Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

CRITERION 5

Criterion 5 is a rule that establishes conditions for continued inpatient stay in a psychiatric facility. Under this rule, Transition Services reimbursement may be utilized for continued non-acute, psychiatric inpatient hospitalization when there is a clear absence of appropriate community-based services available if discharge were to occur. This service is targeted towards Medicaid recipients age 17 and under who no longer meet the criteria for acute care, but require transitional services from the acute care setting in order to implement their individual discharge plan and remain safe. The purpose of the service is to provide continued treatment in a safe environment, maintain the therapeutic gains acquired during the acute inpatient stay, and avoid decompensation or regression while working towards discharge to a lower level of care. The LME/MCO has authority to authorize the use of Transition Services reimbursement to the hospital for continued stay services rendered.

The acute care facility provider must request continuation of service, up to 7 days, under Criterion 5 (Y2343) by completing this form and sending into our secure UM address at UM@TrilliumNC.org.

Required documents for review include the Criterion 5 Service Needs/Discharge Planning Status Form, which must be signed by a Trillium Care Coordinator, and a copy of the hospital discharge plan. The care manager at the acute care facility may submit reauthorization requests in Provider Direct, up to 7 days, providing updated information regarding placement efforts and transition plans for discharge.

Completion Instructions for Criterion 5 Service Needs/Discharge Planning Status Form:

Identifying Data

Please fill in name, date of birth, age, and Medicaid number of the recipient. The "Admission Date" is the date of recipient's admission into current facility. The "Decertification Date" is the date of the last bed day approved by Trillium Utilization Management. The "Type of Residence" refers to the recipient's location when admitted to the hospital (e.g. Family Home, Level III Group Home, Therapeutic Foster Care), while the "County of Residence" refers to the county in which the recipient's Medicaid is active.

Section I

For an initial request, check all services that are needed for recipient; identify those that are not expected to be available and indicate anticipated date of availability if known.

Section II

The date should reflect the date of the weekly progress update, and the recipient status should reflect a recipient status for each service indicated in Section I. For instance, if it is indicated in Section I that the client requires Day Treatment, Section II should indicate the status of the application for that service, such as the client being on a waiting list. "Steps Taken to Obtain Necessary Service" should indicate QP/case manager efforts such as contacting the LME/MCO to locate providers and dates appropriate providers were contacted as well as when the client referral was sent. "Anticipated Date of Availability" should be an update of the date indicated in Section I under each identified service need.

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Criterion #5
Service Needs/ Discharge Planning Status Form

In order for this form to be processed, all blanks must be completed and legible.

Recipient Name:_____ Date of Birth:_____ Age:____Medicaid#:_____

Admission Date:_____Decertification Date:_____County of Residence:_____

Type of Residence at Time of Admission:_____

Section I(Complete when requesting initial authorization)

Check if Needed	Service	Service Available Yes	Service Available No	If no, Anticipated Date of Availability
☐	Outpatient Treatment: Type:_____	☐	☐	
☐	Community Support/	☐	☐	
☐	Assertive Community Treatment	☐	☐	
☐	Day Treatment	☐	☐	
☐	Intensive In Home	☐	☐	
☐	Multisystemic Therapy	☐	☐	
☐	Residential Treatment Level: _____	☐	☐	
☐	PRT (Psychiatric Residential Treatment Facility)	☐	☐	
☐	Psychiatric Evaluation and Medication Management	☐	☐	
☐	Respite	☐	☐	
☐	SAIOP	☐	☐	
☐	SACOT	☐	☐	
☐	Other (Identify):_____	☐	☐	
☐	Other (Identify):_____	☐	☐	
☐	Other (Identify):_____	☐	☐	

Section II (Update Information for reauthorization and discharge)				
Date	**Recipient Status**	**Service Required (Checked Above)**	**Steps Taken to Obtain Necessary Service**	**Anticipated Date of Availability**

Is the patient at risk of decompensating if services are not available: ☐ Yes ☐ No;
Explain stating specific behaviors:

LME/MCO Signature/Title:_____ Date:_____

Print Name:_____ Telephone: _____ FAX:_____

I have reviewed this form and I am aware of the efforts that the LME/MCO is undertaking.

Hospital Name:_____

Hospital Signature/Title:_____ Date: _____