian/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 youth's legal guardian/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 review outcome 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 attending physician. 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, a denial letter will be issued and reconsideration rights will apply. Written notification of denial determination is sent to the PRTF provider, attending physician and the youth's legal guardian/representative/responsible party. The youth's legal guardian/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.

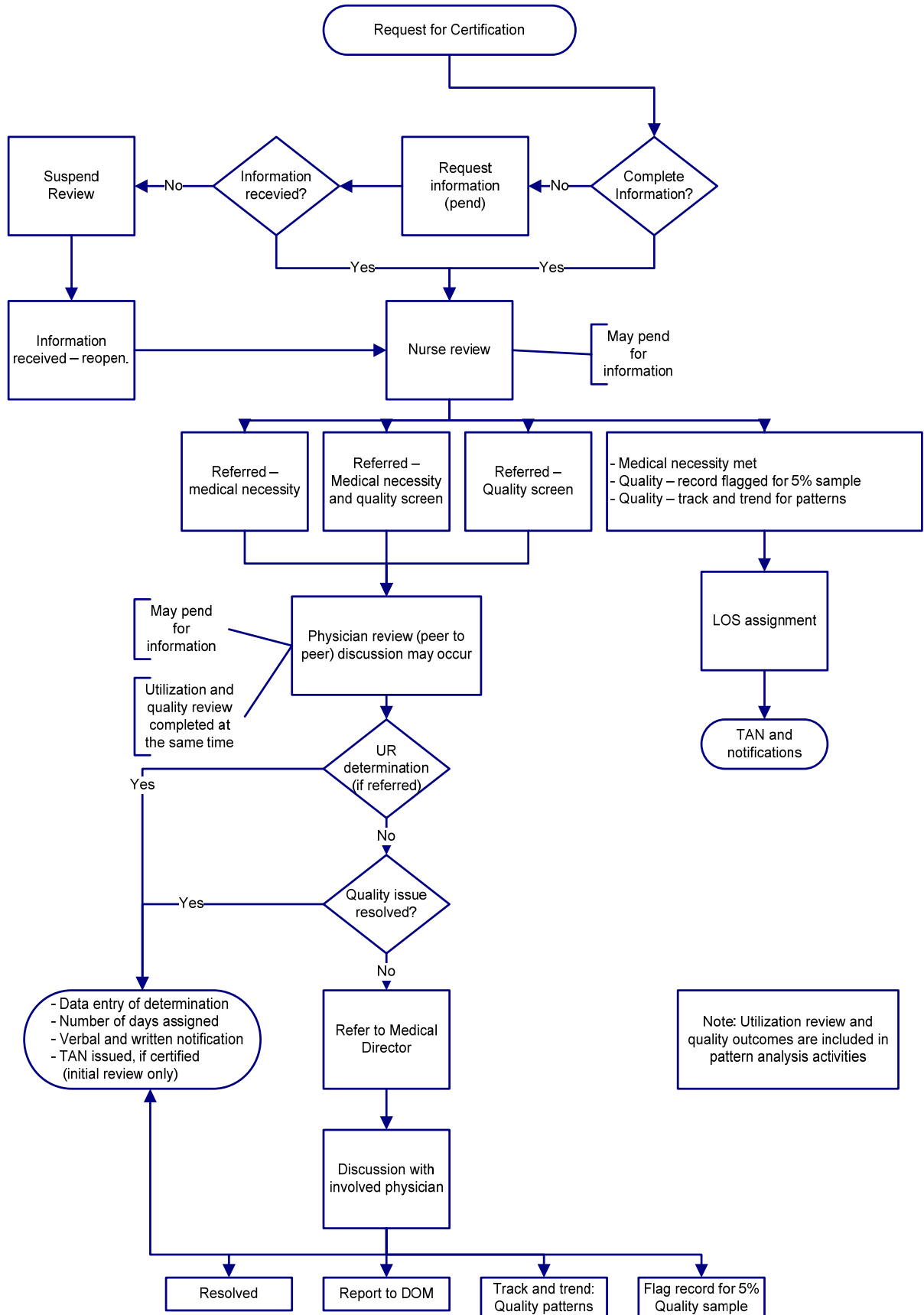
Review Type	Review Determination and Verbal Notification	Written Notification
<ul style="list-style-type: none"> Preadmission Continued Stay 	Within three business days of receipt of review request and necessary information.	Within one business day of review determination.
<ul style="list-style-type: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

Written notifications of review certification (approval) and determinations involving denial 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
Certification (Approval)	Date of notice	√	√
	Brief statement of HSM's authority and responsibility for review	√	√
	Reason for determination	√	√
	Date(s) of service approved	√	√
	Type service certified	√	√
	Number of units/days certified	√	√
	Total number and 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. Review Process Flow Chart



VI. Reconsideration Review Process

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

- Youth's legal guardian/representative/responsible party.
- PRTF Provider.
- Attending physician.

A second 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 modify, the youth's legal guardian or 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 PRTF 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. Quality sampling may include health care services provided to all age groups.

Please see the ***Quality Review 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.

IX. Forms and Instructions

- Monthly Census Report
- Precertification Review Request
- Continued Stay Review Request
- Additional Information

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
MEDICAID MONTHLY CENSUS REPORT**

*Psychiatric Residential Treatment Facilities (PRTFs) **must** submit a monthly census report to HSM indicating the current patients, new admits (including date) and discharges (including date). The report for the preceding month should be submitted to HSM **no later than the last day of every month**. Submit report to:*

**HealthSystems of Mississippi
175 E. Capitol Street, Suite 250, Jackson, MS 39201
ATTN: PRTF Census Report
FAX (601) 352-6358**

PRTF Name: _____ **Provider Number:** _____
Phone Number: _____ **Fax Number:** _____
CENSUS MONTH: _____ **REPORT DATE:** _____

CURRENT PATIENTS				
Name	Medicaid Number	Admit Date	Number of	
			Seclusion	Restraints

NEW ADMISSIONS					
Name	Medicaid Number	Admit Date	Planned D/C Date	Number of	
				Seclusion	Restraints

DISCHARGES				
Name	Medicaid Number	Admit Date	D/C Location	Discharge Date

Submitted by: _____ **Date:** _____

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Information	Provider Information
Beneficiary Name: _____	Facility 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"/>
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"/>	Facility Name: _____
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Physician Name: _____
Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>	Physician 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"/>
Beneficiary Account #: _____ <i>(if applicable)</i>	Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician
	Requester 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"/> <input type="text"/>
	Note: Attestation Statement on last page of form must be signed and dated by the physician.

Admission Information

Request Date: / /

Service Dates

Planned Date of Admission: / / Number of days requested:

Can the patient be managed in an outpatient or alternative level of care (if available)? Yes No IQ:

MEDICAL INFORMATION

Diagnoses and Procedures

Axis I (ICD-9-CM Codes)	Narrative Description <i>(Primary diagnosis cannot be substance abuse diagnosis.)</i>
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"/>

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____

Medicaid#: _____

PAST TREATMENTS

Did the youth receive related health care services prior to being recommended for PRTF services? Yes No Unknown
If yes, complete the following **Treatment History** section.

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

# Psychiatric Inpatient Admits	<input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6 or more	Latest Discharge Date <input type="text"/> / <input type="text"/> / <input type="text"/>
Other Care/Institution	<input type="checkbox"/> None <input type="checkbox"/> NF <input type="checkbox"/> ICF/MR <input type="checkbox"/> PRTF	<input type="text"/> / <input type="text"/> / <input type="text"/>

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

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

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 Psychiatric Residential Treatment Facility Precertification Plan of Care Form

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 |
| <input type="checkbox"/> 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"/>	<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 Psychiatric Residential Treatment Facility Precertification Plan of Care Form

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 Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____ Medicaid#: _____

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

Current Living Arrangement <i>(Select only one)</i>		
<input type="checkbox"/> Alone	<input type="checkbox"/> Foster Home	<input type="checkbox"/> Shelter
<input type="checkbox"/> With Spouse	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Assisted Living Facility
<input type="checkbox"/> Parent / Guardian	<input type="checkbox"/> Friend	<input type="checkbox"/> Personal Care Home
	<input type="checkbox"/> Group Residential Facility	<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"/>		
<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 Psychiatric Residential Treatment Facility Precertification Plan of Care Form

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

Physician Attestation, Signature and Date

A physician who attests to prescribed psychiatric residential treatment facility 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.

Physician'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.

HealthSystems of Mississippi

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

Section I Beneficiary Information

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

Section II Provider Information

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

Section III Admission Information

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

Section IV Service Dates

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

Section V Medical Information

1. **ICD-9-CM Codes/Diagnoses/GAF Score** - Enter the ICD-9-CM code and narrative description for the beneficiary's diagnoses for Axis I, Axis II, Axis III, and Axis IV. For Axis V, record the beneficiary's baseline and current Global Assessment of Functioning (GAF) scores.

Section VI Treatment History

1. **Past Treatments:**
 - A. **Did the youth receive other related health care services prior to being recommended for PRTF services?** - Indicate whether the beneficiary received other health care services related to the current primary diagnosis prior recommendation for this admission. If yes, complete the **Treatment History** section.
2. **Treatment History:**
 - A. **Psychiatric Inpatient Admits/Latest Discharge Date** - Indicate the number of psychiatric inpatient hospitalizations within the last year. Record the discharge date for the most recent psychiatric inpatient hospitalization.
 - B. **Other Care/Institution/Latest Discharge Date** - Indicate whether the beneficiary received other care and type of institution, if applicable. Record the date of most recent discharge from that care, if applicable.
 - C. **Other Treatment and Settings: Community Mental Health Center, Outpatient Hospital Provider, Private Practice and Discharge Date** - Complete the grid, indicating all types of care and applicable setting in which the beneficiary received care within the last year. Indicate the discharge date or leave the date blank if the beneficiary is receiving active care.

Section VII Current Symptoms/Behavior

Complete the grid by indicating the beneficiary's current symptoms/behavior regarding danger to him or herself and/or to others. Select a valid value (0-5) for each listed area.

Section VIII Behavioral/Evidence

The behavior/evidence section includes presence of ideations and/or intentions, previous attempts/gestures, presence of plan, access to and lethality of intended means, ability to contract for safety and other social supports such as family. Complete the grid by indicating the behavior or evidence demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

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

Section IX Current Psychological Stressors/Events

Complete the grid by indicating all applicable current psychological stressors/events. If none of the listed options are selected, check “other” and specify the stressors/events in the space provided.

Section X Current Functioning

Current physical/cognitive function and verbal interactions are recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

Section XI Current Communication

Current ability to communicate with others is recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-2) for each listed area.

Section XII Current Drug Use

Current drug use is recorded in this section. Complete the grid by indicating the whether the beneficiary is currently using illegal drugs and whether use occurred within the past 24 hours or within the past 30 days. Select a valid value (0-3) for each drug listed.

Section XIII Current Skill/Ability Assessment

Complete the grid by indicating the results of the beneficiary’s current skills and ability assessment. Select a valid value (0-4) for each listed area.

Section XIV Current Work/School Schedule

1. **Employment/School Hours per Week** – Indicate whether the beneficiary is employed or in school and the numbers of hours per week. Check only one option.
2. **Employment Type** – Indicate whether the beneficiary is in school or the employment type. Check only one option.
3. **Date of Last Employment and Occupation**– If the patient is **no longer employed**; indicate the date of last employment and the beneficiary’s occupation.

Section XV Current Living Arrangement

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

Section XVI Resource/Needs Assessment

Complete the grid by indicating the results of the beneficiary’s resource/needs assessment. Select a valid value (0-4) for each listed area.

Section XVII Studies/Labs/X-rays

Record the date, name and results/findings of diagnostic studies, lab and x-ray tests that are associated with the primary diagnoses. Be sure to include pertinent abnormal results.

Section XVIII Medications

1. **Medication List** – Complete the medication grid by recording the date of order, the medication’s name, dosage, frequency, and route. If the medication was discontinued prior to submission of the review request, record the date of discontinuation. Include oral “stat” medications and adjustments to routine medications.
2. **Is the beneficiary compliant with home medications?** Indicate whether the beneficiary has been compliant with home medications.
 - A. If **yes**, this section is complete.
 - B. If **no**, indicate the length of time of the non-compliance.

Section XIX Treatment Plan/Frequency

List all planned treatment beginning with those related to the current diagnosis/diagnoses. Include up to five of the most urgent goals that will address specifically the diagnosis/diagnoses and specific reason for this service level.

Section XX Family Therapy

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

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

Section XXI Discharge Plans

1. **Will/can the beneficiary return to current living arrangements?** Indicate whether the beneficiary will/can return to his or her current living arrangements.
2. **Anticipated Discharge Date** – Record the anticipated discharge date.
3. **Anticipated discharge to:** - Indicate the anticipated discharge location or care arrangement. If the beneficiary is transferred to an acute care hospital, record the hospital's name in the space provided. If the beneficiary is released to custody of DHS or DYS, record the county. If none of the listed options are appropriate, check "Other" and specify the location in the space provided.
4. **Anticipated Follow-Up Care** - Indicate the anticipated follow-up care for the beneficiary. If none of the listed options are selected, check "Other" and specify the anticipated follow-up plans in the space provided.

Section XXII Clinician Attestation, Signature and Date

1. **Signature of MYPAC Medical Director and Date** - When submitting certification requests by fax or mail the MYPAC Waiver provider's medical director must sign this form. Although the form can be completed by any MYPAC staff responsible for supporting certifications for proposed services to Medicaid beneficiaries, the medical director must validate that the information documented on this form is correct to the best of their knowledge and that the information to be submitted to HSM is medically necessary.

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

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Continued Stay Plan of Care

Beneficiary Information	Provider Information
Beneficiary Name: _____	Facility 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"/>
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"/>	Facility Name: _____
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Physician Name: _____
Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>	Physician 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"/>
Beneficiary Account #: _____ <i>(if applicable)</i>	Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician
	Requester 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"/>
	Note: Attestation Statement on last page of form must be signed and dated by the physician.

Continued Stay Information

Request Date: / / Treatment Authorization Number (TAN):

Admit Date: / / Last Day Certified: / / Additional Days Requested:

New Diagnosis Since Last Review

New Axis I (ICD-9-CM)	New Diagnosis Narrative Description	Date Identified
1.		
2.		
3.		
New Axis II (ICD-9-CM)	New Diagnosis Narrative Descriptions	Date Identified
1.		
2.		
3.		
New Axis III (ICD-9-CM)	New Diagnosis Narrative Descriptions	Date Identified
1.		
2.		
3.		
New Axis IV (ICD-9-CM)	New Diagnosis Narrative Descriptions	Date Identified
1.		
2.		
3.		
Axis V	Base line GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>	Current GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>
Date of Procedure	ICD-9-CM Codes	Procedure Description <i>(If Applicable)</i>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

HealthSystems of Mississippi

Psychiatric Residential Treatment Facility Continued Stay Plan of Care

Beneficiary Name: _____ Medicaid#: _____

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

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"/>
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"/>

HealthSystems of Mississippi

Psychiatric Residential Treatment Facility Continued Stay Plan of Care

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, cont.	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"/>
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"/>

HealthSystems of Mississippi

Psychiatric Residential Treatment Facility Continued Stay Plan of Care

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 Skill/Ability Assessment					
	0 Unable to Assess	1 None	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"/>
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"/>

**HealthSystems of Mississippi
Psychiatric Residential Treatment Facility Continued Stay Plan of Care**

Beneficiary Name: _____ Medicaid#: _____

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"/>		

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"/>
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<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Continued Stay Plan of Care

Beneficiary Name: _____ Medicaid#: _____

RESPONSE TO TREATMENT PLAN FOR PREVIOUS 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. *Explain below.* _____ % (0 - 10)

FAMILY THERAPY: Please list the date(s) family therapy was provided during the prior review period.

Therapy Dates	Check one of the following			Therapy Dates	Check one of the following		
	Face to Face	Phone	Waiver		Face to Face	Phone	Waiver
<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"/> / <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"/> / <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"/>				<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"/> / <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"/> / <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"/>			
<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"/> / <input type="checkbox"/> <input type="checkbox"/>			

CURRENT TREATMENT PLAN/FREQUENCY

(Include treatment related to the current diagnosis. Include up to five of the most urgent goals.)

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Continued Stay Plan of Care

Beneficiary Name: _____ Medicaid#: _____

DISCHARGE PLANS

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

Anticipated Discharge Date: / /

Anticipated Discharge to: *(Check one)*

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Acute Care
<input type="checkbox"/> Custody DHS
<input type="checkbox"/> Custody DYS
<input type="checkbox"/> Home with family
<input type="checkbox"/> Group home
<input type="checkbox"/> Foster home
<input type="checkbox"/> Shelter
<input type="checkbox"/> Independent living
<input type="checkbox"/> Left AMA
<input type="checkbox"/> Other: <i>(Specify.)</i> | Facility: _____
County: _____

<input type="checkbox"/> Case Management
<input type="checkbox"/> Day Treatment - CMHC
<input type="checkbox"/> DME
<input type="checkbox"/> Family Therapy
<input type="checkbox"/> Follow-Up w/PCP /Specialist
<input type="checkbox"/> Follow-Up w/Pharmacy
<input type="checkbox"/> Group Therapy
<input type="checkbox"/> Home Health
<input type="checkbox"/> Individual Therapy
<input type="checkbox"/> Other: <i>(Specify.)</i> | <input type="checkbox"/> Med Management
<input type="checkbox"/> PDN
<input type="checkbox"/> OT/PT/ST Outpatient Therapy
<input type="checkbox"/> SNF/NH
<input type="checkbox"/> Substance Abuse Counseling
<input type="checkbox"/> Vocational Rehab |
|--|---|--|

Physician Attestation, Signature and Date

A physician who attests to prescribed psychiatric residential treatment facility 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.

Physician'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.

HealthSystems of Mississippi

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

Section I Beneficiary Information

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

Section II Provider Information

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

Section III Continued Stay Information

1. **Request Date** - Enter the date of the request in month, day, and year format.
2. **Date of Admit** - List the date services began for the admission for which continued services are requested and for which a treatment authorization number (TAN) was previously issued.
3. **Treatment Authorization Number** - This is the TAN number provided to you during the initial precertification review.
4. **Last Day Certified** - Enter the last date that was certified for the previous review.
5. **Additional Days requested** - Enter the number of additional days for which certification is requested for this hospitalization.

Section IV Medical Information

1. **ICD-9-CM Codes/Diagnoses/GAF Score** - Enter the ICD-9-CM code and narrative description for any new diagnoses identified since the previous review for Axis I, Axis II, Axis III, and Axis IV. Record the date that the new diagnosis was first noted in the medical record. For Axis V, record the beneficiary's baseline and current Global Assessment of Functioning (GAF) scores.
2. **Date of Procedure** - Enter the date of any procedure required by the beneficiary during the prior review period and any scheduled to occur. List the ICD-9-CM code and description of the procedure. Please attach an additional information form if more space is needed.
3. **Specifically, why does the beneficiary need continued PRTF services? Please describe what will be the focus of continued PRTF services.** Record a response in the space provided.

Section V Current Symptoms/Behavior

Complete the grid by indicating the beneficiary's current symptoms/behavior regarding danger to him or herself and/or to others. Select a valid value (0-5) for each listed area.

Section VI Behavioral/Evidence

The behavior/evidence section includes presence of ideations and/or intentions, previous attempts/gestures, presence of plan, access to and lethality of intended means, ability to contract for safety and other social supports such as family. Complete the grid by indicating the behavior or evidence demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

Section VII Current Psychological Stressors/Events

Complete the grid by indicating all applicable current psychological stressors/events. If none of the listed options are selected, check "other" and specify the stressors/events in the space provided.

Section VIII Current Functioning

Current physical/cognitive function and verbal interactions are recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

Section IX Current Communication

Current ability to communicate with others is recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-2) for each listed area.

HealthSystems of Mississippi
Instructions for Completing the Psychiatric Residential Treatment Facility Continued Stay Plan of Care Form

Section X Current Skill/Ability Assessment

Complete the grid by indicating the results of the beneficiary's current skills and ability assessment. Select a valid value (0-4) for each listed area.

Section XI Resource/Needs Assessment

Complete the grid by indicating the results of the beneficiary's resource/needs assessment. Select a valid value (0-4) for each listed area.

Section XII Studies/Labs/X-rays

Record the date, name and results/findings of diagnostic studies, lab and x-ray tests that are associated with the primary diagnoses. Be sure to include pertinent abnormal results.

Section XIII Medications

1. **Medication List** – Complete the medication grid by recording the date of order, the medication's name, dosage, frequency, and route. If the medication was discontinued prior to submission of the review request, record the date of discontinuation. Include oral "stat" medications and adjustments to routine medications.

Section XIV Response to Treatment Plan for Previous Review Period

Please evaluate and provide the percentage of completion of the overall treatment plan as a whole in which treatment interventions were requested during the previous review period. Example: If all goals and objectives were met during the previous review period select option

1. If no progress was made and option 4 was selected, provide an explanation. Available options are listed below.
 - A. Successfully met all goals and objectives.
 - B. Partially met goals and objectives.
 - C. Minimally met goals and objectives.
 - D. No progress evident.

Section XV Family Therapy

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

Section XVI Current Treatment Plan/Frequency

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

Section XVII Discharge Plans

1. **Will/can the beneficiary return to current living arrangements?** Indicate whether the beneficiary will/can return to his or her current living arrangements.
2. **Anticipated Discharge Date** – Record the anticipated discharge date.
3. **Anticipated discharge to:** - Indicate the anticipated discharge location or care arrangement. If the beneficiary is transferred to an acute care hospital, record the hospital's name in the space provided. If the beneficiary is released to custody of DHS or DYS, record the county. If none of the listed options are appropriate, check "Other" and specify the location in the space provided.
4. **Anticipated Follow-Up Care** - Indicate the anticipated follow-up care for the beneficiary. If none of the listed options are selected, check "Other" and specify the anticipated follow-up plans in the space provided.

Section XVIII Clinician Attestation, Signature and Date

Signature of PRTF Attending Physician and Date - When submitting certification requests by fax or mail the attending physician must sign this form. Although the form can be completed by any PRTF staff responsible for supporting certifications for proposed services to Medicaid beneficiaries, the attending physician must validate that the information documented on this form is correct to the best of their knowledge and that the information to be submitted to HSM is medically necessary.

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

