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:

Molina
Attn: Pre-Certification Unit
8591 United Plaza Blvd., Suite 100
Baton Rouge, LA 70809
FAX 1+800+717-4329

Medicaid 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 III – R 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. See reverse for specific instructions.)