Instructions for Completion of BHSF Form 142-C

All items which apply to the patient and the facility must be legible and properly completed.

Certification of Need is a requirement of federal regulations found at 42 CFR 441.152. Specifically, the need for inpatient psychiatric services **must** be established and documented by a team of professional personnel, as described below. Accordingly, the form must contain the signatures and credentials of either independent or interdisciplinary team members who are knowledgeable of the circumstances necessitating admission.

The composition of the appropriate professional team is dependent upon the status of the patient's Medicaid certification at the time of admission.

Independent Team

Certification for an individual who is a Medicaid recipient at the time of admission **must** be made by an **independent team** consisting of a physician licensed to practice in Louisiana and another professional, including an RN, BCSW, MSW, Psychologist, or Licensed Professional Mental Health Counselor. Additionally, this team must have: (1) competence in the diagnosis and treatment of mental illness, preferably in child psychiatry; and (2) knowledge of the individual's situation.

NOTE: **NO member of the independent team may be employed by or have a consultant relationship with the admitting hospital.**

Admitting Hospital Interdisciplinary Team

Certification for an individual who applies for Medicaid at or during admission **may** be made by the admitting hospital's **interdisciplinary** team. At a minimum, this team **must** include either (1) a Board-eligible or Board certified psychiatrist; **OR** (2) a clinical psychologist who has a doctoral degree **and** is a licensed physician; **OR** (3) a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases **and** is a psychologist who has a master's degree in clinical psychology and who has been certified by the State or by the State psychological association. The team must also include (1) an RN with specialized training or one year's experience in treating mentally ill individuals; **OR** (2) a psychiatric social worker, a licensed occupational therapist with specialized training or one year's experience in treating mentally ill individuals, or a psychologist with a master's degree in clinical psychology or who has been certified by the State or the State psychological association.

To obtain pre-certification authorization of admission, submit this form with other supporting documentation to the state fiscal intermediary:

Magellan of Louisiana
8550 United Plaza Blvd, Suite 410
Baton Rouge, LA 70810
Fax: 888-656-4961

Payment **will not** begin until the date of the **last** signature.

Louisiana's MEDICAID PROGRAM
Certification of Need for Psychiatric Hospitalization

Patient's Name________________________DOB:___/____/____SS #:_____-______-_________

Facility:______________________________Provider #:______________DOA:___/_____/_____

Hospital Treating Physician:____

Type of Care:____(Substance or Mental Disorder)

DSM IV-TR Axis I Diagnosis and ICD-9 Code:____

Primary Reason for Admission:____

Admission

- ❑ Patient is currently Medicaid eligible – 13-digit Medicaid ID #:_____________________
- ❑ Patient is applying for Medicaid for Medicaid – Application Date:___/____/_____
- ❑ Emergency admission (Note: Supporting documentation **must be** attached.)
- ❑ Court-ordered admission (NOTE: These admissions are subject to the listed criteria to qualify for Medicaid reimbursement.)

The patient named above **requires** care in a mental facility /program. The following requirements are met:

1. Ambulatory care resource available in the community have been tried **or** are currently inadequate to meet the treatment needs of this patient (the availability or lack of outpatient resources in not a determining factor for Medicaid reimbursement); **and**
2. Proper treatment of this patient's psychiatric condition **requires** services on an in-patient basis under the direction of a psychiatrist or a physician under the supervision of a psychiatrist; **and**
3. The services can be expected to improve this patient's condition within a **reasonable** period of time **or** prevent further regression to the extent that services will no longer be needed.

Independent Team
(Not Associated with Admitting Hospital – If Medicaid Certified)

Date___/___/___ ____(signature)
____(name & credentials)
Date___/___/___ ____(signature)
____(name & credentials)

Admitting Hospital Interdisciplinary Team
(If Not Medicaid Certified)

Date___/___/___ ____(signature)
____(name & credentials)
Date___/___/___ ____(signature)
____(name & credentials)
Date___/___/___ ____(signature)
____(name & credentials)

(Certification by the appropriate team **cannot be made earlier than five (5) days** prior to admission. A **minimum** of two signatures are required. Se reverse for specific instructions.)