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.

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|  | (124) PRTF Services |  |
| Type of review: | Prior Authorization | Retro-eligibility |

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| 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: |

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| 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: | |

| 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 | | | | | | | |

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| Treatment History | | | | |
| Service | Name of Facility | Admit Date | Discharge Date (if applicable) | Reason for Treatment |
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| Less restrictive services are documented to be insufficient to meet the individual's severe and persistent clinical needs? | |
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| Yes  No | Please Describe: |

| DSM-V Codes and Descriptions | | | | | |
| --- | --- | --- | --- | --- | --- |
| Primary Diagnosis | | | | | |
| CODE: | |  | Description: |  | |
| CODE: | |  | Description: |  | |
| CODE: | |  | Description: |  | |
| CODE: | |  | Description: |  | |
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| 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) | | | |
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| 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). |
|  |  | 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: | | |
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| 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: |  |

| 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 | Delusions:  Not Present  Somatic  Persecutory  Other: | Religious  Sexual  Paranoid |
| If experiencing hallucinations, are they baseline?  Yes  No  Is there presence of command hallucinations?  Yes  No  **Explain:** | |
| 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 | |
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| 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 |
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| PRN Medications (Includes now and stat) | | | | |
| --- | --- | --- | --- | --- |
| Medications | Dose/Route | Frequency | Date Given | Effectiveness |
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| Treatment |
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| Please List Treatment Plan/Goals |
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| Does treatment plan include both individual and group psychotherapy?  Yes  No  List treatment modalities. |
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| 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. |

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| Magellan Medicaid Administration’s Use Only | | | | | |
| Approved: | From: |  | Through: |  | |
| Denied: | From: |  | Through: |  | |
| Reviewer Signature: | | | | | Date: |