

Psychiatric Rehabilitation Program (PRP)-Transitional Age Youth (TAY) Concurrent Request V5

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Medical Necessity Criteria for PRP can be found at:

https://maryland.optum.com/content/dam/ops-maryland/documents/provider/providermanual/Maryland_ASO_MNC_BH2564_1.07.21.pdf

Service Request Information

Note: This form is to be used by TAY providers for participants aged 18-25 only.

Person completing this request:* Contact Phone #:* Ext Contact E-Mail:* Is this a telephonic request? (INTERNAL OPTUM USE ONLY)**
 Yes No

Rehabilitation Specialist:* Rehabilitation Specialist Phone #:* Rehabilitation Specialist Ext Rehabilitation Specialist E-mail:*

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

Preferred Contact

Person completing form Rehabilitation Specialist Preferred method of contact:**
 Phone Email

Category A - 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

Other Referral Information

1. Is the participant eligible for fully funded Developmental Disabilities Administration services?*

Yes No

2. Have family or peer supports been successful in supporting this youth?*

Yes No

3. Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder?*

Yes No

PLEASE NOTE: Question #4 has changed. Please read carefully before answering.

4. Has the participant been judged to be in enough behavioral control to be safe in a PRP program and benefit from the rehab provided?*

Yes No

5. Will the participant's level of cognitive impairment, current mental status or developmental level negatively impact their ability to benefit from PRP?*

Yes No

Clinical Information

1. Is youth currently in mental health outpatient or inpatient treatment?*

Yes No

a. Name of treating Licensed Mental Health Professional referring individual to PRP*

b. Credential*

c. Agency:*

d. 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

e. Is the primary clinical treatment provider the person making this referral?*

Yes No

f. Date of Referral/Clinical Collaboration*

List any additional treating providers:

Name

Credential

Agency:

2. Is the referral source in some way paid by the PRP program or receives other benefit from PRP program?*

Yes No

3. The youth has been engaged in active, documented outpatient treatment for:*

Less than a month Between one and three months Six months or more

4. 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

5. Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting?*

Yes No

6. PRP may not be routinely provided in conjunction with:

- Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)
- Targeted Case Management (TCM)
- Inpatient Psychiatric Services
- Crisis Residential Services
- Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC)
- Mental Health- Intensive Outpatient Program (IOP)
- Mental Health- Partial Hospitalization Program (PHP)
- Respite
- Therapeutic Behavioral Services (TBS)
- Residential Substance Use Disorder Treatment Level 3.3 or higher
- Substance Use Disorder-Intensive Outpatient Program (IOP)
- Substance Use Disorder- Partial Hospitalization Program (PHP)

Is the youth currently in treatment or receiving services from any of the services listed above?*

Yes No

7. Has medication been considered for this youth?*

Not Considered Considered and Ruled Out Initiated and Withdrawn Ongoing Other

Functional Criteria

1. Functional Impairment(s):

*Within the past three months, the individual's emotional disturbance has resulted in:**

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

Yes No

b. An emerging risk to the safety of the youth or others?*

Yes No

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

Yes No

2. 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?*

3. Has the youth made progress toward age appropriate development, more independent functioning and independent living skills?*

Yes No

4. Has a crisis plan been completed with family and/or guardian?*

Yes No

5. 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:*

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.

DLA-20 Required:

Yes

Data Capture Required:

Yes