



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
BUREAU FOR MEDICAL SERVICES

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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, 2<sup>nd</sup> 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: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

II. **Member Information:**

Member's Name: \_\_\_\_\_ DOB \_\_\_\_\_ Medicaid No. \_\_\_\_\_

Member's Name: \_\_\_\_\_

**III. Presenting Problem:**

Current symptoms:

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

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Treatment to date:

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Proposed discharge plan:

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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 ( )