

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Psychiatric Residential Treatment Facility (PRTF) Individual Plan of Care and Authorization

KEPRO

Attention MN Medicaid
2810 N Parham Road, Suite 305
Henrico, VA 23294
Fax: 866-889-6512
Phone: 866-433-3658

- Initial plan of care
 Updated plan of care
 Plan of care review for continued stay (plus 30 days)
 Change in insurance to Medicaid Fee for Service
 Discharge notification

PRTF Provider Information

NAME OF FACILITY		NPI NUMBER	
CONTACT NAME		PHONE NUMBER	FAX NUMBER
PHYSICIAN NAME			PHYSICIAN NPI NUMBER

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	RECIPIENT ID
DATE OF ADMISSION			ANTICIPATED DATE OF DISCHARGE (if known)	
PRIMARY DIAGNOSIS <input type="checkbox"/> Check if change in diagnosis				
DESCRIPTION				
SECONDARY DIAGNOSIS				
DESCRIPTION				
ADDITIONAL DIAGNOSES REQUIRING TREATMENT OR SERVICES				
DESCRIPTION				
<input type="checkbox"/> Recipient has been assessed and meets criteria for certification of need for services in PRTF.				
PRIMARY COVERAGE		SECONDARY COVERAGE		PREVIOUS COVERAGE (if applicable)

Presenting Symptoms Requiring PRTF Services

<input type="checkbox"/> Behavioral or psychiatric symptoms requiring treatment. Describe below.
<input type="checkbox"/> Severe, chronic and frequent aggression or danger to self or others. Describe below.
<input type="checkbox"/> Functional impairment (unable to maintain behavioral control, frequent interpersonal conflict, unable to appropriately engage in activities of daily living). Describe below.

Integrated Plan of Care

Active Treatment	Amount or Frequency	Provider(s)
<input type="checkbox"/> Individual therapy		
<input type="checkbox"/> Family therapy		
<input type="checkbox"/> Group therapy		
<input type="checkbox"/> Other therapy (list below)		
Other Activities	Frequency	Provider(s)
Arranged Services	Frequency	Provider(s)
<input type="checkbox"/> Rehab (OT, PT, speech)		
<input type="checkbox"/> Psychological testing		
<input type="checkbox"/> Neuropsychological testing		
<input type="checkbox"/> Other therapy (list below)		
Other arranged services not provided at the facility (medical, dental, etc.)		
<input type="checkbox"/> PRTF will arrange for all necessary medical and dental care while recipient is admitted to the facility.		

Comprehensive Discharge Planning - Coordination with Community-Based Providers

Provider	Service Type	Frequency
Therapeutic Leave Days Planned	Date(s)	Total Number of Days

Concurrent Services (service provided by community-based provider for purpose of discharge)		
Provider	Service	Frequency

Alternative placement arrangement upon discharge (other than home). Yes No

If yes, describe plans for placement and responsible person or agency

Attachments include

- Individual treatment plan (ITP) attached containing specific treatment goals
- Updated ITP attached (if possible)
- Weekly progress report(s) attached (last 30 days)
- Current risk or safety assessment
- If plan includes arranged or concurrent services, include MHCP Authorization Form ([DHS-4695-ENG](#)) and any additional documentation required per service MHCP provider manual instructions.

Recertification Only

Attestation that the PRTF provided the following required services included in the initial plan of care (PoC):

- Individual therapy: a minimum of two out of every seven days
- Family engagement activities: a minimum of one out of every seven days
- Group therapy as indicated in the PoC
- Other professional services under arrangement as identified in the PoC
- Discharge planning and consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff or other support planners

Enter date of physician signature on completed PoC or ITP. _____

PROVIDER SIGNATURE	DATE
--------------------	------

Instructions for Individual Plan of Care (PoC) Form

Submit this form no later than 14 days after admission to the facility. If the PRTF has not submitted the PoC within the required 14 days, there is no guarantee the medical review agent will review and authorize the PoC for the days the PRTF requests for authorization. If the PRTF provides services without authorization, there is no guarantee of payment.

- MHCP will not pay claims for services a PRTF provides if a PoC has not been submitted, reviewed and authorized.
- Ensure that all information is entered correctly in this form. The medical review agent may return incomplete forms as missing information or denied.

Continued Stay Authorization Requirements

An updated PoC form is required to demonstrate that the recipient continues to meet criteria for PRTF services and is making progress towards treatment goals and discharge to approve an additional 30 days of treatment.

- The PRTF must submit an updated PoC before the thirtieth day of the last authorized date of service.
- The PRTF must submit an updated Authorization Form (DHS-4695-ENG) any time changes are made to a PoC.
- Submit an updated PoC when:
 - Requesting additional days beyond the initial 60 days of treatment
 - Adding or changing arranged services to the PoC that require authorization
 - Adding or changing concurrent services to the PoC as part of the discharge plan
 - Adding or changing therapeutic leave days
- MHCP will not pay claims for services a PRTF provides if a PoC has not been submitted, reviewed and authorized

Changes in Insurance Coverage

If a recipient becomes eligible for Medical Assistance while admitted to a PRTF, the PRTF must update and submit this form to document change in coverage.

Updated Plan of Care for Arranged or Concurrent Services Authorization

Anytime a PRTF requests additions or changes to arranged or concurrent services, the PRTF must submit an updated PoC to the medical review agent.