Psychiatric Rehabilitation Program (PRP)-Transitional Age Youth (TAY) Initial 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 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*

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)
- 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. How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills?*

4. Is a documented crisis response plan in progress or completed?**
◯ 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.

Data Capture Required:
◉ Yes