Magellan HEALTHCARE®

Service Request Application (SRA) for:

Psychiatric Residential Treatment Facility (PRTF) & Therapeutic Group Homes (TGH) Continued Stay Request

ALL ITEMS ARE REQUIRED

After response is entered, use the **Tab key** to advance to next item.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name		Provider Name	
Member Last Name		Clinical Contact Name	
Medicaid Number		Provider MIS#	
Member Date of Birth		Provider Tax ID#	
Gender	☐ Male ☐ Female	Provider NPI	
		Provider Phone	
Member Phone		Provider Email	
Member Address City, State & Zip Code		Service Address City, State & Zip Code	

CLINICAL INFORMATION			
Procedure Code	☐ **99221** ☐ **99231** ☐ **H2020 HW** ☐ **H2020 HK** ☐ **H2022 HW** ☐ **H2022 HK**		
Primary Diagnosis			
Secondary Diagnosis			
Requested Units			
Requested Start Date		Requested End Date	
Is CSA paying for any portion of this stay?	☐ Yes ☐ No If yes, Locality Code:		
Is this an EPSDT funded service or stay?	☐ Yes ☐ No ☐ Not Applicable		

INTAKE
1. Admission date to this facility:
2. Is this a request from an out-of-state provider? ☐ Yes ☐ No a. If yes, complete the attached "Out-of-State Provider Requirements Form" (pg. 7 of this form).
3. Is this a retro review request? ☐ Yes ☐ No a. If yes, then the disposition date of Medicaid activation must be within 30 days of this request.
4. Have you submitted an SRA for this service <u>and</u> for this individual within the last 30 days which was not approved? ☐ Yes ☐ No

INTAKE
a. If yes, describe what changes have occurred to indicate that this service is now necessary?
5. Are you requesting a 1:1 under EPSDT for this member with this request? ☐ Yes ☐ No c. **If yes, please submit an EPSDT Residential 1:1 Care request on www.magellanprovider.com separately from this request.**
6. Is there a Comprehensive Individual Plan of Care (CIPOC) with all the required elements completed, signed, and dated as required (includes individual-specific long- and short-term goals, measurable objectives, interventions with timeframes, and family therapy as applicable)? ☐ Yes ☐ No 1. If yes, was individual and their family/legal guardian included in the development of the CIPOC? ☐ Yes ☐ No 2. If yes, are individual-specific long- and short-term goals and measurable objectives aligned with CANS assessment and ACES screening? ☐ Yes ☐ No **3. Please attach a copy of the CIPOC with this SRA; service cannot be authorized without a copy of a current CIPOC.**

CLINICAL	
7. Number of Therapeutic Day Passes since the last review period:	
a. Successful:	Unsuccessful:
b. If None, please describe why no passes occurred:	

CLINICAL	
c. If there were unsuccessful passes, please describe why they were unsuccessful:	
d. Who were the passes with (i.e. family members, mentor, social worker, etc.)	
e. Dates of Therapeutic Day Passes since the last review:	
8. Number of Therapeutic Overnight Passes since the last review period:	
a. Successful:	Unsuccessful:
b. If None, please describe why no passes occurred:	

CLINICAL
c. If there were unsuccessful passes, please describe why they were unsuccessful:
d. Who were the passes with (i.e. family members, mentor, social worker, etc.)
e. Dates of Therapeutic Day Passes since the last review:
9. Total number of therapeutic passes individual has had since admission:
10. Are you requesting any therapeutic passes beyond the 24 pass admission limit? ☐ Yes ☐ No
a. If yes, please include the clinical rationale for the additional passes and how they relate to treatment goals:

CLINICAL
11. Is individual therapy by an LMHP-Type occurring 3 out of every 7 days for Psychiatric Residential Treatment Facilities and weekly for Therapeutic Group Home? ☐ Yes ☐ No
a. If no, please describe barriers:
12. Are a minimum of 3 interventions for Psychiatric Residential Treatment Facilities or a minimum of 1 daily intervention for Therapeutic Group Homes occurring every 24-hour period including nights and weekends (excluding individual treatment, group therapy, medical appointments, school attendance, and family therapy) ☐ Yes ☐ No
a. If no, please describe barriers:
13. Has a family engagement activity occurred at least weekly? ☐ Yes ☐ No
a. If yes, Frequency and Type of involvement:

CLINICAL
b. If no, is there an identified family member who is available for family engagement? ☐ Yes ☐ No
i. If no to question 13b, describe the care coordination that has occurred between the residential provider and the Local Department of Social Services:
ii. If no to question 13b, what is the status of Family Finding?
iii. If yes to question 13b, what family engagement activities were offered (include dates they were offered):

CLINICAL
iv. If yes to question 13b, what are the barriers to family engagement?
v. If yes to question 13b, please describe all steps taken by the provider to overcome the barriers to family engagement?
vi. If yes to question 13b, what is the plan to engage the family moving forward:

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CLINICAL
14. How many family therapy sessions have occurred since the last review period:
a. If they have occurred, what is the frequency and type of sessions that have occurred:
b. What family members have been engaged in family therapy since the last review?
c. If none, please describe why this has not occurred and the actions being taken to overcome the barriers to family therapy:

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CLINICAL
15. Please describe the individual's behaviors in the 30 days prior to submission of this request that warrant this level of care. Please describe the individual's current functioning, social functioning, current medications or recent changes to medications, and individual's ability to care for self and complete activities of daily living (ADL). Please avoid using vague words such as 'aggressive' and include dates behaviors occurred:
16. Has the individual expressed suicidal ideation during the last authorization period? ☐ Yes ☐ No
a. If yes, what is the safety plan?
17. Does there continue to be symptoms or emergence of new symptoms that are amenable to treatment? ☐ Yes ☐ No
a. If Yes, please describe how the treatment plan that is attached to this request has been amended:

CLINICAL
18. What resources have been identified in the individual's community that will support the individual after discharge?
19. Describe how the individual's current functioning cannot be addressed using these resources at this time:
20. Will the individual be discharged in the next 30 days? ☐ Yes ☐ No
a. If yes, are aftercare services being arranged in coordination with the family? Please explain:

CLINICAL
21. Please describe the individual's current identified step-down placement and discharge plan. (Please avoid simply stating where individual will live upon discharge.):
a. What is the estimated discharge date?
b. What is the expected discharge disposition (for example: home with parent, foster care home, Therapeutic Group Home):
c. What are the recommended aftercare services for this individual?
d. List the specific agencies to which the individual will be connected prior to leaving residential care?

CLINICAL
e. What are the individual's natural support systems and/or community supports that will aid him/her in remaining in the community?
f. Identify barriers to discharge and how they will be addressed prior to discharge (this may include both environmental and individual risk factors):

OUT-OF-STATE PROVIDER REQUIREMENT FORM
1. Please select one of the four questions which best meets the reason you are requesting Out-of-State Provider Services and specify how the request meets the selected reason. Services provided out-of-state for circumstances other than these specified reasons shall not be covered:
☐ **The medical services must be needed because of a medical emergency;** *a. Is there documentation of a psychiatric/ behavioral health emergency?*
☐ **Medical service must be needed and the Individual's health would be endangered if they were required to travel to their own state of residence;** *b. Is there documentation that the individual's psychiatric/behavioral health condition will continue to decompensate if required to travel back to Virginia?*
☐ **The state determines on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;** *c. Based on a physician's advice, is the Psychiatric Residential Treatment Facility (PRTF) service more readily available in the other state? That is, what documentation is there that these services are not available in Virginia? Are there particular service needs that can only be addressed by this particular out of state provider? If so, provide supporting documentation of all needs and the services to be provided.*
☐ **It is the general practice from Individuals in a particular locality to use medical resources in another state** *d. What locality is the individual a resident of?* *e. Is it the general practice for individuals in this locality to use psychiatric/behavioral health resources out of state?* ☐ Yes ☐ No *f. If yes, which state?* *g. Is this a Department of Medial Assistance Services (DMAS) recognized "border state"?* ☐ Yes ☐ No *Enrollment of providers for Level C Residential Psychiatric Treatment for Children and Adolescents are generally limited to those located in Virginia or within 50 miles of the state line. KY, TN, NC, MD, and WV are all border states of Virginia.* *h. If the request is for a different state than noted in "c", why this state?*
Explain selected response:
2. Enrolled as a Provider with Magellan of Virginia? ☐ Yes ☐ No

Out of state provider may enroll with Magellan by going to: http://www.magellanofvirginia.com/for-providers-va/join-the-network.aspx. At the top of the page click on Provider Services and then Provider Enrollment in the drop-down box. It may take up to 10 business days to become a Virginia participating provider.