

Department of Mental Health
TRANSMITTAL LETTER

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|---|-------------------------|----------------|
| SUBJECT Psychiatric Residential Treatment Facility (PRTF) Medical Necessity Determination Process | | |
| POLICY NUMBER DMH Policy 200.7 | DATE JAN 13 2012 | TL# 158 |

Purpose. One of the Department of Mental Health's (DMH's) primary goals is to treat and therefore maintain children/youth within their own communities in the least restrictive and supportive environments. Placing a child or youth in a Psychiatric Residential Treatment Facility (PRTF) is a serious decision and all efforts should be made to address the treatment needs of the child/youth through community based services prior to any PRTF placement.

This policy establishes the procedures for the DMH medical necessity determination process for admission to and continued stays of children and youth in a PRTF whose needs cannot be met in the community.

Applicability. This policy governs (1) DMH medical necessity determinations prior to admitting any Medicaid eligible child or youth in a PRTF, except for those children currently enrolled with a Medicaid Managed Care Organization (MCO); (2) medical necessity determinations for all Medicaid eligible children currently in a PRTF; and (3) medical necessity determinations for all other referrals of children for placement in a PRTF by a District agency.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

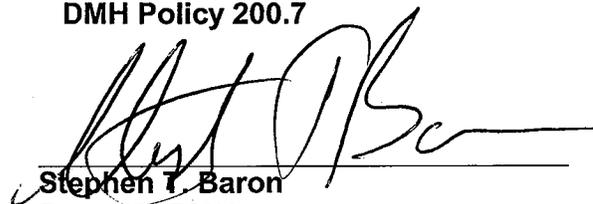
Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *This policy is effective immediately.*

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must promptly file this policy with their **DMH** Policy and Procedures, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY
None

INSERT
DMH Policy 200.7


Stephen T. Baron
Director, DMH

| | | | |
|---|----------------------------|----------------------------|---------------|
| GOVERNMENT OF THE DISTRICT OF COLUMBIA  DEPARTMENT OF MENTAL HEALTH | Policy No. 200.7 | Date JAN 13 2017 | Page 1 |
| | Supersedes None | | |

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1. **Purpose.** One of the Department of Mental Health's (DMH's) primary goals is to treat and therefore maintain children/youth within their own communities in the least restrictive and supportive environments. Placing a child or youth in a Psychiatric Residential Treatment Facility (PRTF) is a serious decision and all efforts should be made to address the treatment needs of the child/youth through community based services prior to any PRTF placement.

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2. **Applicability.** This policy governs (1) DMH medical necessity determinations prior to admitting any Medicaid eligible child or youth to a PRTF, except for those children currently enrolled with a Medicaid Managed Care Organization (MCO); (2) medical necessity determinations for all Medicaid eligible children currently in a PRTF; and (3) medical necessity determinations for all other referrals of children for placement in a PRTF by a District agency.

3. **Authority.** 42 CFR § 441.152, Certification of Need for Services; Department of Mental Health Establishment Amendment Act of 2001; Title 22-A, DCMR, Chapter 34, Mental Health Rehabilitation Services (MHRS) Provider Certification Standards; and Title 29 DCMR § 948, Standards for Participation of Residential Treatment Centers for Children and Youth.

4. **Definitions.** For purposes of this policy, the following definition applies:

Psychiatric Residential Treatment Facility (PRTF). A psychiatric facility that (1) is not a hospital; and (2) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state in which it is located; and (3) provides inpatient psychiatric services for individuals under the age of twenty-two (22) and meets the requirements set forth in §§ 441.151 through 441.182 of Title 42 of the Code of Federal Regulations, and is enrolled by the District of Columbia Department of Health Care Finance (DHCF) to participate in the Medicaid program.

5. **Background.** Pursuant to D.C. Municipal Regulation 29 DCMR § 948, DMH has the authority and responsibility to determine medical necessity for all PRTF placements for Medicaid eligible children and youth. PRTFs are intended for children and youth who are often involved with multiple agencies, who have had difficulty maintaining linkages to community mental health services and other important supports (such as schools, family, peers, and vocational programs) and who are unable to reside safely in the community in a less restrictive setting.

This policy sets forth the requirements and procedures that DMH will follow when conducting medical necessity determinations for all PRTF placements. To ensure an efficient and transparent process, DMH has developed a uniform referral process for admission to PRTFs that requires: (a) participation by an inter-agency PRTF Review Committee; (b) exploration of all community-based alternatives to residential placement before a PRTF placement recommendation is made; and (c) documentation of teaming efforts to stabilize the child/youth, which include an explanation of why lower levels of community services have not been successful, and compelling reasons why placement in a PRTF is necessary. DMH has also developed a uniform referral process for continued stay in a PRTF and criteria that must be met in order for the child/youth to remain in a PRTF beyond the original medical necessity certification.

6. Policy.

6a. Community-based alternatives to residential placement must be explored through a teaming process prior to referring a child or youth for psychiatric residential placement, absent exceptional circumstances.

6b. After all efforts have been made to address the treatment needs of the child and youth in the least restrictive, clinically appropriate, community-based setting, a referral for review of medical necessity for placement in a PRTF may be submitted to the PRTF Review Committee for a medical necessity determination.

6c. The PRTF Review Committee shall serve as the single point of access and accountability for medical necessary determinations for PRTF placements and continued stays.

6d. If a child/youth has been ordered to be placed in a PRTF by a court or by a hearing officer determination, the placing agency shall refer the child/youth to the PRTF Review Committee in accordance with Section 8a below.

7. PRTF Review Committee.

7a. Role. The PRTF Review Committee is an independent inter-agency team that ensures that referrals for admission to a PRTF and continued stays meet federal guidelines in accordance with 42 CFR § 441.152 in order to issue a medical necessity determination for PRTF placement, D.C. Municipal Regulation 29 DCMR § 948, and the requirements of this policy.

The PRTF Committee will review:

- Referrals of children for placement in a PRTF by a District agency including, but not limited to, DMH, Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), Office of the State Superintendent of Education (OSSE), and DC Public Schools (DCPS);
- Referrals from any other entity seeking PRTF admission for a Medicaid eligible child or youth (e.g., Court Social Services [CSS], or parent or legal guardian);
- Referrals for children who have just been approved for placement in a PRTF by an MCO and the child's insurance will convert to Fee-for-Service Medicaid as a result of the placement in the PRTF; and
- Referrals for children currently in a PRTF for whom continued stay is recommended.

7b. Membership. The following District agencies will appoint in writing one (1) primary and alternate mental health professional to serve on the committee. The committee chairman and non-government members will be appointed by the DMH Director. The PRTF Review Committee shall consist of the following:

- DMH board certified child and adolescent psychiatrist,
- DYRS representative,
- CFSA representative,
- DCPS representative,
- OSSE representative,
- CSS representative,
- Representative from agency designated as the family advocacy group for families with children receiving care from DMH, and
- DMH PRTF Review Coordinator (non-voting member).

7c. PRTF Medical Necessity Determination.

(1) In order to issue a medical necessity determination for placement of a child or youth in a PRTF, the PRTF Review Committee must make the following findings:

(a) Community-based services available in the District do not meet the treatment needs of the child or youth;

(b) Proper treatment of the child or youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(c) Services in a PRTF can reasonably be expected to improve the child or youth's condition or prevent further regression so that PRTF services will no longer be needed.

(2) If the Committee determines that the child or youth does not meet medical necessity for placement in a PRTF and can be served best in the community, the Committee will deny the referral and provide a list of recommended services and actions necessary to properly serve the child or youth's needs in the community.

(3) There must be at least five (5) voting members present in order for the Committee to make a medical necessity determination. A majority vote by committee members participating in the review is required to certify PRTF placement. Only Committee members may be present while the Committee votes.

7d. Meeting Schedule/Minutes.

(1) The PRTF Review Committee will determine its regular meeting schedule. Meetings will be scheduled on a timely basis in order to ensure the timely review of requests for PRTF placements.

(2) The PRTF Coordinator shall record minutes from each PRTF Review Committee meeting and maintain a record of all actions taken on each referral. Records will be maintained in accordance with DMH privacy policies regarding confidentiality of mental health information. Also see Section 10 below.

- 7e. Annual Report. The PRTF Review Committee will produce an annual report to include:
- summary of all referrals by referral source, date of referral, type, date of committee review, and final decision of the Committee;
 - list of PRTFs used and the addresses; and
 - trends and recommendations.

8. Responsibilities.

8a. Referring Entities (as described in Section 7a above) shall:

- (1) **Complete** the DMH Admission to a PRTF Medical Necessity Review Referral Form (*Exhibit 1*), and DMH HIPAA Form 3 – CYSD, Authorization to Use or Disclose Protected Information (*Exhibit 2*) and **submit** electronically to: PRTF.ReviewCommittee@dc.gov.
 - Referrals that are illegible, incomplete, or do not have the required supporting documentation will not be reviewed by the PRTF Review Committee, and will be sent back to the referring party with further instructions.
- (2) **Be available** during the Committee's scheduled review of referral to answer questions and provide additional information as needed.
- (3) **Notify** PRTF Coordinator of the date of admission, name and address of PRTF when child or youth is placed in a PRTF.
- (4) If the child or youth needs to stay in a PRTF past the time of the initial certification, submit electronically the DMH Continued Stay in a PRTF Medical Necessity Review Referral Form (*Exhibit 3*) to: PRTF.ReviewCommittee@dc.gov at least one (1) month prior to the end of the current certification period.
 - If the referral is not submitted at least one (1) month prior to the end of the current certification period, the referral may not be reviewed prior to the expiration date of the initial medical necessity determination.
 - Referrals sent after the expiration date of the current certification period will be reviewed only after all other pending referrals have been reviewed.
 - The Department of Health Care Finance will not authorize Medicaid payment for a child or youth in a PRTF without a current medical necessity determination.

8b. The PRTF Coordinator shall:

- (1) **Review** all referrals within two (2) business days of receipt for completeness and content.
 - If additional information is needed, the PRTF Coordinator will request information from the referring entity with a specific due date for submission.
- (2) For complete referrals, Prepare and send a written summary to PRTF Review Committee members.
- (3) **Schedule** the child/youth referral packet for review by the Committee.
- (4) **Coordinate** date and time for meeting, and **send** agenda to Committee members.
- (5) **Attend, prepare, distribute and maintain** minutes of all Committee meetings.

(6) **Issue** written decision on medical necessity within 1-2 business days of Committee's determination to the referring entity and the Department of Health Care Finance (DHCF), and for continued stays, to the PRTF.

(7) **Maintain** a data base of all referrals received, and **maintain** a record of all actions taken on all referrals.

(8) **Notify** referring party of all pending expiration of certifications at least two (2) months prior to expiration of certification.

(9) **Compile** annual committee report (also see Section 7e above).

(10) **Maintain** roster of committee members.

9. **Appeals.** The referring entity or parent or legal guardian has the right to appeal a denial of medical necessity made by PRTF Review Committee by filing a written request for reconsideration.

9a. The appealing party will **submit** the Medical Necessity Determination Appeal Request Form (Exhibit 4) with supporting documentation to PRTF.ReviewCommittee@dc.gov within ten (10) business days of the date of the letter of the DMH denial of medical necessity.

9b. The DMH Program Manager for PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health or designee will:

- **ensure** that the appeal is complete, including all documents (clinical notes and evaluations on the youth) in DMH possession.
- **submit** the appeal to an independent reviewer (a board certified child and adolescent psychiatrist who is contracted by DMH for this purpose) within one (1) business day of verifying a complete packet.
- **send** a copy to the DMH Chief Clinical Officer.

9c. The Independent Reviewer will **submit** a recommendation on medical necessity and length of stay, if applicable, based on a review of all submitted materials, within seven (7) business days of receipt of the appeal, to the DMH Chief Clinical Officer.

9d. The DMH Chief Clinical Officer will:

- **make** a determination within seven (7) business days of receipt of the recommendation from the independent reviewer;
- **send** the written determination to the PRTF Coordinator, who will disseminate the determination letter to all appropriate parties within one (1) business day of receipt (appealing party; Associate Chief Clinical Officer for Children and Youth; and the Program Manager for PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health).

9e. If the appealing party is not satisfied with the written determination rendered by the DMH Chief Clinical Officer, the determination may be appealed to the Office of Administrative Hearings (OAH) or the Office of the Health Care Ombudsman and Bill of Rights for a fair hearing within ten (10) business days of the date of the determination letter.

10. **Confidentiality.** The PRTF Review Committee is subject to all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Mental Health Information Act (MHIA).

11. **Inquiries.** Questions regarding this process may be directed to the DMH PRTF Coordinator or the Associate Chief Clinical Officer for Children and Youth.

12. **Related References.**

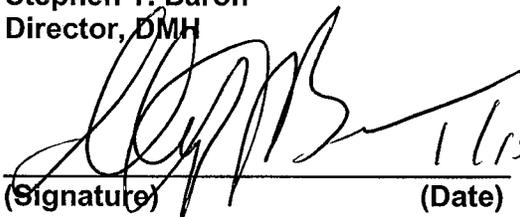
- DMH Policy 300.5A, Maintaining Children and Youth in Their Homes
- DMH Policy 340.10, High Fidelity Wraparound Care Planning Process
- DMH Policy 340.11, Child/Youth and Family Teaming

13. **Exhibits.**

- Exhibit 1 - DMH Admission to a PRTF Medical Necessity Review Referral Form
- Exhibit 2 - DMH HIPAA Form 3 – CYSD, Authorization to Use or Disclose Protected Information
- Exhibit 3 - DMH Continued Stay in a PRTF Medical Necessity Review Referral Form
- Exhibit 4 - DMH Medical Necessity Determination Appeal Request Form

Approved By:

Stephen T. Baron
Director, DMH


(Signature) **1/13/12**
(Date)

GOVERNMENT OF THE DISTRICT OF COLUMBIA



Department of Mental Health
Admission to a Psychiatric Residential Treatment Facility
Medical Necessity Review Referral Form

Every child/youth who is referred for review of medical necessity for psychiatric residential level of care should be a part of an ongoing family-driven team-based process. The team should consider the strengths and needs of the child/youth and the family in order to determine what supports and services would meet the needs of the child/youth. After multiple meetings and attempts at community-based services, if the team comes to a consensus that psychiatric residential treatment would best meet the needs of the child/youth, then this referral form should be completed and submitted to DMH.

- 1.) PLEASE COMPLETE THE REFERRAL FORM AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION (SEE THE ATTACHED DMH HIPAA-FORM 3- CYSO). SUBMIT THESE WITH ALL OTHER SUPPORTING DOCUMENTATION AS LISTED ON PAGE 2.
- 2.) REFERRALS WHICH ARE ILLEGIBLE, INCOMPLETE, OR DO NOT HAVE REQUIRED SUPPORTING DOCUMENTATION WILL NOT BE REVIEWED BY THE PRTF REVIEW COMMITTEE. **IF THE REFERRAL PACKET IS INCOMPLETE, IT WILL BE SENT BACK TO THE REFERRING PARTY WITH FURTHER INSTRUCTIONS.**
- 3.) THE REFERRAL FORM AND ALL SUPPORTING DOCUMENTATION SHOULD BE SENT ELECTRONICALLY TO PRTF.REVIEWCOMMITTEE@DC.GOV. IF YOU NEED TO SEND THE DOCUMENTATION BY AN ALTERNATIVE METHOD, PLEASE CONTACT THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) COORDINATOR AT 202- 673-3451.
- 4.) ONCE A REFERRAL PACKET IS RECEIVED, THE PRTF COORDINATOR WILL REVIEW THE PACKET FOR COMPLETENESS. BASED ON THE INITIAL REVIEW OF THE PACKET, THE COORDINATOR MAY REQUEST ADDITIONAL INFORMATION FROM THE REFERRING PARTY WHICH MUST BE PROVIDED WITHIN A SPECIFIED DUE DATE. THE COORDINATOR WILL THEN PROVIDE A CASE SUMMARY TO THE PRTF REVIEW COMMITTEE.
- 5.) UNLESS ADDITIONAL, ESSENTIAL INFORMATION IS REQUIRED TO MAKE A DETERMINATION, THE PRTF REVIEW COMMITTEE WILL REVIEW THE CASE AND MAKE A MEDICAL NECESSITY DETERMINATION.
- 6.) WITHIN 1-2 BUSINESS DAYS OF THE DETERMINATION, THE PRTF COORDINATOR WILL PROVIDE THE WRITTEN DETERMINATION TO THE REFERRING PARTY WITH ANY ADDITIONAL RECOMMENDATIONS MADE BY THE REVIEW COMMITTEE, AND PROVIDE A COPY TO THE DEPARTMENT OF HEALTH CARE FINANCE (DHCF).

IF THERE ARE ANY QUESTIONS REGARDING THIS PROCESS,
PLEASE CONTACT THE PRTF COORDINATOR AT 202-673-3451.

BELOW IS A LIST OF REQUIRED SUPPORTING DOCUMENTATION FOR THIS REFERRAL FOR REVIEW OF MEDICAL NECESSITY FOR PRTF.

Please check all that are included in the referral packet.

| |
|--|
| DMH Medical Necessity Review Referral Form |
| Authorization to Use or Disclose Protected Information (Use DMH-HIPAA FORM-3-CYSD) |
| Parent/Caregiver Authorization for Medical Necessity Review for Psychiatric Residential Treatment (page 8 of referral) |
| All Psychiatric Evaluations (within last year) |
| All Psychological Evaluations (within last 2 years) |
| All Psycho-educational Evaluations (within last 2 years) |
| Diagnostic Assessment (completed within last year, if Psychiatric and/or Psychological Evaluations are not available) |
| Treatment Plan and Discharge Recommendations (if youth is in a facility or hospital) |
| Discharge Summaries from last 2 Hospitalizations |
| Psychosocial Evaluation/Summary |
| Social Study from Court Social Services (CSS) |
| Recent Court Reports (must include description of any recent offenses, judge, attorney, defense attorney) |
| Current Plan of Care or Team Meeting Notes over last 6 months (including sign-in sheets) |
| Individualized Education Program (if applicable) |
| Any other information relevant to this review (i.e., 504 plan, recent progress notes, other evaluations, etc.) |

Referral Packet completed by (print): _____

Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

By signing below, I am certifying that the District agency/entity clinical team working with this child/youth believes that he/she meets medical necessity and this referral includes all of the above required documentation for this review:

Referring Agency Representative (print): _____

Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

Supervisor (print): _____

Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

Organization/Agency Affiliation: _____

PRTF Referral Form

| Referred Youth's Information | | | |
|--|---------------|--|---|
| Name (Last, First, Middle Initial): | | Date of Birth: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address: (Current address, city, state, zip code) | | | Phone #: |
| Primary Language Spoken: | | Secondary Language (if any): | |
| <input type="checkbox"/> The family reads and speaks English at home | | <input type="checkbox"/> Family speaks a different language at home: | |
| The family needs an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No | | If different language, please list: | |
| Medicaid Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> TBD | | If, yes, please provide Medicaid #: | |
| Check One: <input type="checkbox"/> Fee For Service <input type="checkbox"/> Managed Care <input type="checkbox"/> HSCSN | | | |
| Race/Ethnicity: (If Hispanic/Latino, choose from Section B; all others, choose from Section A) | | | |
| Section A: | | Section B: | |
| <input type="checkbox"/> American Indian/Alaska Native | | <input type="checkbox"/> Mexican | |
| <input type="checkbox"/> Asian | | <input type="checkbox"/> Puerto Rican | |
| <input type="checkbox"/> Black or African American | | <input type="checkbox"/> Cuban | |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islands | | <input type="checkbox"/> Dominican | |
| <input type="checkbox"/> White | | <input type="checkbox"/> Central American | |
| <input type="checkbox"/> Biracial (Specify): | | <input type="checkbox"/> South American | |
| <input type="checkbox"/> Other (Specify): | | <input type="checkbox"/> Other (Specify): | |
| Parent Information (If parents are separated, include information for both parents) | | | |
| Mother's Name: (Last, First, Middle Initial) | | | |
| Address: (Home address, city, state, zip code) | | | |
| Home Phone #: | Work Phone #: | Other Phone #: | |
| Email Address: | | Best Time To Call: | |
| Primary Language Spoken: | | Secondary Language (if any): | |
| Father's Name: (Last, First, Middle Initial) | | | |
| Address: (Home address, city, state, zip code) | | | |
| Home Phone #: | Work Phone #: | Other Phone #: | |
| Email Address: | | Best Time To Call: | |
| Primary Language Spoken: | | Secondary Language (if any): | |
| Primary Caregiver/Legal Guardian Information (if not parent) | | | |
| Name: (Last, First, Middle Initial) | | | Relationship to Child/Youth: |
| Address: (Home address, city, state, zip code) | | | |
| Home Phone #: | Work Phone #: | Other Phone #: | |
| Email Address: | | Best Time To Call: | |
| Primary Language Spoken: | | Secondary Language (if any): | |
| Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, provide name: | | | |

| Other Important Contacts | | |
|--|------------------------|--------|
| If we cannot contact one of the parents or caregivers, please list the name of an additional involved contact person (e.g., grandparent, adult sibling, aunt/uncle): | | |
| Name: | Relationship to Youth: | Phone: |
| Name: | Relationship to Youth: | Phone: |

| Sibling Information (attach additional sheet as needed) | | | | | |
|---|---------------|---------------|-----------------------|--------------|-------------------|
| Name (First & Last) | Gender M/F | Date of Birth | Relationship to Youth | School/Grade | Current Residence |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| School Information | | |
|---|---|---|
| Local Education Agency (LEA): (for example, DCPS, Charter School, etc.) | | |
| School Name: | | |
| Current Academic Performance: | | Grade Level: |
| <input type="checkbox"/> Regular Education (specify accommodations, if any): | <input type="checkbox"/> Special Education (attach Individualized Education Program) <input type="checkbox"/> Primary Disability Category: | <input type="checkbox"/> Other (specify): |
| Is the attendance of the youth an issue/concern? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes, what has been done to address it: | | |

| Teaming |
|---|
| Team Meeting Notes or Plan of Care Attached <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has the team met routinely and adjusted the Plan of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how often: |
| If No, please explain: |
| |
| Teaming/ Care Coordination provided by: |
| <input type="checkbox"/> DC Choices Wraparound Process |
| <input type="checkbox"/> Far Southeast Collaborative Child and Family Teaming <input type="checkbox"/> GA Avenue Collaborative Child and Family Teaming |
| <input type="checkbox"/> DYRS Youth and Family Teaming <input type="checkbox"/> CSS Family Group Conferencing |
| <input type="checkbox"/> Other (specify): |
| |
| Name of Team Facilitator/Care Coordinator: |
| Is the team in consensus about referring this youth to PRTF? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If No, identify the parties who disagree and why: |
| |

| Current System Involvement and Team Members (Select all that apply) | | | |
|---|----------------|---------|-------|
| | Contact Person | Phone # | Email |
| <input type="checkbox"/> Court Social Services (Probation) | | | |
| <input type="checkbox"/> Department of Youth Rehabilitation Services | | | |
| <input type="checkbox"/> Education | | | |
| <input type="checkbox"/> Child and Family Services Agency | | | |
| Parents' Rights Terminated: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| <input type="checkbox"/> Special Education | | | |
| <input type="checkbox"/> Mental Health Provider (agency name: _____) | | | |
| <input type="checkbox"/> Specialty Mental Health Provider: (For example, CBI, MST, FFT, private therapist) | | | |
| <input type="checkbox"/> Hospital | | | |
| <input type="checkbox"/> Physical Health Care Agency/Clinic/Provider | | | |
| <input type="checkbox"/> Substance Abuse Agency/Clinic/Provider | | | |
| <input type="checkbox"/> Other (Please specify) | | | |
| <input type="checkbox"/> Other (Please specify) | | | |

| Current Living Situation of Youth | |
|---|--|
| <input type="checkbox"/> Two Parent Biological Family | <input type="checkbox"/> Therapeutic Group Home |
| <input type="checkbox"/> One Parent Biological Family | <input type="checkbox"/> Youth Shelter House |
| <input type="checkbox"/> Two Parent Adoptive Family | <input type="checkbox"/> Runaway/Homeless |
| <input type="checkbox"/> One Parent Adoptive Family | <input type="checkbox"/> Detention: <input type="checkbox"/> Youth Services Center <input type="checkbox"/> New Beginnings |
| <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Residential Treatment Center Name: |
| <input type="checkbox"/> Other Relative's Home | <input type="checkbox"/> Psychiatric Residential Treatment Facility Name: |
| <input type="checkbox"/> Other Non-Relative's Home | <input type="checkbox"/> Acute Care Inpatient Hospital: |
| <input type="checkbox"/> Traditional Foster Care | <input type="checkbox"/> Sub-Acute Care Inpatient Hospital: |
| <input type="checkbox"/> Therapeutic Foster Care | <input type="checkbox"/> Other specify: |
| <input type="checkbox"/> Traditional Group Home | |
| <i>Anticipated discharge date from above (If applicable):</i> | |

| Out of Home Placement Due to Family Court: | |
|---|--|
| Is placement related to Child Welfare? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is placement related to Juvenile Justice? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Family Court Involvement: |
|----------------------------------|
| Next Court Date: |
| Type of Hearing: |
| Name of Judge: |

| During the Past 6 Months, was the Youth the Enrollee/Recipient of any of the Following? (Select all that apply) |
|---|
| <input type="checkbox"/> Medicaid (Check one) <input type="checkbox"/> Fee For Service <input type="checkbox"/> Managed Care <input type="checkbox"/> Health Services for Children with Special Needs |
| <input type="checkbox"/> TANF (public assistance): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Private Insurance (specify): |
| <input type="checkbox"/> Social Security Disability Income & Amount (SSI Benefits): _____ |

DSM Diagnosis Source (provided within last 12 months)

Which professional source made the diagnosis as indicated in the following information below?

- | | | |
|--|--|---|
| <input type="checkbox"/> Child Psychiatrist | <input type="checkbox"/> Licensed Clinical Social Worker | <input type="checkbox"/> Child Psychologist |
| <input type="checkbox"/> General Psychiatrist | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> General Psychologist |
| <input type="checkbox"/> Licensed Professional Counselor | <input type="checkbox"/> Other: _____ | |

Name of Clinician:

Date of Diagnosis:

DSM Diagnosis Information**AXIS I: CLINICAL DISORDERS** (Please list Axis 1 Primary Diagnosis first.)**AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION** (If any)**AXIS III: GENERAL MEDICAL CONDITIONS** (If any)**AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS**

(Select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Economic problems |
| <input type="checkbox"/> Problems related to the social environment | <input type="checkbox"/> Problems with access to health care services |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Other psychosocial and environmental problems | <input type="checkbox"/> Housing problems |
| <input type="checkbox"/> Problems related to interaction with the legal system/crime | |

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (GAF):**What are the problems within last 6 months that led to this referral for PRTF?****Check and Circle all that apply**

- | |
|---|
| <input type="checkbox"/> Suicide-related problems (including suicide ideation, suicide attempt, self-injury) |
| <input type="checkbox"/> Depression-related problems (including major depression, dysthymia, sleep disorders, somatic complaints) |
| <input type="checkbox"/> Anxiety-related problems (including fears and phobias, generalized anxiety, social avoidance, obsessive-compulsive behavior, post-traumatic stress disorder) |
| <input type="checkbox"/> Hyperactive and attention-related problems (including hyperactive, impulsive, attention difficulties) |
| <input type="checkbox"/> Conduct/delinquency-related problems (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact) |
| <input type="checkbox"/> Substance use, abuse, and dependence-related problems |
| <input type="checkbox"/> Adjustment-related problems (including changes in behaviors or emotions in reaction to a significant life stress) |
| <input type="checkbox"/> Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors) |
| <input type="checkbox"/> Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior) |
| <input type="checkbox"/> Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech and language delay) |
| <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> School performance problems not related to learning disabilities |
| <input type="checkbox"/> Eating Disorders (anorexia, bulimia, obesity) |
| <input type="checkbox"/> Trauma (community violence, school violence, complex trauma, domestic violence, medical trauma, natural disasters, neglect, physical abuse, refugee and war zone trauma, sexual abuse, terrorism, traumatic grief) |
| <input type="checkbox"/> Other Problems (Please specify): |

CRITICAL INFORMATION FOR ELIGIBILITY

IMPORTANT: Eligibility factors are largely based on risk of out-of-home placement or hospitalization. Be explicit and detailed including the level of severity and frequency of the behaviors. *DC PRTF Admission criteria listed on page 9 of this referral form should be addressed here. Add additional pages if necessary.*

At-Home: (examples: safety concerns for youth and/or family, rebellious, curfew violations, physical aggression, trauma)

In School: (examples: attendance, suspension, altercations, weapons)

In Community: (examples: involvement with Crisis Services, Juvenile Justice involvement, substance abuse)

Services Received within Last Year to Attempt to Stabilize Youth :

Please select all that apply and add additional pages regarding outcomes if necessary

| | Agency/Individual | Dates of Service |
|--|-------------------|------------------|
| <input type="checkbox"/> Inpatient Acute Hospitalization (s) | | |
| <input type="checkbox"/> Inpatient Sub-acute Hospitalization (s) | | |
| <input type="checkbox"/> Psychiatric Residential Treatment (any time within last 5yrs) | | |
| <input type="checkbox"/> Individual Therapy (frequency:) | | |
| <input type="checkbox"/> Family Therapy (frequency:) | | |
| <input type="checkbox"/> Community Support | | |
| <input type="checkbox"/> Community Based Intervention | | |
| <input type="checkbox"/> Multi-Systemic Therapy | | |
| <input type="checkbox"/> Functional Family Therapy | | |
| <input type="checkbox"/> Trauma-Focused Cognitive Behavior Therapy | | |
| <input type="checkbox"/> School Mental Health Services (specify type:) | | |
| <input type="checkbox"/> Substance Abuse Treatment | | |
| <input type="checkbox"/> Day Treatment | | |
| <input type="checkbox"/> One-on-One Staff (frequency/setting:) | | |
| <input type="checkbox"/> Special Education Services (IEP) | | |
| <input type="checkbox"/> Other (specify) | | |
| <input type="checkbox"/> Other (specify) | | |

Justification for PRTF Level of Care

Indicate why lower levels of service have not been successful in stabilizing this youth and why he/she requires PRTF to meet her/her needs.

Expectations from PRTF

Please identify the goals of treatment in PRTF, the anticipated length of stay in PRTF, and anticipated plans upon discharge.

Goals:

Anticipated Length of Stay:

Anticipated Discharge Plans:

Youth & Family Strengths

Describe youth and family **strengths** that will assist in keeping the youth at home and within the community; or, what strengths will assist in the successful return of the youth from placement.

To Be Completed By Parent/Legal Guardian Only:

The Department of Mental Health recognizes that families have a voice and choice during the process for reviewing for medical necessity for treatment in a Psychiatric Residential Treatment Facility (PRTF). I, as the parent/caregiver, understand that my family's strengths and needs were identified prior to this review. I will continue to work with my child/family team to help determine what will work best for my child and family.

Name of Parent or Legal Guardian (Print): _____

Signature: _____ Date: _____

District of Columbia PRTF Admission Criteria

Beneficiaries are considered a candidate for this level of care if they present with items 1-9:

- 1) The child/adolescent/young adult must be between the ages of 5 and 21 years old;
- 2) Presence of a severe emotional disturbance as evidenced by all of the following:
 - a) An Axis I primary diagnosis provided by a licensed professional working within his/her scope of practice; and
 - b) Documented history of multiple unsuccessful treatment approaches which include receiving a wide range of modalities (i.e. in-home and community based services, acute psychiatric hospitalizations, psychiatric medication intervention, etc.) at least within the past year resulting in poor outcomes; and
- 3) Maladaptive behaviors are expected to continue for six (6) months or longer without treatment;
- 4) Clinical documentation indicating current and consistent severe functional impairment within the past six (6) months in multiple life domains that include two or more of the following:
 - a) Recurrent suicidal/homicidal ideation without current intent, plan or means;
 - b) Pattern of absconding from primary care taker and school placement;
 - c) Impulsivity and/or physical aggression;
 - d) Problematic sexual behaviors, such as:
 - Sexually reactive behavior, or
 - Sex offending behavior;
 - e) Persistent substance abuse/use regardless of continued or increasing negatively associated consequences and multiple treatment attempts;
 - f) Psychosis that has not responded favorable to in-home and community-based supports and services; and/or
 - g) Persistent maladaptive behaviors that are related to a mood disorder.
- 5) Disturbances/behaviors/symptoms are such that treatment cannot be successfully provided in a lower level of care.
- 6) The child/adolescent/young adult has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and intervention.
- 7) The child/adolescent/young adult requires a time limited period for stabilization and community re-integration.
- 8) The child/adolescent's/young adult's behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment.
- 9) A Child and Family Teaming process where the child/youth, family members, natural/informal supports, community-based mental health providers, and other professional supports have been involved in the intensive in-home and community-based care planning process and the decision for a referral to review for a PRTF Level of Care. Included in the Child and Family Teaming process are multiple meetings over a period of time where there has been tracking and adjusting of the in-home and community-based Plan of Care, outreach and engagement strategies with family, if needed, have occurred, and a mix of traditional and non-traditional supports have been included in the Plan of Care.

Authorization
to Use or Disclose Protected Information
Department of Mental Health (DMH)
Child and Youth Services Division (CYSD)

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to District of Columbia children or youth with mental health issues. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations.

I hereby give permission to use and disclose health, mental health, alcohol and drug, education, child welfare, and juvenile justice records as described below.

The person whose information may be used or disclosed is:

| | |
|--|-------------------------|
| Name of child or youth (type or print) | eCura # (if applicable) |
| Address | Date of Birth |
| City/State/Zip Code | Other name(s) used |

The information that may be used or disclosed includes: (check all that apply)

- Health Records
- Mental Health Records
- Alcohol/Drug Records
- School or Education Records
- Child Welfare Records
- Juvenile Justice Records
- Other records (list) _____
- All of the records listed above

This information may be disclosed by:

- Any person or organization that possesses the information to be disclosed as a result of providing health, education, child welfare, juvenile justice, or other related services.
- The organizations listed on Page 4
- The following persons or organizations that provide services to me:

| |
|--|
| |
| |
| |

This information may be disclosed to:

- Any person or organization that needs the information to provide services to the child/youth who is the subject of the record; pay for those services; or engage in quality assurance or other health care operations related to the child/youth as a result of providing health, education, child welfare, juvenile justice, or other related services.
- The organizations listed on Page 4
- The following persons or organizations:

| |
|--|
| |
| |
| |

The purposes for which this information may be used and disclosed include:

Evaluation of eligibility to participate in a child and family teaming process or review for medical necessity for Psychiatric Residential Treatment Facility (PRTF);
Delivery of services as a result of providing health, education, child welfare, juvenile justice, or other related services, including care coordination and case management;
Payment for such services; and
Health care operations, such as quality assurance.
Other, List: _____

EXPIRATION: This authorization will expire 365 days from the date this form was signed unless one or both of the following is checked, in which case it will expire on the earliest occurrence.

- On ____ / ____ / _____ (cannot be more than 365 days from the date of this form).
- When the following happens: _____
(must relate to the consumer or to the purpose of this request, e.g., discharge from PRTF, court case closed).

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization will *not* affect any action by the organization that was authorized to release this information before it received my written notice of revocation. I understand that my right to revoke this authorization may be limited if the purpose of this authorization involves applying for health or life insurance.

I revoke this authorization effective ____ / ____ / _____

Signature of child/youth if age of 14, or parent or legal guardian and relationship to the child/youth

UNAUTHORIZED DISCLOSURE:

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

I understand that this information cannot legally be redisclosed by the person or organization that received it without my authorization.

OTHER RIGHTS:

I understand that I have the right to inspect my record of protected health information. I also understand that I cannot be denied enrollment or services if I decide not to sign this form. However, I may not be able to apply for benefits or renewal of benefits that would help pay for these services.

AUTHORITY TO ACT ON BEHALF OF CHILD OR YOUTH (check one):

Parent _____ Legal guardian _____ (for legal guardian, must provide the guardianship order)

_____ Custodial agency representative, if parental rights are terminated.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

I, _____, understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

Signature Date: _____

Print or type full name

Address: _____

Phone Number: _____

SIGNATURE OF MINOR:

If the consumer is at least 14 years of age, but under 18 years of age, this authorization is not valid unless the child/youth signs in addition to the parent/legal guardian/agency representative. A minor of any age may authorize disclosure based on his or her signature alone, if (1) he or she is an emancipated minor, or (2) he or she is receiving treatment or services without a parent or legal guardian giving consent.

Signature of Minor Date: _____

Print or type full name Date of Birth: _____

Address: _____

Phone Number: _____

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the child if age 14 or parent or legal guardian.
2. Put signed original in the child/youth's clinical record.
3. Send a copy of this form with the information to be disclosed.

This permission to use or disclose protected information applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to District of Columbia children and youth.

___ Department of Mental Health (DMH)

___ Child and Family Services (CFSA)

___ Department of Youth Rehabilitation Services (DYRS)

___ Court Social Services (CSS)

___ DC Public Schools (DCPS)

___ Office of the State Superintendent of Education (OSSE)

___ Managed Care Organization (MCO) that provides services to the child or youth: _____
(Name)

___ Contracted mental health providers that provide services or supports to the child or youth (e.g., child's CSA, subproviders and specialty providers, DC choices)

___ Addiction Prevention and Recovery Administration (APRA)

___ Psychiatric Institute of Washington (PIW)

___ Children's National Medical Center (CNMC)

___ Psychiatric Residential Treatment Facility (PRTF) where child is placed

___ Other, list below:

GOVERNMENT OF THE DISTRICT OF COLUMBIA



Department of Mental Health
Continued Stay in a Psychiatric Residential Treatment Facility
Medical Necessity Review Referral Form

- 1) REFERRALS FOR CONTINUED STAY IN A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) MUST BE RECEIVED FROM THE MONITOR OR PLACING AGENCY AT LEAST ONE (1) MONTH PRIOR TO THE END OF THE CURRENT CERTIFICATION PERIOD. IF NOT, THE REFERRAL MAY NOT BE REVIEWED PRIOR TO THE EXPIRATION DATE.
- 2) REFERRALS SENT AFTER THE EXPIRATION DATE OF THE CURRENT CERTIFICATION PERIOD WILL BE REVIEWED ONLY AFTER ALL OTHER PENDING REFERRALS HAVE BEEN REVIEWED.
 - *The Department of Health Care Finance (DHCF) will not authorize Medicaid payment for a child or youth in a PRTF without a current medical necessity determination.*
- 3) REFERRALS WHICH ARE ILLEGIBLE, INCOMPLETE, OR DO NOT HAVE REQUIRED SUPPORTING DOCUMENTATION WILL NOT BE REVIEWED BY THE PRTF MEDICAL NECESSITY REVIEW COMMITTEE. **IF THE REFERRAL PACKET IS INCOMPLETE, IT WILL BE SENT BACK TO THE REFERRING PARTY WITH FURTHER INSTRUCTIONS.**
- 4) PLEASE COMPLETE THE REFERRAL FORM AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION (DMH HIPAA-FORM 3- CYSD). SUBMIT THESE WITH ALL OTHER SUPPORTING DOCUMENTATION AS LISTED ON PAGE 5.
- 5) THE REFERRAL FORM AND ALL SUPPORTING DOCUMENTATION SHOULD BE SENT ELECTRONICALLY TO PRTF.REVIEWCOMMITTEE@DC.GOV. IF YOU NEED TO SEND THE DOCUMENTATION BY AN ALTERNATIVE METHOD, PLEASE CONTACT THE PRTF COORDINATOR AT 202-673-3451.
- 6) ONCE A REFERRAL PACKET IS RECEIVED, THE PRTF COORDINATOR WILL REVIEW THE PACKET FOR (1) COMPLETENESS AND (2) CONTENT. THE COORDINATOR MAY REQUEST ADDITIONAL INFORMATION FROM THE REFERRING AGENCY WHICH MUST BE PROVIDED WITHIN A SPECIFIED DUE DATE. THE COORDINATOR WILL THEN PROVIDE A CASE SUMMARY TO THE PRTF REVIEW COMMITTEE.
- 7) UNLESS ADDITIONAL, ESSENTIAL INFORMATION IS REQUIRED TO MAKE A DETERMINATION, THE PRTF REVIEW COMMITTEE WILL REVIEW THE CASE AND MAKE A DETERMINATION.
- 8) WITHIN 1-2 BUSINESS DAYS OF THE DETERMINATION, THE PRTF COORDINATOR WILL PROVIDE THE WRITTEN DETERMINATION WITH ANY ADDITIONAL RECOMMENDATIONS MADE BY THE REVIEW COMMITTEE TO THE REFERRING PARTY, DHCF, AND THE PRTF.

IF THERE ARE ANY QUESTIONS REGARDING THIS PROCESS,
PLEASE CONTACT THE PRTF COORDINATOR AT 202-673-3451.

Time-length of last Medical Necessity Certification: ___ months

End Date of Last Certification: _____

Projected Discharge Date: _____

Additional certification time recommended by the Treatment Team: _____

The information provided below is from the following sources (as applicable):

Telephone interview with _____ Date: _____
Name Title

Telephone interview with _____ Date: _____
Name Title

Psychiatric Evaluation completed by _____, M.D. Date: _____

Comprehensive Individual Plans of Care for these Dates: _____

Notes of Progress (i.e., either summaries or notes from individual therapy, family therapy, etc.):

_____ Date(s): _____
Name Title

_____ Date(s): _____
Name Title

Other (if applicable, please specify with dates):

Diagnosis(es) according to most recent treatment plan from the PRTF:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF

Current Medications (including dose and schedule of administration):

Facility's response to PRTF Committee's recommendation on previous Letter of Certification:

PRTF Continued Stay Criteria:

Using the Continued Stay Criteria below, please provide *detailed justification for each item below* (please include separate pages to address this section).

- 1) Admission criteria continue to be met. *(Please address each of the PRTF Admission Criteria as outlined on page 6.)*
- 2) Caregivers (parents/legal guardian and foster parents), and other family members, are actively involved in their child's treatment and discharge planning, and are actively involved in their child's treatment as outlined in the treatment plan that is based on the family's needs.
- 3) The legal custodian/lead agency is actively involved in the child's treatment and discharge planning, and is actively involved in their child's treatment as outlined in the treatment plan that is based on the family's needs.
- 4) Treatment is individualized and documentation of needed adjustments are made.
- 5) Symptoms/behaviors are reasonably expected to improve with continued treatment so that the child/youth/young adult may be transitioned to a lower less restrictive level of care. *(Include evidence of treatment effectiveness. For example, indicate observable behaviors which have improved. Also include efforts towards discharge planning.)*

All of the following documents must be included for a complete referral packet
 (Please check each box to indicate that these documents are included with this referral):

- Completed Referral Form with Justification for Criteria Completed
- Copy of previous medical necessity determination Level of Care (LOC) letter
- Authorization to Use or Disclose Protected Health Information signed by parent/legal guardian (Use the attached DMH HIPAA Form 3-CYSD)
- All Psychiatric Evaluations (within the last year)
- Last 2 Treatment Plans/Reviews/Summaries
- Summary of Progress in Therapy
- Court Order for PRTF (if applicable)
- All Psychological Evaluations (within the last two years)
- All Psycho-educational Evaluations (within the last two years)
- Most recent Individualized Education Program (IEP), if applicable
- Most recent Social Study completed by Court Social Services (CSS), if applicable

Referral Packet completed by (print): _____

Signature: _____ Name/Title Date: _____

Email: _____ Phone: _____

By signing below, I am certifying that the District agency/entity clinical team working with this child/youth believes that he/she meets medical necessity and this referral includes all of the above required documentation for this review:

Referring Agency Representative (print): _____

Signature: _____ Name/Title Date: _____

Email: _____ Phone: _____

Supervisor (print): _____

Signature: _____ Name/Title Date: _____

Email: _____ Phone: _____

Organization/Agency Affiliation: _____

PRTF Admission Criteria

Beneficiaries are considered a candidate for this level of care if they present with items 1-9:

- 1) The child/adolescent/young adult must be between the ages of 5 and 21 years old;
- 2) Presence of a severe emotional disturbance as evidenced by all of the following:
 - a) An Axis I primary diagnosis provided by a licensed professional working within his/her scope of practice; and
 - b) Documented history of multiple unsuccessful treatment approaches which include receiving a wide range of modalities (i.e. in-home and community based services, acute psychiatric hospitalizations, psychiatric medication intervention, etc.) at least within the past year resulting in poor outcomes; and
- 3) Maladaptive behaviors are expected to continue for six (6) months or longer without treatment;
- 4) Clinical documentation indicating current and consistent severe functional impairment within the past six (6) months in multiple life domains that include two or more of the following:
 - a) Recurrent suicidal/homicidal ideation without current intent, plan or means;
 - b) Pattern of absconding from primary care taker and school placement;
 - c) Impulsivity and/or physical aggression;
 - d) Problematic sexual behaviors, such as:
 - Sexually reactive behavior, or
 - Sex offending behavior;
 - e) Persistent substance abuse/use regardless of continued or increasing negatively associated consequences and multiple treatment attempts;
 - f) Psychosis that has not responded favorable to in-home and community-based supports and services; and/or
 - g) Persistent maladaptive behaviors that are related to a mood disorder.
- 5) Disturbances/behaviors/symptoms are such that treatment cannot be successfully provided in a lower level of care.
- 6) The child/adolescent/young adult has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and intervention.
- 7) The child/adolescent/young adult requires a time limited period for stabilization and community re-integration.
- 8) The child/adolescent's/young adult's behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment.
- 9) A Child and Family Teaming process where the child/youth, family members, natural/informal supports, community-based mental health providers, and other professional supports have been involved in the intensive in-home and community-based care planning process and the decision for a referral to review for a PRTF Level of Care. Included in the Child and Family Teaming process are multiple meetings over a period of time where there has been tracking and adjusting of the in-home and community-based Plan of Care, outreach and engagement strategies with family, if needed, have occurred, and a mix of traditional and non-traditional supports have been included in the Plan of Care.



DEPARTMENT OF MENTAL HEALTH

**MEDICAL NECESSITY DETERMINATION
APPEAL REQUEST FORM**

The Department of Mental Health (DMH) provides an opportunity for an Appeal of a denial of medical necessity certification for Psychiatric Residential Treatment Facility (PRTF) placement.

1. **An appeal request form with supporting documentation must be sent to: prtf.reviewcommittee@dc.gov within ten (10) business days of the date of the DMH Denial of Medical Necessity letter.**
2. If you need to fax the documentation, please fax the information to 202-673-7502 to the attention of the Child and Youth Services Division Program Assistant and titled as "LOC Appeal".
3. **Upon emailing or faxing the appeal request, call 202-671-2901 to confirm receipt.**
4. The written request for an appeal must include signature of the appealing party and the date of submission.
5. The appeal request form should include a clear, brief statement of appeal with factual support (clinical and other documentation), if appropriate, and an explanation of why the appealing party disagrees with the determination that was made.
6. The appeal packet should also include a copy of the recent child and family team's Individualized Plan of Care and a copy of the medical necessity determination being appealed.
7. The Program Manager for PRTF Diversion, Technical Assistance, and Coaching for Children's Mental Health, or designee, will ensure that the appeal is complete, including all documents (clinical notes and evaluations on the youth) in DMH possession.
8. The Program Manager for PRTF Diversion, Technical Assistance, and Coaching for Children's Mental Health, or designee, will submit the appeal to an independent reviewer (a board certified child and adolescent psychiatrist contracted by DMH for this purpose) within one (1) business day of verifying a complete packet. A copy will also be sent to the DMH Chief Clinical Officer.
9. The independent reviewer will submit a recommendation on medical necessity and length of stay, if applicable, based on a review of all submitted materials, within (7) seven business days of receipt of the appeal and will communicate that recommendation (electronically) to the DMH Chief Clinical Officer. The independent reviewer will mail the hard copy of the appeal recommendation to the DMH Chief Clinical Officer.
10. **The DMH Chief Clinical Officer will make a determination within seven (7) business days of receiving the recommendation from the independent reviewer.** Once the determination has been made, the Office of the Chief Clinical Officer will send the written determination to the PRTF Coordinator, who will send the determination letter to the appealing party; the Associate Chief Clinical Officer for Children and Youth; and the Program Manager for PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health within one (1) business day of receipt.
11. If the appealing party is not satisfied with the written determination rendered by the DMH Chief Clinical Officer, the determination may be appealed to the Office of Administrative Hearings (OAH) or the Office of the Health Care Ombudsman and Bill of Rights for a fair hearing within ten (10) business days of the date of the determination letter.

**DMH MEDICAL NECESSITY DETERMINATION
APPEAL REQUEST FORM**

| | |
|---|--|
| <p>Name of Child/Youth: _____ DOB: _____</p> <p>Next Court Date: _____ Judge: _____</p> <p>Date of last child and family team meeting: _____</p> <p>Date of medical necessity determination: _____</p> <p>Appellant's relationship to child: <i>(if not legal guardian, must supply proof that legal guardian supports appeal)</i></p> | <p>Daytime Telephone Number of Appealing Party</p> <hr/> <p>Name, Agency, Address and Email of Appealing Party</p> |
|---|--|

SPECIFIC REASON(S) FOR APPEAL:
Explain why you disagree with the DMH Denial of PRTF Medical Necessity determination. Include any behavior, treatment or placement records that post-date the medical necessity determination or that were not previously included in the initial packet.

Please include contact information of any interested parties (family members, service providers, guardian *ad litem*, etc.).

Describe attempts to fulfill the recommendations of the medical necessity determination, and why these attempts were unsuccessful. (Attach additional sheets if necessary)

| | |
|-----------------------------|-----------------------|
| Requestor's Name _____ | Agency _____ |
| Requester's Signature _____ | Date of Request _____ |

Are the services of an interpreter required for any requested contacts? Yes No

If yes, what type _____