



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Jim Justice
Governor

Bureau for Medical Services
350 Capitol Street - Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1451

Bill J. Crouch
Cabinet Secretary

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

Mail or fax to: KEPRO
100 Capitol Street, Suite 600
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: _____
Agency: _____
Address: _____
Phone: _____

Name: _____
Agency: _____
Address: _____
Phone: _____

II. Member Information:

Member's Name: _____ DOB _____ Medicaid No. _____

Member's Name: _____

III. Presenting Problem:

Current symptoms:

Diagnosis: (Utilizing DSM-5/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 ()