PROVIDER***ALERT***

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **November 10, 2017**

Subject: **Psychiatric Residential Treatment Facility (PRTF) Guidelines**

Summary: AmeriHealth Caritas Louisiana is sending this notification to assist providers in appropriately placing and treating children in Psychiatric Residential Treatment Facilities (PRTF).

PRTF Guidelines:

PRTF is an intensive level of care that results in a child being placed in a setting away from their family and community. Other interventions that can be provided while the child is at home should be considered prior to a referral to a residential treatment facility.

The intensive outpatient interventions as outlined below are options that can be considered: Family Functional Therapy (FFT), Multi-systemic Therapy (MST), Homebuilders (HB), Mental Health Rehabilitation Services (MHRS) with or without Coordinated System of Care (CSoC).

1) Members that are admitted to PRTF should be linked to CSoC before admission. If the member's symptoms and clinical history show medical necessity for a length of stay of 90 days or less, CSoC can provide intensive outpatient parent training and family support to the caregivers while the member is in the PRTF. Regardless of CSOC status, the PRTF will be required to provide weekly family therapy sessions starting the first week the member is admitted to the facility. AmeriHealth Caritas Louisiana can assist with securing transportation for the family if needed.

2) Behavioral Health Utilization Management (BH UM) will conduct utilization reviews every 2 weeks (or more often if clinically indicated).

3) All PRTF authorizations are based on medical necessity of services. Supporting clinical documentation must be submitted with the attached **PRTF Authorization Request Form**. All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to BH UM for a medical necessity determination. A failure to submit all clinical documentation may result in a delay of processing this request. Fax completed form to the AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (BH UM) department at **1-855-301-5356**. The PRTF Authorization Request Form can also be found on our website at **www.amerihealthcaritasla.com > Providers > Forms.**

Questions:
Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact BH UM at 1-855-285-7466.

AmeriHealth Caritas Louisiana

Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

Fax completed form to the AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (BH UM) department at **1-855-301-5356**. If you have any questions, please contact BH UM at **1-855-285-7466**.

All PRTF authorizations are based on medical necessity of services. The below supporting clinical documentation must be submitted with the PRTF Authorization request form. **All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide a medical necessity determination to BH UM. Failure to submit all clinical documentation may result in a processing delay.**

1. The request must include the below supporting documentation to be reviewed for medical necessity:
    a. Most recent psychosocial and/or diagnostic assessment by an licensed mental health practitioner (LMHP) within the last six months.
    b. Court order for placement and custodial orders, if applicable.
    c. Most recent IEP/504 plan, if applicable.
    d. Psychological and/or neuropsychological testing, if applicable.
2. Upon receiving all clinical information, BH UM will schedule a telephonic review to determine medical necessity. The telephonic review must include the LMHP who has completed a face-to-face assessment/session with the member.

Referral information		
Date of referral:	Referral contact:	
Referring facility/agency:	Phone:	Fax:

Demographic information (please print)			
Child's name:	Date of birth:	Age:	Medicaid ID:
Ethnicity:	Language:	Diagnosis:	
Home address and phone number:			
City:	State:		ZIP:
Custody (Department of Children and Family Services [DCFS], parents, other family, juvenile court, other agency):			
Name of custodian:	Relationship:		Phone:

LMHP recommending PRTF level of care	
Provider name:	Phone:
Contact person:	Phone:
NPI or tax ID number:	Fax:
Date the LMHP completed a face-to-face assessment or session with the member?	
What is the member's current status or placement?	

Reason for referral		
Current mental health and/or substance use disorder symptoms (frequency, dates, or consequences that led to a referral for PRTF):		
What are the contributing factors to the main clinical need or problem?		
What are the goals for the PRTF and recommended interventions for the contributing factors indicated above?		
Current living situation:		
Family history (psychiatric, substance use, domestic violence, family stressors, etc.):		
Family's role in treatment:		
DCFS, JOC, Legal FINS, or OJJ involvement? ☐ Yes ☐ No If yes, indicate type:	Contact name:	Phone number:
Child's current grade level:	Current school:	Special education classification? ☐ Yes ☐ No
Academic, behavioral, or social functioning in school (note any suspensions or expulsions):		

All medication	Dose	Schedule	Prescribing M.D.	Target symptoms

Treatment history	Yes/no/unknown	Provider	Service date
Psychiatric hospitalization	☐ Yes ☐ No ☐ Unknown		
Substance use treatment	☐ Yes ☐ No ☐ Unknown		
Mental Health Reporting System (MHRS)	☐ Yes ☐ No ☐ Unknown		
Coordinated System of Care (CSOC)	☐ Yes ☐ No ☐ Unknown		
Psychiatric Residential Treatment Facility (PRTF)	☐ Yes ☐ No ☐ Unknown		
Therapeutic group home	☐ Yes ☐ No ☐ Unknown		
Crisis stabilization	☐ Yes ☐ No ☐ Unknown		
Therapeutic foster care	☐ Yes ☐ No ☐ Unknown		
Psychological and/or neuropsychological testing	☐ Yes ☐ No ☐ Unknown		
Medical treatments/concerns	☐ Yes ☐ No ☐ Unknown		

A medical necessity determination will be made after a review of all required clinical information and a telephonic review. Once a medical necessity determination is made, the referral source and/or PRTF — if one has accepted the member — will be notified within 48 hours of the determination. If the PRTF admission is determined medically necessary and a PRTF placement has not been solidified, this will be required of the referral source.