Department of Behavioral Health
TRANSMITTAL LETTER

SUBJECT **Psychiatric Residential Treatment Facility (PRTF) Medical Necessity Determination Process**		
POLICY NUMBER **DBH Policy 200.7**	**DATE** AUG 1 9 2014	**TL#** 263

Purpose. This policy was updated to convert the Department of Mental Health (DMH) policy to a Department of Behavioral Health (DBH) policy. Other changes include: adding a medical necessity review process for Medicaid Managed Care Organization's initial placement in a PRTF; updating the HIPAA Form 3A – CYSD authorization form; adding a PRTF Continued Stay Frequently Asked Questions sheet; and requiring a psychiatric evaluation within the last six (6) months verses one (1) year for initial placement in a PRTF.

Applicability. This policy governs DBH medical necessity determinations prior to admitting any Medicaid eligible child or youth to a PRTF, and continued stay medical necessity determinations for all Medicaid eligible children currently in a PRTF.

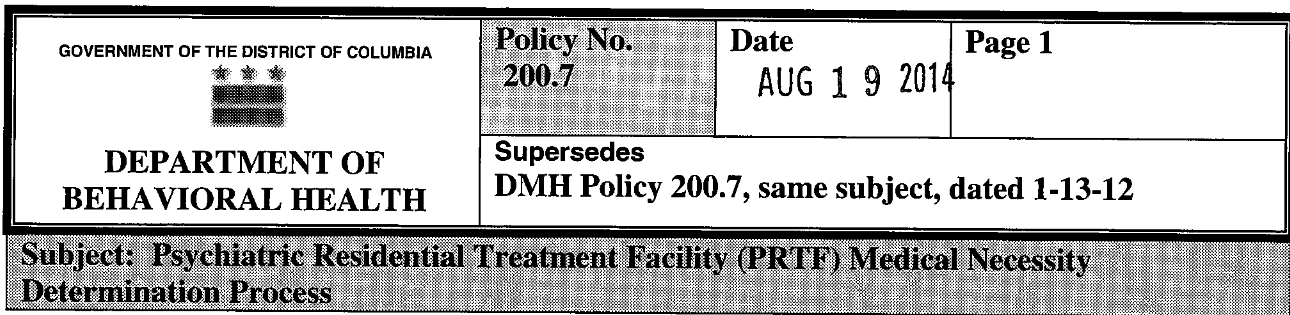
Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority offices.

Effective Date. This policy is effective immediately.

Superseded Policies. This policy replaces DMH Policy 200.7, same subject, dated January 13, 2012.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff are familiar with the contents of this policy.

Stephen T. Baron
Director, DBH



GOVERNMENT OF THE DISTRICT OF COLUMBIA **DEPARTMENT OF BEHAVIORAL HEALTH**	**Policy No.** 200.7	**Date** AUG 1 9 2014	**Page 1**
	Supersedes DMH Policy 200.7, same subject, dated 1-13-12		

Subject: Psychiatric Residential Treatment Facility (PRTF) Medical Necessity Determination Process

1. **Purpose**. The Department of Behavioral Health (DBH) works to treat and support children and youth within their own communities with appropriate services and supports that involves the family and natural supports. Placement of a child or youth in a Psychiatric Residential Treatment Facility (PRTF) requires a determination of medical necessity.

This policy establishes the procedures for the DBH 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.

2. **Applicability**. This policy governs (1) DBH medical necessity determinations prior to admitting any Medicaid eligible child or youth to a PRTF, and (2) continued stay medical necessity determinations for all Medicaid eligible children currently in a PRTF.

3. **Authority**. 42 CFR § 441.152, Certification of Need for Services; Department of Behavioral Health Establishment Act of 2013; 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, DBH has the authority and responsibility to determine medical necessity for all PRTF placements for Medicaid eligible children and youth. This policy sets forth the requirements and procedures that DBH will follow when conducting medical necessity determinations for all PRTF placements. To ensure an efficient and transparent process, DBH has developed referral procedures 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 includes an explanation of why lower levels of community services have not been successful, and compelling reasons why placement in a PRTF is necessary. DBH 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 with community-based mental health services, 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 for organizations listed in 7b below.

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.

6e. When DBH is contacted by a Medicaid Managed Care Organization (MCO), a PRTF sub-group will review an MCO's initial placement in collaboration with the MCO. See Exhibit 6 for the MCO PRTF Medical Necessity Review Referral Process.

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 the guidelines in 42 CFR § 441.152, D.C. Municipal Regulation 29 DCMR § 948, and the requirements of this policy in order to issue a medical necessity determination for PRTF placement.

7b. The PRTF Review Committee will review:

- Referrals of children and youth for placement in a PRTF by a District agency including, but not limited to, DBH, 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 and youth that are MCO beneficiaries whose insurance will convert to Fee-for-Service Medicaid as a result of the placement in the PRTF *(See Exhibit 6 for MCO initial placements in PRTFs)*; and
- Referrals for children currently in a PRTF for whom continued stay is recommended.

7c. Membership. The following District agencies/organizations will appoint in writing a primary and alternate mental health professional to serve on the committee. The Committee chairman and non-government members will be appointed by the DBH Director.

- DBH board certified child and adolescent psychiatrist,
- Department of Youth Rehabilitation Services (DYRS),
- Child and Family Services Agency (CFSA),
- DC Public Schools (DCPS),
- Office of the State Superintendent of Education (OSSE),
- Court Social Services (CSS),
- The agency designated as the family advocacy group for families with children receiving care from DBH, and
- DBH PRTF Coordinator (non-voting member).

7d. PRTF Medical Necessity Determination.

(1) In order to issue a medical necessity determination for placement of a child or youth in a PRTF, the following PRTF medical necessity criteria must be met:

(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.

7e. 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 DBH privacy policies regarding confidentiality of protected health information. Also see Section 10 below.

7f. Annual Report. The PRTF Review Committee will produce an annual report on PRTF referrals and post on the DBH website. The report will include the following:

- summary of all referrals by referral source,
- final decision of the Committee, and
- list of PRTFs used and the addresses.

No individually identifiable information will be included in the annual report.

8. **Responsibilities**.

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

(1) Complete the DBH Admission to a PRTF Medical Necessity Review Referral Form *(Exhibit 1),* and DBH HIPAA Form 3A – CYSD, Authorization to Use or Disclose Protected Information (Exhibit 2) and submit electronically to: PRTF.ReviewCommittee@dc.gov.

- Referrals that are illegible, deemed 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 present the reasoning by which they believe the child/youth meets medical necessity criteria and to answer questions and provide additional information as needed.

(3) Notify the Clinical Program Manager of the DBH RTC Reinvestment Program of the date of admission and name of PRTF within 48 hours of placement 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 DBH 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. Also see Exhibit 4 for PRTF Continued Stay Frequently Asked Questions (FAQs) for information on telephonic case presentation, medical necessity determination, etc.

- 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 (DHCF) 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 referrals deemed complete, 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 and prepare/maintain minutes of all Committee meetings.

(6) Issue written decision on medical necessity and length of stay to the referring entity and the DHCF within two (2) business days of Committee's determination, and for continued stays, to the PRTF as well.

(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 7f 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 DBH Medical Necessity Determination Appeal Request Form (Exhibit 5) with supporting documentation to PRTF.ReviewCommittee@dc.gov within ten (10) business days of the date of the letter of the DBH denial of medical necessity.

9b. The PRTF Coordinator will:

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

9d. The DBH 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 and the DBH Associate Chief Clinical Officer).

9e. If the appealing party is not satisfied with the written determination rendered by the DBH 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.

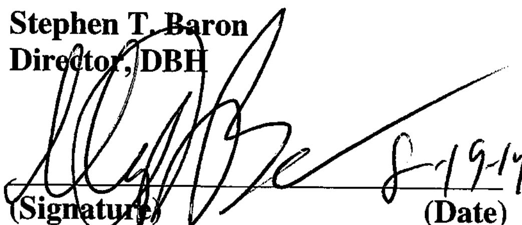
10. **Confidentiality**. The PRTF Review Committee is subject to all requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Information Act (MHIA), and 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, regarding use and disclosure of protected health information.

11. **Inquiries**. Questions regarding this process may be directed to the DBH PRTF Coordinator or the DBH Associate Chief Clinical Officer.

12. **Exhibits**.
Exhibit 1 - DBH Admission to a PRTF Medical Necessity Review Referral Form
Exhibit 2 - DBH HIPAA Form 3A – CYSD, Authorization to Use or Disclose Protected Information
Exhibit 3 - DBH Continued Stay in a PRTF Medical Necessity Review Referral Form
Exhibit 4 - PRTF Continued Stay FAQs
Exhibit 5 - DBH Medical Necessity Determination Appeal Request Form
Exhibit 6 – MCO PRTF Medical Necessity Review Referral Process

Approved By:

Stephen T. Baron
Director, DBH



(Signature) 8-19-14 **(Date)**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Admission to a Psychiatric Residential Treatment Facility Medical Necessity Review Referral Form

Every child/youth that 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 the Department of Behavioral Health (DBH).

1.) Please complete the PRTF Referral form and authorization to use or disclose protected information (see the attached DBH HIPAA Form 3A – CYSD). Submit these with all other supporting documentation as listed on page 2.

2.) Referrals which are illegible, deemed incomplete, or do not have required supporting documentation will not be reviewed by the PRTF Review Committee. **If the referral packet is deemed 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 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 PRTF Coordinator may request additional information from the referring party which must be provided within a specified due date. The PRTF Coordinator will then provide a complete and vetted referral packet 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 two (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 PRTF 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.

	Authorization to Use or Disclose Protected Information (Use DBH HIPAA FORM 3A-CYSD)
	Parent/Caregiver Authorization for Medical Necessity Review for Psychiatric Residential Treatment (page 8 of referral)
	All Psychiatric Evaluations completed within last six (6) months. Any Referral without a psychiatric evaluation completed within the last six (6) months will be considered incomplete, unless there are extenuating circumstances approved by the PRTF Coordinator and Chairman.
	All Psychological Evaluations completed within last two (2) years
	All Psycho-educational Evaluations completed within last two (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 currently in a facility or hospital)
	Discharge Summaries from last two hospitalizations (if applicable)
	Psychosocial Evaluation/Summary completed within last two (2) years
	Social Study from Court Social Services (CSS) completed within last two (2) years
	Recent All Court Reports from past two (2) years (must include description of any recent offenses, judge, attorney, defense attorney)
	Current Plan of Care or Team Meeting Notes over last six (6) months (including sign-in sheets)
	Individualized Education Program (if applicable)
	Any other information relevant to this review (such as 504 plan, recent progress notes, evaluation, neuropsychological evaluation, neurologic examination, and other evaluations)

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: ☐ Male ☐ Female
Address: (Current address, city, state, zip code)		Phone #:

Primary Language Spoken:	Secondary Language (if any):
☐ The family reads and speaks English at home	☐ Family speaks a different language at home:
The family needs an interpreter: ☐ Yes ☐ No	If different language, please list:
Medicaid Eligible: ☐ Yes ☐ No ☐ TBD	If, yes, please provide Medicaid #:
	Check One: ☐ Fee For Service ☐Managed Care ☐ HSCSN

Race/Ethnicity: (If Hispanic/Latino, choose from Section B; all others, choose from Section A)	
Section A:	**Section B:**
☐ American Indian/Alaska Native	☐ Mexican
☐ Asian	☐ Puerto Rican
☐ Black or African American	☐ Cuban
☐ Native Hawaiian or Other Pacific Islands	☐ Dominican
☐ White	☐ Central American
☐ Biracial (Specify):	☐ South American
☐ Other (Specify):	☐ 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: □ Yes □ 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:
□ Regular Education (specify accommodations, if any):	□ Special Education (attach Individualized Education Program) □ Primary Disability Category:	□ Other (specify):
Is the attendance of the youth an issue/concern? □ Yes □ No		
If Yes, what has been done to address it:		

Teaming	
Team Meeting Notes or Plan of Care Attached □ Yes □ No	
Has the team met routinely and adjusted the Plan of Care? □ Yes □ No If Yes, how often:	
If No, please explain:	
Teaming/ Care Coordination provided by:	
□ DC Choices Wraparound Process	
□ Far Southeast Collaborative Child and Family Teaming □ GA Avenue Collaborative Child and Family Teaming	
□ DYRS Youth and Family Teaming	□ CSS Family Group Conferencing
□ Other (specify):	
Name of Team Facilitator/Care Coordinator:	

Is the team in consensus about referring this youth to PRTF? □ Yes □ No
If No, identify the parties who disagree and why:

If the child is currently hospitalized, is the inpatient team recommending PRTF placement upon discharge? If not, explain. (If applicable, please list the name of the hospital and treating psychiatrist.)

Current System Involvement and Team Members (Select all that apply)			
	Contact Person	Phone #	Email
□ Court Social Services (Probation)			
□ Department of Youth Rehabilitation Services			
□ Education			
□ Child and Family Services Agency			
Parents' Rights Terminated: □Yes □ No			
□ Special Education			
□ Mental Health Provider agency name:			
□ Specialty Mental Health Provider: (For example, CBI, MST, FFT, private therapist)			
□ Hospital			
□ Physical Health Care Agency/Clinic/Provider			
□ Substance Abuse Agency/Clinic/Provider			
□ Guardian ad Litem or Attorney			
□ Other (Please specify)			

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

Out of Home Placement Due to Family Court		
Is placement related to Child Welfare?	□ Yes	□ No
Is placement related to Juvenile Justice?	□ Yes	□ 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)
☐ Medicaid (Check one) ☐Fee For Service ☐Managed Care ☐Health Services for Children with Special Needs
☐ TANF (public assistance): ☐ Yes ☐ No ☐ Private Insurance (specify):
☐ Social Security Disability Income & Amount (SSI Benefits):

DSM Diagnosis Source (provided within last 6 months)		
Which professional source made the diagnosis as indicated in the following information below?		
☐ Child Psychiatrist	☐ Licensed Clinical Social Worker	☐ Child Psychologist
☐ General Psychiatrist	☐ Nurse Practitioner	☐ General Psychologist
	☐ Other: ______________	
Name of Clinician:		Date of Diagnosis:

DSM Diagnosis Information
Psychiatric Diagnosis:

What are the problems within last 6 months that led to this referral for PRTF? **Check** and **Circle** all that apply
☐ Suicide-related problems (including suicide ideation, suicide attempt, self-injury)
☐ Depression-related problems (including major depression, dysthymia, sleep disorders, somatic complaints)
☐ Anxiety-related problems (including fears and phobias, generalized anxiety, social avoidance, obsessive-compulsive behavior, post-traumatic stress disorder)
☐ Hyperactive and attention-related problems (including hyperactive, impulsive, attention difficulties)
☐ 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)
☐ Substance use, abuse, and dependence-related problems
☐ Adjustment-related problems (including changes in behaviors or emotions in reaction to a significant life stress)
☐ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
☐ Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)
☐ Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech and language delay)
☐ Learning Disabilities

□ School performance problems not related to learning disabilities
□ Eating Disorders (anorexia, bulimia, obesity)
□ 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)
□ 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
□ Inpatient Acute Hospitalization (s)		
□ Inpatient Sub-acute Hospitalization (s)		
□ Psychiatric Residential Treatment (any time within last five [5] years)		
□ Individual Therapy (frequency:)		
□ Family Therapy (frequency:)		
□ Community Support		
□ Community Based Intervention		
□ Multi-Systemic Therapy		
□ Functional Family Therapy		
□ Trauma-Focused Cognitive Behavior Therapy		
□ School Mental Health Services (specify type:)		
□ Substance Abuse Treatment		
□ Day Treatment		
□ One-on-One Staff (frequency/setting:)		

☐ Special Education Services (IEP)		
☐ Other (specify)		
☐ 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 Behavioral 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 the following items:

1) The child/youth 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) A primary psychiatric 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.
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 (2) 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/youth has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and intervention.
7) The child/youth requires a time limited period for stabilization and community re-integration.
8) The child/youth'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.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Child and Youth Services Division
Authorization to Use or Disclose Protected Information

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 behavioral health issues. It permits use and disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations to ensure all of the child/youth's needs are met.

The person whose information may be used or disclosed is:

Name of child/youth (type or print) ______________________ Identification Number ______________

Address ____ Date of Birth ______________

____

City/State/Zip Code Other name(s) used

<u>The information that may be used or disclosed includes</u>: (check all that apply)

___ Health Records ___ Mental Health Records ____ Alcohol/Drug Records
___ School or Education Records ___ Child Welfare Records ____ Juvenile Justice Records
___ Records of presence of a communicable or non-communicable disease, and tests for records of HIV/AIDS
___ Other records (list) ____
___ All of the records listed above

<u>Limitations for Release</u>: (only check if there is a limitation)
☐ Only for dates of service from ________________ to ________________
☐ Exclusions ***(must list if there are any exclusions)*** ______________________________
☐ Only the following: ***(must list specific documents if applicable)*** ______________________

<u>This information may be disclosed by</u>: (check one)
___ The organizations listed on page 3.
___ Only the following persons or organizations that provide services to me: (List)

<u>This information may be disclosed to</u>: (check one)
___ The organizations listed on page 3.
___ Only the following persons or organizations:

<u>The purposes for which this information may be used and disclosed include</u>:
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.

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

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.

SIGNATURE OF PARENT OR LEGAL GUARDIAN, OR YOUTH AGE 18 OR OLDER:

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

Signature: ____ Date: __________

Print/Type Full Name: ____

Address: ____ Phone #: __________

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 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/Type Full Name: ____________________________________ Date of Birth: ____________

Address: ____________________________________ Phone #: ______________

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.

This information may be Disclosed By the following organizations: (cross out any that do not apply)	**This information may be Disclosed To the following organizations:** (cross out any that do not apply)
Department of Behavioral Health (DBH)	Department of Behavioral Health (DBH)
Child and Family Services (CFSA)	Child and Family Services (CFSA)
Department of Youth Rehabilitation Services (DYRS)	Department of Youth Rehabilitation Services (DYRS)
Court Social Services (CSS)	Court Social Services (CSS)
DC Public Schools (DCPS)	DC Public Schools (DCPS)
Office of the State Superintendent of Education (OSSE)	Office of the State Superintendent of Education (OSSE)
Rehabilitation Services Administration (RSA)	Rehabilitation Services Administration (RSA)
Department of Disability Services (DDS)	Department of Disability Services (DDS)
Managed Care Organization (MCO) that provides services to the child or youth: (Name) ______________________	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)	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)
Substance Use Disorder (SUD) Provider: (Name) ______________________	Substance Use Disorder (SUD) Provider: (Name) ______________________
Psychiatric Residential Treatment Facility (PRTF) where child is placed	Psychiatric Residential Treatment Facility (PRTF) where child is placed
Other: (List)	Other: (List)

I revoke this authorization effective ____________________

____

Signature of child/youth if age of 14, parent or legal guardian and relationship to the child/youth, or youth age 18 or older

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the child if age 14 & parent or legal guardian, or youth age 18 or older.
2. Put signed original in the child/youth's clinical record.
3. Send a copy of this form with the information to be disclosed.

DBH Policy 200.7
Exhibit 3 - 8a(4)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Continued Stay in a Psychiatric Residential Treatment Facility Medical Necessity Review Referral Form

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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.**
   Please note that 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.

2. **Referrals sent after the expiration date of the current certification period will be reviewed only after all other pending referrals have been reviewed.**

3. Referrals which are illegible, deemed 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.**

4. Please complete the referral form and authorization to use or disclose protected information (DBH HIPAA Form 3A – CYSD). Submit these forms with all other supporting documentation as listed on page 5.

5. The referral form and all supporting documentation should be sent electronically to the 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 completeness and content. The PRTF Coordinator may request additional information from the referring agency which must be provided within a specified due date. The PRTF 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 two (2) business days of the determination, the PRTF Coordinator will provide the written determination with any additional recommendations made by the PRTF 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.

Continued Stay in a PRTF
Medical Necessity Review Referral Form

Child/Youth Name: ______________________________ DOB: __________________

Provider/Facility: _____________________________Date of Admission: ___________

Father's Name: _____________________________ Phone: ______________________

Mother's Name: _____________________________ Phone: ______________________

Legal Guardian (if not parent) Name: _________________________________
Phone: _________________________________

Family Involvement in:
Treatment Planning Yes No (if no, indicate why): ____________________
____

Family Therapy Yes No (if no, indicate why): ____________________
____

Agency Involvement (please check all that apply):

Child and Family Services Agency (CFSA)
Court Social Services (CSS)
Department of Behavioral Health (DBH)
Department of Youth Rehabilitation Services (DYRS)
Office of the State Superintendent of Education (OSSE)
Local Education Agency (for example: DCPS, Charter School, etc.): ______________________
Public Defender Services
Other (please specify): ____

Name of Family Court Judge(s): (if applicable) ______________________________________

Next Court Date and Type of Hearing: (if applicable) ________________________________

Court-Order for PRTF? Yes No
(If yes, court order must accompany referral packet)

Education-Related Hearing Officer Determination (HOD) for PRTF Yes No
(If yes, HOD must accompany referral packet)

Date of Most Recent Treatment Team Meeting: ____________

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:

Current Medications (including dose and schedule of administration):

____
____
____
____
____

Prior Medications prescribed while in PRTF since admission (including dose, schedule and reasoning for discontinuation):

____

____

____

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

____

____

____

<u>PRTF Continued Stay Criteria</u>:

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 is made.

5) Symptoms/behaviors are reasonably expected to improve with continued treatment so that the child/youth 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 item 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 DBH HIPAA Form 3A-CYSD)

___ All Psychiatric Evaluations (within the last year)

___ Last two (2) Treatment Plans/Reviews/Summaries

___ Summary of Progress in Therapy

___ Court Order for PRTF (if applicable)

___ All Psychological Evaluations completed since admission to the PRTF

___ All Psycho-educational Evaluations completed since admission to the PRTF

___ 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): ____
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: ____________

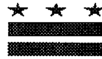
Organization/Agency Affiliation: ____

District of Columbia PRTF Admission Criteria

Beneficiaries are considered a candidate for this level of care if they present with the following items:

1) The child/youth 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) A primary psychiatric 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.
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 <u>without</u> 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/youth has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and intervention.
7) The child/youth requires a time limited period for stabilization and community re-integration.
8) The child/youth'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.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health



PRTF Continued Stay Frequently Asked Questions

Q1. What is the role of the PRTF Review Committee?

1) To determine whether it is medically necessary for a youth's treatment to continue in a Psychiatric Residential Treatment Facility (PRTF), and
2) To inform the District Department of Health Care Finance (DHCF) of the Committee's decision.
   a. If the Committee finds medical necessity, Medicaid will begin or continue to pay for the youth's treatment in the PRTF.
   b. If the Committee does not find medical necessity, Medicaid will discontinue payment.

Q2. What criteria must be met for the Committee to find medical necessity?

1) Community based services available in the community do not meet the treatment needs of the child or youth;
2) Proper treatment of the child or youth's psychiatric condition requires services on an inpatient basis under the direction of a physician, and
3) 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.

Q3. What District agencies/organizations are represented on the Committee?

1) Department of Behavioral Health (DBH)
2) Child and Family Services Agency (CFSA)
3) Department of Youth Rehabilitation Services (DYRS)
4) Court Social Services (CSS)
5) District of Columbia Public Schools (DCPS)
6) Office of the State Superintendant (OSSE)
7) The agency designated as the family advocacy group for families with children receiving care from DBH.

Q4. What is the Committee's process for making a medical necessity determination?

1) Each Committee member reviews the referral packet submitted to the Committee's coordinator.
   a. Even if a referral packet is filled out by a staff member from the PRTF, it must be co-signed by a representative (case manager, social worker, or Local Education Agency (LEA) representative) from the District agency that placed the youth in the PRTF.
   b. Completed referral packets must be submitted to the Committee's coordinator at least 30 days before the original/current authorization expires.

2) The Committee convenes for a telephonic case presentation by the PRTF treatment team, the youth's guardian, and relevant District agency representatives.
    a. The presenters should focus their presentation on why they believe the three (3) medical necessity criteria continue to be met (also see Q2 above).
    b. Committee members will ask the presenters specific questions they feel must be answered in order to make a medical necessity determination.
    c. The time allotted for the presentation and question/answer session is 45 minutes.

3) The Committee excuses the presenters, and deliberates about whether continued stay is medically necessary.

4) The Committee's decision is made through a majority vote on the following:
    a. Whether medical necessity has been met, and
    b. How much additional time (typically in months) medical necessity is anticipated to be met for.

5) The Committee makes recommendations for the PRTF treatment team and relevant District agency that follow from its medical necessity determination.

6) The Committee's coordinator prepares a letter documenting the Committee's decision and recommendations which is to reach the PRFT within two (2) business days.
    a. It is the Committee's expectation that its recommendations be included/addressed in the facility's next monthly treatment team meeting.
    b. The committee will inquire about the status of its recommendations in the event that a subsequent continued stay request is made.

Q5. What/how should the facility treatment team prepare for their telephonic presentation to the Committee?

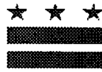
1) Arrange for the following staff at the facility to be available to participate:
    a. Individual therapist
    b. Psychiatrist
    c. Nurse
    d. Teacher or school personnel familiar with the youth's academic and behavioral functioning
    e. Milieu counselor
    f. Utilization Review Staff

2) Be prepared to answer the questions on the following:
    a. Diagnostic clarification
        i. Justification for persistence of "rule-out" and "NOS" diagnoses
        ii. Support of diagnoses with clinical measures, e.g. Conners' Rating Scales
        iii. GAF scores – admission vs. current

b. Medication management
    i. Indications for why medications were started, titrated/tapered, or discontinued
    ii. Serum levels of medications for which such monitoring is indicated
    iii. Lab monitoring of metabolic parameters when atypical antipsychotics are prescribed
    iv. Plan(s) for future medication changes
c. Progress in therapy
    i. What issues are being worked on?
    ii. What yet needs to be addressed?
d. Nursing
    i. Monitoring of BMI and vital signs
    ii. Diet
    iii. Screening for STIs, including HIV
e. Unusual Incident Reports
    i. Dates and clear description of incident(s)
        1. Including trigger(s), location, and context
    ii. Use of PRNs or restraint/seclusion
f. Family involvement
    i. Participation in family therapy
    ii. Dates and outcomes of off-grounds and home visits
    iii. Preparation for home disposition
g. School
    i. Is there an IEP
        1. If so, is it being implemented?
        2. The entire treatment team should be aware of this
    ii. Educational level at which the youth is functioning?
        1. Standard scores on academic assessments are helpful
    iii. Education plan upon discharge.
        1. Has the LEA representative been contacted?
h. Disposition Plan
    i. What specific strategies will be implemented to negate need for a subsequent continued stay request

3) Have the medical record available.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health



MEDICAL NECESSITY DETERMINATION APPEAL REQUEST FORM

The Department of Behavioral Health (DBH) 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 DBH Denial of Medical Necessity letter.

2. The written request for an appeal must include signature of the appealing party and the date of submission.

3. 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.

4. 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.

5. The PRTF Coordinator will ensure that the appeal is complete, including all documents (clinical notes and evaluations on the youth) in DBH possession.

6. The PRTF Coordinator will submit the appeal to an independent reviewer (a board certified child and adolescent psychiatrist contracted by DBH for this purpose) within one (1) business day of verifying a complete packet. A copy will also be sent to the DBH Chief Clinical Officer.

7. 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 and will communicate that recommendation (electronically) to the DBH Chief Clinical Officer. The independent reviewer will mail the hard copy of the appeal recommendation to the DBH Chief Clinical Officer.

8. The DBH 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 and the Associate Chief Clinical Officer within one (1) business day of receipt.

9. If the appealing party is not satisfied with the written determination rendered by the DBH 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.

DBH MEDICAL NECESSITY DETERMINATION
APPEAL REQUEST FORM

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

SPECIFIC REASON(S) FOR APPEAL:
Explain why you disagree with the DBH 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)

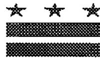
Requestor's Name ______________________________ **Agency** ________________________

Requester's Signature ____________________________ **Date of Request**__________________

Are the services of an interpreter required for any requested contacts? Yes No
If yes, what type ____

7-29-14

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health



MANAGED CARE ORGANIZATION PRTF MEDICAL NECESSITY REVIEW REFERRAL PROCESS

A Managed Care Organization (MCO) will collaborate with the Department of Behavioral Health (DBH) to make a medical necessity determination for PRTF admission of an MCO beneficiary prior to their placement in a PRTF.

The MCO will contact the Department of Behavioral Health (DBH) PRTF Coordinator to request a medical necessity review.

The PRTF Coordinator will work with the MCO to schedule a collaborative review by a PRTF Review Committee sub-group within three (3) business days of the MCO's request.

The MCO will submit a referral packet of relevant clinical information, and a signed authorization for release of information signed by the child or youth and/or their parent or legal guardian, to the PRTF Coordinator at the time of the request for medical necessity review.

A PRTF Review Committee sub-group will conduct the medical necessity review. The sub-group will consist of the following:

- DBH Board certified child and adolescent psychiatrist
- MCO psychiatrist
- One other member of the PRTF Review Committee (Committee members will participate on a rotating basis)

Medical necessity determinations are determined by a majority vote. Length of stay upon disenrollment from the MCO is determined by the PRTF Review Committee sub-group.

In order to issue a medical necessity determination for placement of a child or youth in a PRTF, the PRTF Review Committee subgroup must determine that community-based services available in the District do not meet the treatment needs of the child or youth. By collaborating with DBH, the MCO agrees to adhere to the DBH Policy 200.7, which outlines PRTF medical necessity determinations.

If approved, DBH will issue a written decision regarding medical necessity within two (2) business days of the determination, and provide the written decision to the MCO and the Department of Health Care Finance (DHCF).

The MCO beneficiary may appeal a denial by following the DBH Appeal Process outlined in Section 9 of DBH Policy 200.7, PRTF Medical Necessity Determination Process.

The MCO must notify the Clinical Program Manager of the DBH RTC Reinvestment Program of the date of admission and name of the PRTF within forty-eight (48) hours of placement in a PRTF.