471-000-89 Instructions for Completing Form MC-14, "Confidential Report"

Use: An Institution for Mental Disease (IMD) uses Form MC-14 to determine the initial need for inpatient psychiatric care. The psychiatrist completes Form MC-14 within 48 hours after the client's admission to the IMD, or at the time the client applies for Medicaid, if this date is later than the date of admission. The 48-hour period does not include weekends or holidays.

Number Prepared: One original and two copies of Form MC-14 are prepared.

Completion: Form MC-14 is completed as follows:

Item 1: Enter all identifying information as indicated. Include the client's eligibility date if available.

Item 2: The client's facility social worker completes and signs this item.

Items 3-12: The psychiatrist completes these items. Medicaid requires a primary psychiatric diagnosis in Item 7 to justify medical necessity for inpatient psychiatric services. The psychiatrist must complete all areas under Item 12.

Signature: The psychiatrist must sign and date Form MC-14. Other professionals sharing in the determination may also sign Form MC-14. Signatures and dates must be legible.

Distribution and Retention: The IMD retains the original copy of Form MC-14 as a permanent part of the client's medical record. The IMD sends a copy to the Medicaid Division. The Division retains the copy of Form MC-14 for ten years after the last activity.

CONFIDENTIAL REPORT

For use in Certifying the Need for Inpatient Psychiatric Care

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Facility Name, Address and Phone Number	Name of Client	
	Social Security Number	
	D.O.B.	Admission Date
	Sex ❑ Male ❑ Female	County
	Name and Address of Examining Physician	
Eligibility Date		

The individual named above is an applicant for or recipient of assistance. The findings which you are asked to report on this form are used to determine eligibility for inpatient psychiatric care. It is important that your report be specific enough to indicate the kind and extent of treatment and services required.

2. SOCIAL HISTORY (Identify dysfunctions and problem behaviors related to the psychiatric diagosis. Include relevant biopsychosocial information.)

Sign Here ▸ _____
Social Worker

3. MEDICAL HISTORY (Give pertinent history of major diseases and operations, including previous inpatient care. Include psychiatric history).

4. PHYSICAL FINDINGS (Complete for each individual)

Height_____ Weight_____ Pulse_____ Blood Pressure_____

a. Respiratory

b. Gastro-intestinal

c. Genito-urinary

d. Cardio-vascular

e. Neurological, muscular and skeletal

5. MENTAL STATUS:

6. PERTINENT LABORATORY FINDINGS, INCLUDING X-RAY, EKG, AND EEG (When such procedures have been required)

MC-14 Rev. 3/04 (56058)
(Use previous version 6/00 was obsolete)

7. DIAGNOSIS (Please list all diagnosis) Primary (Psychiatric)	Secondary

8. TREATMENT PLAN:

9. PROGNOSIS:

10. DIET AND DRUGS PRESCRIBED:

11. COMMENTS:

12. CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES:

A. Are ambulatory care resources available in the community able to meet the treatment needs of the patient? ❑ Yes ❑ No

B. Does proper treatment of the recipient's psychiatric condition require services on an inpatient basis under the direction of a physician? ❑ Yes ❑ No

C. Can the inpatient services being sought reasonably be expected to improve the patients' condition, or prevent further regression so that inpatient hospital services will no longer be needed? ❑ Yes ❑ No

Sign Here ▸ _____

Psychiatrist's Signature — Date

Sign Here ▸ _____

Signature of Other Professional (Sharing in the above determination) — Title — Date

Sign Here ▸ _____

Signature of Other Professional (Sharing in the above determination) — Title — Date

RETURN TO: Health and Human Services, Finance and Support, Medicaid Division, P.O. Box 95026, Lincoln, NE 68509-5026