Psychiatric Residential Treatment Facilities
Prior Authorization Request

Healthy Blue	Sunflower Health Plan	United Healthcare/OptumHealth
Fax: 1-866-852-8976	Fax: 1-844-824-7705	Fax: 1-855-268-9392

Children's Mercy Pediatric Care Network Fax: 1-888-670-7260

CFR 441.152 Certification of need for services must be met.

Date (of in person PAR as defined in Provider Manual including mental status exam completed on same day):

Member Information

Member name:

Medicaid/ID number:

Member DOB:

Other health insurance: Select One

If yes, please list carrier(s)/policy number(s):

Member's current living situation: Choose One

Member's current custody status: Choose One

Name of parent/legal guardian:

Phone number for parent/legal guardian:

Current mailing address for parent/legal guardian:

Body Mass Index:

Height:

Weight:

IQ (if known):

Referring Concern/Presenting Problem:

☐ Child's current signs and symptoms meet criteria for a DSM diagnosis not solely due to Intellectual or Developmental Disability (IDD) and/or alcohol or drug use.

Statement of Concern:

Principal behavioral health diagnoses:

Primary:

Secondary:

Tertiary:

Dual diagnosis (i.e., intellectual disability, autism spectrum, substance abuse): Please add comments regarding specific treatment needs.

Please include any "Z" codes that are appropriate:

Current medications:

Recent Stressors adding to current behaviors:

Acute Level

(Checking any one of the following may exclude from admission to PRTF unless the PRTF has the capacity to provide care in such situations, for example, 1:1 staffing, crisis management, 24/7 nursing and physician coverage):

- ☐ Acutely suicidal or homicidal, acutely psychotic OR
- ☐ Acute substance use issues, OR
- ☐ Acute medical issues.

Behaviors/Symptoms of Concern for the Last 60 Days

(Mark all that apply to indicate acuity and chronicity of behaviors. Please describe frequency, intensity, duration of the behaviors in the last 60 days for each box checked including details in the text box.)

- ☐ Aggressive or assaultive behavior causing substantial harm to self, others, animals, property, and/or unresponsive to adult de-escalation or direction:
- ☐ Unable to maintain behavioral control for more than 48 hours that may cause acute risk of substantial harm to self or others or substantial dysfunction in the community:
- ☐ Pervasive rejection of adult requests, directions, and rules that puts the child, family or others at risk for substantial harm or dysfunction in the home, school or community:
- ☐ Hostile, threatening or intimidating behavior resulting in fear response in others:
- ☐ Delusions/hallucinations/psychotic symptoms causing substantial dysfunction in daily living:
- ☐ Fire setting/repeated property destruction:
- ☐ Chronic non-suicidal, injurious behaviors:
- ☐ Chronic suicidal and/or homicidal ideas, plans and/or behaviors, please include if a (name) screening has been done and the scores.
- ☐ Repeated arrests or confirmed illegal activity related to the psychiatric diagnosis that could place self/others at risk for substantial harm:
- ☐ Poor impulse control that does/could result in substantial harm to self or others and is unresponsive to adult intervention:
- ☐ Runaway that places self at risk for substantial harm:
- ☐ High-risk sexually inappropriate or abusive behavior:
- ☐ Support system unable or unavailable to manage intensity/safety regarding eating disorder symptoms:
- ☐ Substance use that exacerbates other psychiatric symptoms:
- ☐ Other behaviors of clinical concerns:

Summary of how the items checked impacts the request. Please add any additional comments that supports medical necessity for PRTF admission.

Trauma History:

Current Treatment/Support Services (utilized within less than 30 days) Community resources have been determined to not meet the current treatment needs of the child and family in the past 30 days, as evidenced by meeting ONE of the boxes (1-2) below. **Please attach a list of all services and dates of service in the last 30 days.** ☐ **Attachment**

☐ 1. The child's Community-Based Services Team (CBST) or current treatment team believes that all available and appropriate intensive community services have been tried without sufficient success for at least 30 days, by meeting BOTH boxes (a-b) below:

☐ a. Child and family has participated in community services for at least 30 days. Please address all listed services below. Not all services are required, but it needs to be made clear what available services are currently being used. If a service is not being used, explain why not (not available in the area, not applicable to individual's case, refused by family, etc.)

☐ **Individual Therapy**
If not checked, please provide rationale as to why service was not provided:

☐ **Family Therapy (with child present)**
If not checked, please provide rationale as to why service was not provided:

☐ **Family Therapy (without child present)**
If not checked, please provide rationale as to why service was not provided:

☐ **Group Therapy**
If not checked, please provide rationale as to why service was not provided:

☐ **Medication Management**
If not checked, please provide rationale as to why service was not provided:

☐ **Parent Peer Support**
If not checked, please provide rationale as to why service was not provided:

☐ **Intensive Outpatient Program**
If not checked, please provide rationale as to why service was not provided:

☐ **Substance Abuse Treatment — Residential**
If not checked, please provide rationale as to why service was not provided:

☐ **Substance Abuse Treatment — Outpatient**
If not checked, please provide rationale as to why service was not provided:

Serious Emotional Disturbance Waiver:

☐ **Wrap Around Facilitation**
If not checked, please provide rationale as to why service was not provided:

☐ **Parent Support**
If not checked, please provide rationale as to why service was not provided:

☐ **Independent Living Skills**
If not checked, please provide rationale as to why service was not provided:

☐ **Attendant Care**
If not checked, please provide rationale as to why service was not provided:

☐ **Respite Care**
If not checked, please provide rationale as to why service was not provided:

Community-Based Services:

☐ **Targeted Case Management**
If not checked, please provide rationale as to why service was not provided:

☐ **Community Psychiatric Supportive Treatment (CPST)**
If not checked, please provide rationale as to why service was not provided:

☐ **Psychosocial Rehabilitation**
If not checked, please provide rationale as to why service was not provided:

☐ **Family Preservation:**
If not checked, please provide rationale as to why service was not provided:

Intellectual/Developmental Disability Waiver:

☐ **Targeted Case Management**
If not checked, please provide rationale as to why service was not provided:

☐ **Overnight Respite**
If not checked, please provide rationale as to why service was not provided:

☐ **Personal Care Services**
If not checked, please provide rationale as to why service was not provided:

☐ **Crisis Services at the Community Level**
If not checked, please provide rationale as to why service was not provided:

☐ **Other Services Not Listed Above**

Service used:

List all dates this service was used in the last 30 days:

☐ **Qualified Residential Treatment Program:**

Admission date:

Discharge date:

Services provided within the program:

☐ **Youth Resource Center II:**

Admission date:

Discharge date:

Services provided within the program center:

If member currently receives behavioral health services from a community provider including a community mental health center (CMHC) or other community providers, please identify all community providers, the service(s) and length of time engaged in services: Choose an item

☐ b. Intensive community services have not produced substantive improvement in the child's behaviors and/or psychiatric symptoms. Please explain:

☐ 2. The child's psychiatric and/or psychosocial condition prohibit the child and family from utilizing community services, by meeting ONE of the boxes below:

☐ Multiple inpatient admissions prohibit child and family from utilizing consistent community services. Summarize how this impacts the request.

☐ Child's behaviors/psychiatric condition are so severe that they prohibit child and family from utilizing consistent community services. Summarize how this impacts the request.

☐ The families, schools, or community's efforts to manage the child's behaviors have exhausted all available and accessible resources. Summarize how this impacts the request.

☐ Other, please indicate any other barriers to community-based services.

Summary of how the items checked impacts the request. Please describe frequency, intensity, duration of the behaviors checked.

How has information been gathered? Check all that apply:

☐ Face-to-face ☐ Televideo ☐ Phone Call ☐ Other

Barriers to Treatment: Please list any known barriers to providing outpatient services (example: member location does not have the needed services available, member/guardian's refusal to engage in services, not currently living in a community setting, etc.).

PRTF services can be reasonably expected to improve the child's chronic condition or prevent further regression so that services will no longer be needed, as evidenced by meeting at least ONE of the boxes below:

- ☐ PRTF treatment is expected to increase the child's capacity to form therapeutic relationships and collaborate in their treatment, OR
- ☐ PRTF treatment is expected to increase the child's capacity to collaborate with their parents, teachers, coaches and other adults in their life, OR
- ☐ PRTF treatment is expected to increase the child's capacity to relate with peers in safe, satisfying and meaningful ways.

Treatment team's goals for PRTF treatment

Discharge Plan if the child meets this level of care

Medical Services (including special dietary needs)

Behavioral Services

Educational Needs

Developmental Needs

Psychosocial Needs

Legal Needs

Assessed for waiver needs

If services were obtained from a community provider, including community mental health center (CMHC) or other community providers, **different** than listed on Page 5, please select the appropriate provider:

Choose an item

Current Physical Health Conditions/Concerns

- ☐ Pregnant — number of weeks:
- ☐ Diabetes — insulin dependent: Choose One
- ☐ History of traumatic brain injury:
- ☐ Seizure disorder:
- ☐ Other (please describe):

Inpatient/Residential Treatment History

Please select all that apply:

- ☐ Inpatient psychiatry; dates if known:
- ☐ Psychiatric residential treatment facilities (PRTFs); dates if known:
- ☐ Substance abuse treatment — residential; dates if known:

Educational History:

Currently in school: Choose One

Current grade level:

Alternative school: Choose One

Current individual education plan/504 plan: Choose One

If no IEP/504 Plan, please explain:

Other school-based services/supports: Choose One If yes, please describe:

Full scale intelligence quotient (if known):

Other relevant educational history including truancy:

Placement History Less than 60 Days:

Other Services that Could Be Provided upon Diversion:

- ☐ Intensive outpatient program
- ☐ Substance abuse treatment
- ☐ Serious emotional disturbance waiver
- ☐ Community-based services
- ☐ Therapy (i.e., individual, family, group)
- ☐ Medication management
- ☐ Family preservation
- ☐ Intellectual/developmental disability services
- ☐ Crisis Services at the community level
- ☐ Other, please describe:

Assessor's Recommendation for Treatment and Justification for Decision:

Completed by:

Agency: Name/job title/Credentials:

Phone number: Fax Number:

Date:

If approved for the PRTF level of care, please list the PRTFs that the parent/guardian agreed to have their child referred to and MCO releases of information have been completed.

- ☐ KidsTLC
- ☐ EmberHope
- ☐ Florence Crittenton
- ☐ Camber - Hays
- ☐ Camber - Kansas City
- ☐ Kansas Renewal Institute (KRI)
- ☐ Lakemary Center
- ☐ Pathways Family Services
- ☐ Prairie View
- ☐ St. Francis

This form should be completed with current information in its entirety each time it is requested.