Psychiatric Residential Treatment Facility (PRTF) Prior Authorization Request

Please submit this application and all supporting documentation to:
Magellan Behavioral Health
ATTN: Residential Psychiatric Applications
1221 N Street, Suite 325, Lincoln, NE 68508
Phone (800) 424-0333 ~ Fax (866) 848-4942

The completed application must be sent via fax or postal mail. For security reasons, emailed applications will not be accepted.

Clinical Contact Information
MIS#
Name:
Address:
City/State/Zip:
Phone #:
Fax #:
Client Information:
Name:
Date of Birth:
Medicaid #:
Legal Guardian Name: If Client is State Ward, HHS Case Manager Name:
Legal Guardian Address:
Legal Guardian City, State, Zip:
Legal Guardian Phone #:
Youth Current Residence / Placement:
State Ward? ☐ Yes ☐ No
Please indicate the type of PRTF care requested: ☐ Mental Health Only ☐ Sexual Offending ☐ Substance Use Disorder Only ☐ Eating Disorder Specific ☐ Mental Health/Substance Use Disorder (Dual) ☐ Mental Health/Cognitively Impaired (MH/CI)

*** * * * Attachments * * * ***

THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THE APPLICATION:

- ☐ Initial Diagnostic Interview
- ☐ Current Psychiatric Evaluation including: Patient's history of problems and attempted treatment efforts, recommendations of issues to be addressed during PRTF treatment, and recommendation for PRTF level of care.
- ☐ Most recent other psychological evaluations (if available)
- ☐ Signed Physician and Evaluation Team Certification of Need (required)
- ☐ Treating Clinician Statement from all active MH/SA Providers
- ☐ Parent/Guardian Permission for Treatment
- ☐ If requesting Dual (MH/SA) or SA only treatment, a current substance abuse evaluation (including ASAM)
- ☐ If requesting MH/CI, a current assessment of cognitive functioning including adaptive functioning and full scale IQ.
- ☐ If requesting sex-offender specific treatment, a current sex offender risk assessment
- ☐ Educational records (most recent IEP and psycho-educational testing, if any)
- ☐ Any available and relevant medical, vision and dental documentation (and neurological, if applicable)
- ☐ Discharge summaries from previous inpatient and outpatient treatment (if applicable)
- ☐ Child and Adolescent Needs and Strengths (CANS) assessment (if available)

Lead Agency Involvement? ☐ No ☐ Yes -- If **yes**, please provide: Lead Agency: Care Coordinator Name: Care Coordinator Phone #:	Probation Involvement? ☐ No ☐ Yes -- If **yes**, please provide: If **yes**, please provide: Probation Officer's Name: Probation Officer's Phone #:

Answer questions 1 – 4 below.

1. **Please explain why ambulatory care resources available in the community do not meet the treatment needs of the individual. (Be specific. Include treatment history and response to treatment.) (Please reference PRTF Admission Criteria 1.)**

2. **Please explain why proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician. (Please reference PRTF Admission Criteria 2.)**

3. **Please describe how these services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed. (Please reference PRTF Admission Criteria 3.)**

4. **If applicable, for individuals with coexisting conditions such as organic brain disorders, developmental disabilities, mental retardation, autism spectrum disorders, or physical disorders/disabilities, please explain how the current symptoms result from a mental health/sexual offending/substance use disorder and are best treated in a psychiatric inpatient treatment program.**

If needed, please utilize the following Magellan website link to reference additional information related to PRTF admission criteria: http://magellanofnebraska.com/media/849986/2014-02-03_clinical_medical_necessity_guidelines.pdf

Physician and Evaluation Team Certification of Need for Services:

I have assessed the client and certify that the client meets the PRTF level of care requirements, according to CMS regulations, including:

All Signatories Must Initial All Three:

- ________ **Ambulatory care resources available in the community do not meet the treatment needs of the individual.**
- ________ **Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
- ________ **The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.**

▼ **Physician Signature:**	▼ **Date:**
______________________________	______________________________
▼ **Evaluating Team Member Signature:**	▼ **Date:**
______________________________	______________________________
▼ **Evaluating Team Member Signature:**	▼ **Date:**
______________________________	______________________________
▼ **Evaluating Team Member Signature:**	▼ **Date:**
______________________________	______________________________

All treating clinicians must sign a <u>Treating Clinician Statement</u> (page 4) and Parent/Guardian must sign <u>Permission for Treatment</u> (page 5).

Treating Clinician Statement

Any and all additional current treating providers must review and comment to ensure appropriate coordination of care.

I am aware that an application for Psychiatric Residential Treatment Facility (PRTF) has been submitted for _________________________________.

(Client's Name)

Please check the appropriate box and sign:

I have reviewed the medical necessity criteria for admission to this level of care and the records of this patient. Based on those guidelines and my knowledge of ____ , it is my professional opinion that:

(Client's Name)

☐ The level of care requested is necessary to meet the patient's need OR

☐ The level of care requested is NOT medically necessary or appropriate. Please describe how you think the patient's needs could be met in a different setting:

▼**Treating Clinician's Signature:**	▼**Date client was last seen:**	▼ **Date:**

If you have any questions, please call Magellan at (800) 424-0333.

Parent/Guardian Permission for Treatment

If you have any questions, please call Magellan at (800) 424-0333.

I am aware that an application for Psychiatric Residential Treatment Facility (PRTF) has been submitted for ________________________________
(Client's Name)

Parent or Guardian must check one box below:

☐ **As a Parent/Guardian, I understand and commit to my participation in family therapy as part of my child's treatment.**

☐ **As a Parent or Guardian, I cannot commit to participation in family therapy, but designate** ____________________________(NAME), **who is** ________________________________(RELATIONSHIP) **to participate in family therapy. By signing below, I confirm I have informed the designee of their expected participation in family therapy and they have agreed to participate.**

Parent or Guardian must check one box below:

☐ **As Parent/Guardian, I agree with the need for this level of care and authorize a bed search which allows Magellan to share current and relevant clinical information with any Magellan provider who is credentialed to provide this specific medically necessary treatment.**

☐ **As Parent/Guardian, I believe the level of care requested is NOT necessary or appropriate. Please comment:**

▼Parent/Guardian Signature:	Relationship to the Member:	▼ Date: