Montana Medicaid Youth Prior Authorization Request Form
Psychiatric Residential Treatment Facility (PRTF)

Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.

☐ (124) PRTF Services

TYPE OF REVIEW: ☐ Prior Authorization ☐ Retro-eligibility

REQUEST SUBMITTED BY

It is recommended that a licensed or a supervised in-training mental health professional complete the authorization request, however it is not required.

FIRST NAME:		**LAST NAME:**	
CREDENTIALS: ☐ RN ☐ LCSW ☐ LPC/LCPC ☐ Licensed Psychologist ☐ MD ☐ Other:			
PHONE:	**EXT:**	**FAX:**	**EXT:**

YOUTH RECIPIENT INFORMATION

RECIPIENT LAST NAME:		**FIRST:**	**MIDDLE:**
DATE OF BIRTH:	**AGE:**	**MEDICAID NUMBER:**	**SSN:**

GENDER:
☐ Male ☐ Female

RACE: ☐ African American ☐ Alaskan Native ☐ Asian American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Unknown ☐ Other:

LIVING ARRANGEMENTS:	**STATE CUSTODY:** ☐ Yes ☐ No
CUSTODY: ☐ DOC ☐ CFSD ☐ Juvenile Probation ☐ Parent ☐ Tribal ☐ Unknown ☐ Other:	**TRIBAL AFFILIATION?**
ADDRESS 1:	**ADDRESS 2:**

CITY:	**STATE:**	**ZIP:**	**PHONE:**

RESPONSIBLE PARTY

Responsible party information will be used for all correspondence including letters indicating authorization and determination decisions.

RELATIONSHIP:	**LAST NAME:**	**FIRST NAME:**	**ORGANIZATION NAME:**
ADDRESS 1:		**ADDRESS 2:**	

CITY:	**STATE:**	**ZIP:**	**PHONE:**

To transmit request information:
Fax: 1-800-639-8982
Phone: 1-800-770-3084

CASE MANAGER

CASE MANAGER? ☐ Yes ☐ No	LAST NAME:	FIRST NAME:	AGENCY:
ADDRESS 1:		ADDRESS 2:	
CITY:	STATE:	ZIP:	PHONE:

REQUESTOR'S INFORMATION (ADMITTING FACILITY)

REQUESTOR/AGENCY NAME:		NPI #:	IS PROVIDER IN-STATE? ☐ Yes ☐ No
ADDRESS 1:		ADDRESS 2:	
CITY:	STATE:	ZIP:	
PHONE:	EXT:	FAX:	EXT:

If you are an out-of-state provider, has the recipient been denied for clinical or for bed availability criteria by all in-state Residential Treatment facilities? ☐ Yes ☐ No

Interstate Compact Agreement is attached with request if out-of-state PRTF is requested. ☐ Yes ☐ No

TREATMENT HISTORY

Service	Name of Facility	Admit Date	Discharge Date (if applicable)	Reason for Treatment

Less restrictive services are documented to be insufficient to meet the individual's severe and persistent clinical needs?

☐ Yes ☐ No **Please Describe:**

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DSM-V CODES AND DESCRIPTIONS			
Primary Diagnosis			
CODE:		**DESCRIPTION:**	
CODE:		**DESCRIPTION:**	
CODE:		**DESCRIPTION:**	
CODE:		**DESCRIPTION:**	
CODE:		**DESCRIPTION:**	
CODE:		**DESCRIPTION:**	
CODE:		**DESCRIPTION:**	

Criteria Text	**Criteria Description**
☐ Problems with primary support group?	
☐ Problems related to the social environment?	
☐ Educational problems?	
☐ Occupational problems?	
☐ Housing problems?	
☐ Economic problems?	
☐ Problems with access to health care services?	
☐ Problems related to interaction with the legal system/crime?	
☐ Other psychosocial and environmental problems	

SED (SERIOUS EMOTIONAL DISTURBANCE)

List specific behaviors that demonstrate moderate or severe impairments:

(1) "Serious Emotional Disturbance" (SED) means with respect to a youth from the age of 6 through 17 years of age that the youth meets the requirements of (A) and (B). Serious emotional disturbance (SED) with respect to a youth under six years of age requires that the youth meet the criteria of (C) only.

☐ A. The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-V classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

- ☐ A1. Childhood Schizophrenia (F20.9, F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F25.0, F25.1, F25.8).
- ☐ A2. Bipolar and Related Disorders (F31.12, F31.13, F31.2, F31.32, F31.4, F31.5, F31.62, F31.63, F31.64, F31.73, F31.75, F31.77, F31.81, F31.89, F34.0).
- ☐ A3. Depressive Disorders (F32.1, F32.2, F32.3, F32.4, F33.1, F33.2, F33.3, F33.41, F34.1, F34.8).
- ☐ A4. Anxiety Disorders (F41.0, F41.1, F93.0).
- ☐ A5. Obsessive-Compulsive and Related Disorders (F42).
- ☐ A6. Trauma and Stressor Related Disorders (F43.10, F43.11, F43.12, F94.1, F94.2).
- ☐ A7. Dissociative Disorder (F44.81).
- ☐ A8. Feeding and Eating Disorders (F50.01, F50.2, F50.8).
- ☐ A9. Gender Dysphasia (F64.1, F64.2, F64.8).
- ☐ A10. Neurodevelopmental Disorders (F84.0, F90.0, F90.1, F90.2).
- ☐ A11. Disruptive, Impulse-Control, ad Conduct Disorders (F91.3, F63.81).

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SED (SERIOUS EMOTIONAL DISTURBANCE)

☐ B. As a result of the youth's diagnosis determined in (1)(a) and for a period of at least 6 months, or for a predictable period over 6 months, the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

- ☐ B1. Has failed to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures.
- ☐ B2. Has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships.
- ☐ B3. Has failed to demonstrate a developmentally appropriate range and expression of emotion or mood.
- ☐ B4. Has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings.
- ☐ B5. Has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or
- ☐ B6. Has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

☐ C. Serious emotional disturbance (SED) with respect to a youth under six years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least 6 months or is predicted to continue for a period of at least 6 months, as manifested by one or more of the following:

- ☐ C1. Atypical, disruptive or dangerous behavior which is aggressive or self-injurious.
- ☐ C2. Atypical emotional responses which interfere with the child's functioning; such as, an inability to communicate emotional needs and to tolerate normal frustrations.
- ☐ C3. Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual.
- ☐ C4. Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction.
- ☐ C5. Indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or
- ☐ C6. Inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers.

(2) A youth must be reassessed annually by a licensed mental health professional, as to whether or not they continue to meet the criteria for having a serious emotional disturbance. For the initial or for an annual reassessment, the clinical assessment must document how the youth meets the criteria for having a serious emotional disturbance.

Reason for Admission:

Substantiate the youth's SED diagnosis and functional impairment in a narrative using youth specific behaviors and/or symptoms and timeframe. Include a description of why he/she requires PRTF level of care. (Behaviors and/or symptoms must be of a severe and persistent nature and require 24-hour treatment under the direction of a physician)

If a compromised academic performance is part of the clinical presentation, is there an IEP in place? ☐ Yes ☐ No

If NO, does the treatment plan include a referral for an IEP in writing by the parents or legal guardian to the Home district?

☐ Yes ☐ No **OTHER:**

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MENTAL STATUS

Appearance:
- ☐ Well Groomed
- ☐ Casual
- ☐ Other:
- ☐ Unkempt
- ☐ Bizarre

Level of Consciousness:
- ☐ Alert
- ☐ Lethargic
- ☐ Other:
- ☐ Confused
- ☐ Distracted
- ☐ Hypervigilant

Orientation:
- ☐ Person
- ☐ Place
- ☐ Other:
- ☐ Time
- ☐ Situation

Speech:
- ☐ Normal Rate & Rhythm
- ☐ Hyperverbal
- ☐ Hypoverbal
- ☐ Pressured
- ☐ Other:
- ☐ Loud
- ☐ Soft
- ☐ Slurred
- ☐ Coherent

Mood:
- ☐ Appropriate
- ☐ Depressed
- ☐ Hostile
- ☐ Anxious
- ☐ Euphoric
- ☐ Other:
- ☐ Preoccupied
- ☐ Labile
- ☐ Withdrawn
- ☐ Suspicious

Affect:
- ☐ Appropriate
- ☐ Blunted
- ☐ Constricted
- ☐ Flat
- ☐ Labile
- ☐ Other:
- ☐ Euphoric
- ☐ Suspicious
- ☐ Anxious
- ☐ Sad
- ☐ Guarded

Concentration:
- ☐ Preoccupied
- ☐ Short Attention Span
- ☐ Other:
- ☐ Focused
- ☐ Distracted

Thought Content/Process:
- ☐ Appropriate
- ☐ Intact/Organized
- ☐ Circumstantial
- ☐ Tangential
- ☐ Other:
- ☐ Loose Associations
- ☐ Rumination
- ☐ Disorganized
- ☐ Flighty/Racing Thoughts
- ☐ Cognitive Distortion

Hallucinations:
- ☐ Visual
- ☐ Auditory
- ☐ Olfactory
- ☐ Tactile

If experiencing hallucinations, are they baseline? ☐ Yes ☐ No
Is there presence of command hallucinations? ☐ Yes ☐ No
Explain:

Delusions:
- ☐ Not Present
- ☐ Somatic
- ☐ Persecutory
- ☐ Other:
- ☐ Religious
- ☐ Sexual
- ☐ Paranoid

Memory:
- ☐ No Impairments
- ☐ Other:
- ☐ Recent Memory Impairment
- ☐ Remote Memory Impairment

Insight:
- ☐ Good
- ☐ Other:
- ☐ Impaired
- ☐ Poor

Decision Making:
- ☐ Adequate
- ☐ Other:
- ☐ Impaired

Precautions:
- ☐ Suicide
- ☐ Other:
- ☐ Aggression
- ☐ Elopement

Precaution Intervals:
- ☐ Q15 Minutes
- ☐ Q30 Minutes
- ☐ Other:
- ☐ Q1 hour
- ☐ Routine

Specify other precautions:

SUBSTANCE ABUSE

Substance abuse history? ☐ Yes ☐ No Sobriety? ☐ Yes ☐ No

Name of Drug/Chemical	Date of First Use	Amount/Routine of Use	Date of Last Use	Length of Time at this Level of Use

BALC Done? ☐ Yes ☐ No If yes, enter level:

UDS Done? ☐ Yes ☐ No If yes, enter results:

Withdrawal Symptoms/Detox Meds ☐ Yes ☐ No If yes, then enter details below:

Vital Signs: **BP:** _____ **TEMP:** _____ **PULSE:** _____ **RESPIRATIONS:** _____

SCHEDULED MEDICATIONS

Date Span (REQUIRED)	Medications	Dose/Route	Frequency	Compliant	Drug Level

PRN MEDICATIONS (INCLUDES NOW AND STAT)

Medications	Dose/Route	Frequency	Date Given	Effectiveness

TREATMENT

Please List Treatment Plan/Goals

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TREATMENT
Does treatment plan include both individual and group psychotherapy? ☐ **Yes** ☐ **No** **List treatment modalities.**
Is there active involvement by family members and all pre-admission caregivers? ☐ **Yes** ☐ **No** **Please describe.**
Specialized Therapies: Please describe.
Legal Charges: Please describe.
Discharge Plan: Please describe.

CURRENT ADMISSION	
ADMIT TYPE: ☐ Court Committed ☐ Elective ☐ Emergency ☐ Involuntary ☐ Voluntary	
ADMIT TRANSFER FROM: ☐ Home ☐ Group Home ☐ Foster Home ☐ Crisis Unit ☐ Detention ☐ Hospital ☐ Unknown ☐ Other:	
PROPOSED ADMIT DATE:	**ESTIMATED LENGTH OF STAY:**

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Check the following box to indicate you understand you are required to contact the Magellan Medicaid Administration's Regional Care Coordinator (RCC) to participate in this youth's treatment team meetings or the youth's therapist is required to contact the RCC to update them on youth's treatment, at a minimum of, every 30 days.
☐ Yes, I understand we are required to contact this youth's RCC every 30 days.

Magellan Medicaid Administration's Use Only			
APPROVED:	**FROM:**	**THROUGH**:	
DENIED:	**FROM:**	**THROUGH:**	
REVIEWER SIGNATURE:			**DATE:**

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