

**Residential Treatment Care(Level C)
Prior Authorization Request Fax Form**

Enrollee Last Name:	Enrollee First Name:	Enrollee Medical ID #:
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17) INITIAL REVIEW

a. Initial Plan of Care (IPOC), with all the required elements to include Individual Therapy 3 out of every 7 days; 21 treatment Interventions every 7 days; Family Therapy, as applicable, completed, signed and dated as required? Yes No

Date of MD signature on completed IPOC:

b. Alternative placements tried or explored in the past year? Yes No

Name of Placement(s)	Dates	Successful?
_____	/ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	/ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	/ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	/ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

If placement(s) not successful, please explain:

c. Identify the Discharge Plan:

18) For CSA:

a. CON signed and dated by the physician and 3 members of the FAPT? Yes No

Date of CON:

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Enrollee Last Name:	Enrollee First Name:	Enrollee Medical ID #:
<p>b. CANS completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Date of CANS</p> <p>c. Start date of the Reimbursement Rate Certification:</p> <p>Document the Rate as listed on the Reimbursement Rate Certification:</p> <p>For Non-CSA:</p> <p>d. Pre-Admission Screening Report (DMH224) or CON completed, signed and dated by physician and pre-screener? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Date of Pre-Admission Screening Report or CON signatures:</p> <p>e. For Non-CSA Reviews Only:</p> <p><input type="checkbox"/> Adoption Subsidy Case</p> <p>Education Payment Source</p> <p><input type="checkbox"/> Scholarship (no charge)</p> <p><input type="checkbox"/> Parents</p> <p><input type="checkbox"/> Other:</p>		

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19) Severity of Illness: Current symptoms and behaviors:

For the initial review, provide a narrative of the behaviors exhibited by the client within the last 7 days that warrant the requested level of care. Identify frequency, intensity and duration of behavior. Identify the recipient's current functioning to include the support system, risk behaviors, social functioning, medications or changes to medications, and ADLs.

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Enrollee Last Name:	Enrollee First Name:	Enrollee Medical ID #:
20. Concurrent Review a. Document the Rate as listed on the Reimbursement Rate Certification: (For CSA cases only) Start date of new rate if applicable: b. CIPOC updated every 30 days with required dated signatures? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of most current CIPOC Update: c. Was the CANS completed and current within 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of CANS: 21. Number of Overnight Passes since the last review period: a. Successful/Unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No 22. Individual Therapy occurring 3 out of every 7 days? <input type="checkbox"/> Yes <input type="checkbox"/> No 23. Twenty-one Treatment Interventions provided every week? <input type="checkbox"/> Yes <input type="checkbox"/> No 24. Identify the Discharge Placement: 25. Identify the Orders for Family Therapy: a. Is Family Therapy occurring as ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No b. If Family Therapy is not occurring, please explain:		

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Enrollee Last Name:

Enrollee First Name:

Enrollee Medical ID #:

If no to any of questions 21-25 , please explain:

26) Severity of Illness for Concurrent Review:

Current symptoms and behaviors:

For continued stay, provide a narrative of the current symptoms and behaviors that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. Include medications and changes to medications. If no progress, explain how this is being addressed. Is the resident cooperative with treatment? Explain any changes to the discharge plan and date.

This information should be current within the last month.

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RESIDENTIAL TREATMENT CARE ELECTRONIC FAX FORM INSTRUCTIONS

www.dmas.kepro.org
www.dmas.virginia.gov

This FAX submission form is required for Residential Treatment Care (RTC) prior authorization review.

Please be certain that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via FAX for additional information.

If KePRO determines that your request meets appropriate review guidelines the request will be “tentatively approved” and transmitted to First Health Services (FHS) for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (<http://dmas.kepro.org>) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS’ Fiscal Agent prior to 5:30 PM of that day.

Request type:

- Place a or **X** in the appropriate box.
- **Initial Review:** Use for all new requests, unless the recipient has been in care for more than 30 days, then check continues stay review.
- **Continued Stay Review:** Use for concurrent reviews and for new clients who have been in care for over 30 days. All (extension) submissions should be under Continued Stay Review.
- **Retro Authorizations:** Use when Medicaid eligibility was determined after the admission date. Please include date you were notified of eligibility.
- **Change Request Review:** A change to a previously approved request may be submitted if necessary for an early discharge from services. Please include the existing PA # on the request form and reason for change (discharged early, relocated etc.)

1. Service type:

- Place a or **X** in the appropriate box.
- For CSA cases only, enter the 3 digit locality code in the text box. The locality code will reflect the locality that has fiscal responsibility for the Medicaid recipient and should be provided by the referral source. (Please see the attached list of locality codes)

2. KePRO Case ID #:

- For Continued Stay requests or change requests only
- Case ID # is located on all KePRO fax notifications

3. Start Date requested:

- The date you want the requested service to begin.
- Original date of Admission to the facility
- Place a or **X** in the appropriate box if this is a retroactive request.

4. Expected Discharge (D/C) Date:

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- Enter the expected discharge date on the line provided.
- Enter the expected discharge placement on the line provided (i.e. foster care, return home etc.)

5. Date of Birth:

- Enter the enrollee's date of birth in the MM / DD / YYYY format (for example, 02/25/2008)

6. Enrollee Last Name:

- Enter the enrollee's last name exactly as it appears on the Medicaid card

7. Enrollee First Name:

- Enter the enrollee's first name exactly as it appears on the Medicaid card

8. Enrollee Medicaid ID Number:

- It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.

9. Gender:

- Please place a \sqrt or X in the box to indicate the gender of the enrollee.

10. Provider Name:

- Enter the requesting/service provider name

11. Provider Address:

- a. Enter the requesting/service provider's business address.
- b. **9 Digit Zip Code (Mandatory):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.

12. Provider NPI/API Number:

- Enter the Provider NPI/API number for the provider requesting the service.

13. Provider Contact Person:

- Enter the primary contact for the requesting/service provider.

14. Provider Phone Number:

- Enter the phone number of the requesting/service provider.

15. Provider Fax Number:

- Enter the fax number of the requesting/service provider.

16. DSM-IV Diagnoses:

- Enter the complete DSM-IV diagnosis (**Must include all 5 Axes**)
- Only required for RTC Initial review, unless there are changes to the diagnoses.

17. Initial Review

- a. Please place a \sqrt or X in the box to indicate the required elements to include Individual Therapy 3 out of every 7 days; 21 treatment Interventions every 7 days; Family Therapy, as applicable, completed, signed and dated as required

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- b. Provide the date of Medical Doctor's signature on IPOC
- c. Please place a \checkmark or X in the box to indicate if alternative placements tried or explored in the past year
- d. If applicable provide name of placement and dates in placement.
- e. Explain unsuccessful placements.
- f. Provide the name of placement expected upon discharge.

18. For CSA (a, b or c)

- a. Please confirm CON signed and dated by the physician and 3 members of the team and provide date signed.
- b. Confirm CANS completed and provide date completed
- c. Please provide the start date of the Reimbursement Rate Certification, and document the rate as listed on the Reimbursement Rate Certification

For Non-CSA (d & e)

- d. Please confirm Pre-Admission Screening Report (DMH224) or CON completed, signed and dated by physician and pre-screener and provide date signed.
- e. If this is an adoption subsidy case, it is a Non-CSA case.

19. Severity of Illness for Initial Review:

- For the initial review, provide a narrative of the behaviors exhibited by the client within the last 7 days that warrant the requested level of care. Identify frequency, intensity and duration of behavior. Identify the recipient's current functioning to include the support system, risk behaviors, social functioning, medications or changes to medications, and ADLs.

20. Concurrent Review Requests:

- a. Document the Rate as listed on the Reimbursement Rate Certification and the date of new rate.
- b. Please confirm CIPOC updated every 30 days with required dated signatures and provide the most current date.
- c. Please confirm CANS completed and current within 90 days and provide the date.

21. Please provide the number of overnight passes since the last review period a

- a. Indicate if successful or unsuccessful by place a \checkmark or X in the box.

22. Please confirm Individual Therapy occurring 3 out of every 7 days.

23. Please confirm Twenty-one Treatment Interventions provided every week.

24. Please provide the name of the placement expected upon discharge.

25. Identify the Orders for Family Therapy

- a. Please place a \checkmark or X in the box to indicate if Family Therapy occurring as ordered

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- b. If Family Therapy is not occurring please explain.

26. Severity of Illness for Concurrent Review:

- For continued stay, provide a narrative of the current symptoms and behaviors that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. Include medications and changes to medications. If no progress, explain how this is being address. Is the resident cooperative with treatment? Explain any changes to the discharge plan and date. This information should be current within the last month.

Virginia Locality Codes

CODE	NAME	CODE	NAME	CODE	NAME
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001	Accomack	075	Goochland	153	Prince William
003	Albemarle	077	Grayson	155	Pulaski
005	Alleghany	079	Greene	157	Rappahannock
007	Amelia	081	Greensville	159	Richmond
009	Amherst	083	Halifax	161	Roanoke
011	Appomattox	085	Hanover	163	Rockbridge
013	Arlington	087	Henrico	165	Rockingham
015	Augusta	089	Henry	167	Russell
017	Bath	091	Highland	169	Scott
019	Bedford	093	Isle of Wight	171	Shenandoah
021	Bland	095	James City	173	Smyth
023	Botetourt	097	King and Queen	175	Southampton
025	Brunswick	099	King George	177	Spotsylvania
027	Buchanan	101	King William	179	Stafford
029	Buckingham	103	Lancaster	181	Surry
031	Campbell	105	Lee	183	Sussex
033	Caroline	107	Loudoun	185	Tazewell
035	Carroll	109	Louisa	187	Warren
036*	Charles City	111	Lunenburg	191	Washington
037*	Charlotte	113	Madison	193	Westmoreland
041	Chesterfield	115	Mathews	195	Wise
043	Clarke	117	Mecklenburg	197	Wythe
045	Craig	119	Middlesex	199	York
047	Culpeper	121	Montgomery		
049	Cumberland	125	Nelson		

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051	Dickenson	127	New Kent
053	Dinwiddie	131	Northampton
057	Essex	133	Northumberland
059	Fairfax	135	Nottoway
061	Fauquier	137	Orange
063	Floyd	139	Page
065	Fluvanna	141	Patrick
067	Franklin	143	Pittsylvania
069	Frederick	145	Powhatan
071	Giles	147	Prince Edward
073	Gloucester	149	Prince George

INDEPENDENT CITIES of Virginia

CODE NAME	CODE NAME
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510 Alexandria (city)	683 Manassas (city)
515 Bedford (city)	685 Manassas Park (city)
520 Bristol (city)	690 Martinsville (city)
530 Buena Vista (city)	700 Newport News (city)
540 Charlottesville (city)	710 Norfolk (city)
550 Chesapeake (city)	720 Norton (city)
560 Clifton Forge (city)	730 Petersburg (city)
570 Colonial Heights (city)	735 Poquoson (city)
580 Covington (city)	740 Portsmouth (city)
590 Danville (city)	750 Radford (city)
595 Emporia (city)	760 Richmond (city)
600 Fairfax (city)	770 Roanoke (city)
610 Falls Church (city)	775 Salem (city)
620 Franklin (city)	780 South Boston (city)
630 Fredericksburg (city)	790 Staunton (city)
640 Galax (city)	800 Suffolk (city)
650 Hampton (city)	810 Virginia Beach (city)
660 Harrisonburg (city)	820 Waynesboro (city)
670 Hopewell (city)	830 Williamsburg (city)
678 Lexington (city)	840 Winchester (city)
680 Lynchburg (city)	

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