ADULT 18 TO 64 PSYCHIATRIC PA REQUEST

(instructions available online here)

Request Type: CHOOSE REQUEST TYPE
Date Submitted:

OKLAHOMA
Health Care Authority

MEMBER INFORMATION	
Name:	Medicaid ID Number:
Medicare Part C or other policy name and ID#:	☐ Check box if submitting request because member has exhausted Medicare benefits. Documentation required or request will be deemed incomplete.
Type of Residence: CHOOSE TYPE OF RESIDENCE	Age with DOB:
Please provide member's complete contact information including address and phone number. As applicable, document the member's guardian complete contact information as well:	

PROVIDER INFORMATION	
Name:	Provider ID w/ Service Loc:
Utilization Contact Name:	Utilization Contact Email:
Date/Time of Face-to-Face Assessment:	Estimated Date of Dicharge:
Attending Physician:	Admission Date:
Requested Start Date:	Requested End Date:

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USE FOR RECONSIDERATION REQUESTS ONLY - provide new and/or additional clinical information supporting your original request. Only information occurring prior to the time of admission or extension request will be considered.

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REQUIRED - Describe the circumstances prompting today's admission including who referred the member and how they were transported to your facility. Include any recent stressful life events triggering or exacerbating the member's condition, e.g. legal offenses, family/interpersonal/work/financial issues etc.

PSYCHIATRIC MEDICAL NECESSITY CRITERIA
Criteria #1 - List the member's mental health and co-occurring substance use diagnoses (using the ICD-10- CM codes and descriptors listed in the DSM manual) and significant medical diagnoses. List the primary focus of treatment as the first diagnosis. The primary focus of treatment must be listed in the most recent version of the The Diagnostic and Statistical manual of Mental Disorders (DSM), with the exception of V- codes, adjustment disorders, and substance related disorders. **Requests without ICD-10-CM codes and descriptors will not be accepted.**

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Criteria #2 - Answering YES or NO, is the member's condition directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorders may be secondary to the primary diagnosis.

◉ YES ○ NO

Criteria #3 - Demonstrate that the current disabling symptoms could not be managed, or have not been manageable, in a less intensive treatment program. Example - Describe a recent failure in outpatient services indicating what services and how often the member was participating. If member has not participated in outpatient services, specifically describe the disabling symptoms that cannot be managed on an outpatient basis.

Criteria #4 - Answering YES or NO, is member medically stable? If NO, please explain.

◉ YES ○ NO

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Criteria #5 - Document the **CURRENT BEHAVIORS along with the DATES** the behaviors occurred. Only behaviors occurring **within the past 48 hours** that present an imminent life-threatening emergency as evidenced by one or more of the following items will be considered:

A. Specifically described suicide attempts, suicide intent, or serious threat by the patient; or
B. Specifically described patterns of escalating incidents of self-mutilating behaviors; or
C. Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration; or
D. Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

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Criteria #5 - additional space for notes if needed

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Criteria #6 - Select any of the following reasons why the member requires secure 24-hour nursing/medical supervision for:

- ◯ A. Stabilization of acute psychiatric symptoms; or
- ◯ B. Needs extensive treatment under physician direction; or
- ◯ C. Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision (if primary treatment is medical detox, must use Medical Detox PA Template).

This field is not required. Use only if you wish to provide additional clinical information such as physician or individual/family/group therapy notes, or any other information documented in the medical record you believe would support the case for treatment at this level of care. Please do not duplicate information that has already been documented elsewhere in the request.

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SECTIONS "A" TO "C" ARE REQUIRED FOR EXTENSION REQUESTS BY PSYCHIATRIC HOSPITALS

(A) Document the reason for requesting additional treatment days and what active treatment will be provided:

(B) Medications (document changes and current regimen including strength and frequency at of submission:

(C) Discharge Plan (include recommended follow-up treatment and where member will live):