



## ***Certification of Need for Psychiatric Hospitalization***

All items that 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 certification at the time of admission.

### **Independent team**

Certification for an individual who is a 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 a registered nurse, board-certified social worker, medical social worker, 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:

- Board-eligible/certified psychiatrist.
- Clinical psychologist who has a doctoral degree and is a licensed physician.
- Licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases and who is a psychologist with a master's degree in clinical psychology and has been certified by the state or by the state psychological association.

The team must also include:

- A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
- 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 precertification authorization of admission, submit this form with other supporting clinical documentation to the Precertification Unit for Healthy Blue via fax at **1-844-432-6027**.

Medicaid payment will not begin until the date of the last signature.

**<https://providers.healthybluelouisiana.com>**

Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

BLAPEC-1984-20 August 2020

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_

Social Security number: \_\_\_\_\_ Facility: \_\_\_\_\_

Provider number: \_\_\_\_\_ Date of arrival: \_\_\_/\_\_\_/\_\_\_

Hospital treating physician: \_\_\_\_\_

Type of care: \_\_\_\_\_  
(substance or mental disorder)

Diagnostic and statistical manual of mental disorders DSM-5 diagnosis and ICD-10  
code:

Primary reason for admission: \_\_\_\_\_

**Admission**

(Please select appropriate check box below.)

- Patient is currently Medicaid-eligible:  
13-digit Medicaid ID #: \_\_\_\_\_
- Patient is applying 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, and the following  
requirements are met:

- Ambulatory care resources 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 is not a determining factor for Medicaid reimbursement).
- Proper treatment of this patient's psychiatric condition requires services on an inpatient  
basis under the direction of a psychiatrist or a physician under the supervision of a  
psychiatrist.
- 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: \_\_\_\_\_ Name/credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Name/credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

**Admitting hospital interdisciplinary team**

(If not Medicaid-certified)

Date: \_\_\_\_\_ Name/credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Name/credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Name/credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

I attest that all of the independent team requirements noted above have been fully met. These requirements include the required makeup of the independent team, licensure requirements, and acknowledgement that no member of the team has any employment or consulting relationship with the admitting facility.

Date: \_\_\_\_\_ Name/credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

To be completed by the facility intake coordinator or designee.