STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
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Bill J. Crouch
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Cynthia E. Beane
Commissioner

WEST VIRGINIA TITLE XIX MEDICAID PROGRAM
DETERMINATION OF MEDICAL NECESSITY FOR INPATIENT/RESIDENTIAL SERVICES FOR INDIVIDUALS UNDER 21

Mail or fax to: KEPRO
1007 Bullitt Street, 2nd Floor
Charleston, WV 25301
Fax: 1-866-473-2354
Telephone: (304) 346-6732 or 1-800-378-0284

Federal Regulation (42 CFR) **Subpart D, Inpatient Psychiatric Services for Individuals under the Age of 21 in Psychiatric Facilities or Programs**, Section 441.151, **General Requirements.** (a) Inpatient psychiatric services for individuals under age 21 must be (4) Certified in writing to be necessary in the setting in which the services will be provided. The West Virginia Title XIX Medicaid Program utilizes the MCM-1 to meet the requirement for certification of inpatient services in a Medicaid-approved psychiatric facility for individuals under the age of 21 years. The MCM-1 must be completed **BEFORE** authorization or admission to the facility. The MCM-1 must be forwarded to the above Utilization Management Contractor upon completion to the above number. The **ORIGINAL** MCM-1 is forwarded to the admitting facility for the individual's medical record. Review for admission will not be available unless this evaluation has been submitted.

I. Referral Information: Admitting Facility: _____
Type of Service requested: Acute ( ) Residential (PRTF) ( ) Subacute ( )

Person and Agency making referral:	**Parent/Legal Guardian**:
Name: _____	Name: _____
Agency: _____	Agency: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____

II. Member Information:

Member's Name:_____ DOB _____Medicaid No. _____

Member's Name: _____

III. <u>Presenting Problem</u>:

Current symptoms:

_____
_____
_____
_____
_____
_____

Diagnosis: (Utilizing DSM-5 or ICD-10 Codes)

_____
_____
_____
_____
_____
_____

Treatment to date:

_____
_____
_____
_____
_____

Proposed discharge plan:

_____
_____
_____
_____
_____
_____

Member's Name: _____

IV. Physician's Certification

I certify that the member meets **all of the following criteria:**

1.) This member's psychiatric condition and related health care needs are essentially as indicated in the above information; and

2.) Outpatient care available in the community does not meet the treatment needs of the member; and

3.) Appropriate treatment of the member's psychiatric condition requires inpatient services under the direction of a physician; and

4.) The services can reasonably be expected to improve the member's condition or prevent further regression so that services will no longer be needed.

Evaluation date: _____

Physician's signature: _____

Physician's name (Please type or print) _____

Physician's address: _____

Face-to-face Evaluation: Yes ( ) No ( )