

## Extension Certification Authorization For Continued Inpatient Psychiatric Care

LAST NAME		FIRST NAME		MEDICAID ID (PIC)	
ADDRESS				RESIDED AT ADDRESS>60 DAYS Yes <input type="checkbox"/> No <input type="checkbox"/>	
CITY		STATE	ZIP CODE	COUNTY OF RESIDENCE	CSO IF KNOWN
DATE OF BIRTH	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	SOCIAL SECURITY NUMBER		HOSPITAL	
DATE OF ADMISSION		LEGAL STATUS <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary			
<b>Eligibility Status REQUIRED FOR ITA CLAIMS</b> <input type="checkbox"/> Currently receiving public assistance. <input type="checkbox"/> Applied for public assistance eligibility on ____ date. <input type="checkbox"/> Mental state and condition prevents efforts to determine eligibility (72 hours allowed) <input type="checkbox"/> Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hour allowed) <input type="checkbox"/> Client or responsible party refuses to apply for resources.					
DIAGNOSIS CODE(s)					
REQUESTED DAYS (COVERED)		FROM	TO	NUMBER OF DAYS	
Determination Status <input type="checkbox"/> Approve <input type="checkbox"/> Deny			Authorization Number:		
On this date, a utilization review to assess the need for continuation of psychiatric inpatient care was completed. All required Extension clinical information was reviewed by the MHD Designee. Based upon this information, the above name individual: <input type="checkbox"/> CONTINUES or <input type="checkbox"/> NO LONGER MEETS MEDICAL NECESSITY					
EXTENSION DAYS AUTHORIZED (Covered)		FROM	TO	NUMBER OF DAYS	
ADMINISTRATIVE EXTENSION DAYS AUTHORIZED (Covered):		FROM	TO	NUMBER OF DAYS	
EXTENSION DAYS NOT AUTHORIZED (Non-Covered):		FROM	TO	NUMBER OF DAYS	
Discharge Date: <input type="checkbox"/> Early Discharge <input type="checkbox"/> Left Against Medical Advice					
SIGNATURE OF MHD DESIGNEE		PRINT/TYPE NAME		TITLE	
MHD DESIGNEE ORGANIZATION NAME (RSN)			TELEPHONE NUMBER		DATE
Extension Request due date:					

**Form Instructions**  
**Extension Certification**  
**For Admission to Inpatient Psychiatric Care**

**Purpose:** The Extension Certification is the MHD designee's approval for care for continued inpatient psychiatric admission. The MHD designee certifies the professional's decision regarding the medical necessity for continued inpatient psychiatric care for a client. Copies of a completed Extension Certification form should be kept in the client's hospital file. The MHD designee will also keep a copy. In order to meet federal, state and MHD Designee requirements, the form must be completed in its entirety.

The Extension Certification form is to be utilized statewide. The following information must be completed on each form and submitted with the associated claim or a claim cannot be processed and will be denied. The hospital must be prepared to provide client information on the Extension Certification form as well as the Clinical Data identified in the Inpatient Psychiatric Billing Instructions. At its discretion, an MHD designee may require additional information from the hospital in order to make determinations.

**Form distribution:** The hospital contacts the MHD designee, providing the designee with all of the required client information and clinical data. The MHD designee sends the completed form to the hospital, retaining necessary copies for designee use. All completed Extension Certification forms must accompany the claims related to the dates authorized for payment to be rendered.

**INFORMATION TO BE PRESENTED TO MHD DESIGNEE BY HOSPITAL:**

**Last Name:** The client's Last name.

**First Name:** The client's first name.

**Medicaid ID (PIC):** This is the Patient Identification Code which is obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "**JA 011060 JONES A**".

**Address:** The client's address at time of hospitalization.

**Resided at Address>60 days:** If client has resided at given address more than 60 days, check Yes. If not, check No

**Zip Code:** The client's zip code at time of hospitalization.

**County of Residence:** The county from which the client's medical card was issued.

**CSO (if known):** The DSHS Community Service Office from which the client's medical card was issued.

**DOB:** The client's date of birth.

**GENDER:** The client's gender.

**SSN:** The client's Social Security Number.

**Hospital Name:** The name of the hospital where services are to be provided.

**Date of Admission:** The date the client was admitted to inpatient psychiatric care.

**Legal Status:** The client's legal status which is either voluntary or involuntary. Involuntary legal status applies to only those clients who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW.

**Eligibility Status REQUIRED FOR ITA CLAIMS:** This section *replaces* the Involuntary Treatment Act Patient Claim Form DSHS 13-628. One of the following boxes must be checked for ITA claim payment.

- Currently receiving public assistance...
- Applied for public assistance eligibility on \_\_\_\_\_ date
- Mental state and condition prevents efforts to determine eligibility (72 hours allowed)
- Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hours allowed)
- Client or responsible party refuses to apply for resources

**Diagnosis:** Diagnosis used to reflect the client's principal diagnosis and reason for admission.

**Requested Length of Stay:** The maximum number of days requested, followed by the start and end dates which reflect DSHS 13-822 (10/2007)

the number of days requested.

**TO BE COMPLETED BY MHD DESIGNEE**

**Determination Status:** The MHD designee must mark approve or deny.

**Authorization Number:** The number issued by the MHD designee (RSN of residence) referencing the current episode of inpatient care.

**Certification Statement:** The proclamation by MHD designee that the client does or does not meet Medical Necessity. For a client to be found to meet Medical Necessity, the following must be true:

- Ambulatory care resources available in the community do not meet the treatment needs of the client, AND
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist, AND
- The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning, AND
- The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) which is considered a principal covered diagnosis (see Diagnostic Categories page 23) and warrants extended care in the most intensive and restrictive setting; OR
- The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); OR
- The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care

**Days Authorized:** The maximum number of the requested days that are authorized by the MHD designee for the extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of day authorized.

**Administrative Days Authorized:** If applicable, the maximum number of the requested days that are authorized by the MHD designee at the administrative bed day rate (Revenue Code 0169) for the extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of administrative days authorized.

**Days Not Authorized:** The number of the requested days that are not authorized by the MHD designee for extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the number of days not authorized.

**Discharge Date:** The date the client was discharged, specifying if discharge was early or against medical advise.

**MHD Designee Signature:** The signature of the MHD designee approving the number of extension days allowed. A physician's signature is required for any denials (clients determined to not meet medical necessity).

**Print/Type Name:** The printed or typed name of the person who signed as the MHD designee.

**MHD Designee Organization Name:** The name of the Regional Support Network serving through contract as the MHD designee.

**Telephone:** Telephone number of person who signed as MHD designee.

**Date:** The date the form was signed.

**Extension Request due date:** The date a request for an extension must be submitted to the MHD designee.