DRAFT-Psychiatric Rehabilitation Program (PRP)-Child Concurrent Request Details

Psychiatric Rehabilitation Program (PRP)-Child Concurrent Request

Medical Necessity Criteria for PRP can be found at:
https://maryland.optum.com/content/dam/ops-maryland/documents/provider/Maryland_State%20Supp%20Clin%20Crit_12.31_Final%20(4).pdf

Service Request Information

Person completing this request:* | Contact Phone #:* (___-___-____) | Contact e-mail:*

Is this a telephonic request? (INTERNAL OPTUM USE ONLY)** ○ Yes ◉ No

Rehabilitation Specialist: | Rehabilitation Specialist Phone #: (___-___-____) | Rehabilitation Specialist E-mail:

Requested Start Date for Authorization:* (__/__/____)

Requested Services:** ○ On-Site ○ Off-Site ○ Blended

Diagnostic Information

ICD-10 Primary Diagnosis Code:*

Per COMAR this must be a Public Behavioral Health System (PBHS) specialty mental health diagnosis. For a list of valid diagnosis see:
https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/clinicalutilization/Mental-Health-Diagnosis-codes-ICD-10.pdf

Diagnosis given by:*

Referring Clinician ☐ | Other ☑

Diagnosing Clinician:* | Diagnosing Clinician Title:* | Diagnosing Clinician Agency:*

Other Referral Information

Is the individual eligible for full funding for Developmental Disabilities Administration services?** ○ Yes ○ No

Have family or peer supports been successful in supporting this youth?** ○ Yes ○ No

Is the primary reason for the youth's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder?** ○ Yes ○ No

Does the youth meet criteria for a higher level of care than PRP?** ○ Yes ○ No

Will the youth's level of cognitive impairment, current mental status or developmental level impact their ability to benefit from PRP?** ○ Yes ○ No

Clinical Information

Is youth currently in mental health outpatient or inpatient treatment?**
○ Yes ○ No

Primary clinical treatment provider name:* Credential* Agency:*

List any additional treating providers:

Name: Credential: Agency:

Name: Credential: Agency:

Current frequency of treatment provided to this individual:**
○ At least 1x/week ○ At least 1x/2 weeks ○ At least 1x/month ○ At least 1x/3 months ○ At least 1x/6 months

How long has youth been engaged in active, documented outpatient treatment?**
○ Less than one month ○ 2-3 months ○ 4-6 months ○ 7-12 months ○ More than 12 months

In the past three months, how many ER visits has the youth had for psychiatric care?**
○ No visits in the last three months ○ One visit in the last three months ○ Two or more visits in the last three months

Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting?**
○ Yes ○ No

Does the youth have a Targeted Case Management referral or authorization?**
○ Yes ○ No

Has medication been considered for this youth?**
○ Not Considered ○ Considered and Ruled Out ○ Initiated and Withdrawn ○ Ongoing ◉ Other

Additional information:*

Functional Criteria

Within the past 3 months, the emotional disturbance has resulted in:*

(Check all that apply and list objective evidence in this form, even if other evidence will be attached to this request.)

A clear, current threat to the youth's ability to be maintained in their customary setting.
☑

Evidence of clear, current threat to the youth's ability to be maintained in their customary setting:*

An emerging risk to the safety of the youth or others.
☑

Evidence of emerging risk to the safety of the youth or others:*

Significant psychological or social impairments causing serious problems with peer relationships and/or family members.
☑

Evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members:*

Please note two different options appear based on the answer to the "Has the youth made progress…" question.

What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?*

Has the youth made progress toward age appropriate development, more independent functioning and independent living skills?**
(●) Yes ( ) No

Describe the improvement:*

Has a crisis plan been completed with family and/or guardian?**
( ) Yes ( ) No

Has an individual treatment plan/Individual rehabilitation plan been completed?**
( ) Yes ( ) No

What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?*

Has the youth made progress toward age appropriate development, more independent functioning and independent living skills?**
( ) Yes (●) No

Indicate changes in treatment plan to address lack of progress:*

Has a crisis plan been completed with family and/or guardian?**
( ) Yes ( ) No

Has an individual treatment plan/Individual rehabilitation plan been completed?**
( ) Yes ( ) No

Confirmation & Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

I attest all of the information provided is accurate and reflected in the participant's medical record.*
☐

The information to complete this request was provided by, and is the responsibility of:* Title:*

The Data Capture form will launch automatically when this form is saved. No selection is needed.**
(●) Yes

Important:

1) When this form is saved a pop-up box will appear regarding an additional form being recommended. Click Continue to move to the next form.

2) After the final form is completed you will be returned to the authorization screen.

3) Upload the most recent PRP referral document under Attachments on the authorization screen.

Failure to complete all forms and/or upload required documentation may result in a delay in processing or an administrative denial.