REQUEST FOR TRANSFER TO A CHILD OR ADOLESCENT DMH CONTINUING CARE INPATIENT FACILITY, IRTP OR CIRT PROGRAM**

PATIENT INFORMATION

Patient's Name ____
(last) (first) (MI)

Address
____
(number and street) (apt no) (city) (state) (zip code)

Birth Date _________ Sex _____ Preferred Language __________________________
MM/DD/YY M / F
Does patient speak English? ☐ Yes ☐ No ☐ Limited
Race ___________ Does parent speak English? ☐ Yes ☐ No ☐ Limited

Date of Inpatient Admission: ___________
MM/DD/YY

Legal Status

☐ 10 Day Hospitalization - M.G.L. c. 123, s. 12
☐ Conditional Voluntary Admission - M.G.L. c. 123, ss. 10 & 11
☐ Civil Commitment - M.G.L. c. 123, ss. 7 & 8

Is child currently placed at an Intensive ART level of care? ☐ Yes ☐ No If yes, name of ART _____
____ Admission date?_____________________

Guardianship

Does the patient have a court appointed legal guardian ? ☐ Yes ☐ No
(If Yes, attach copies of relevant guardianships, including Rogers Order.)

Name of legal guardian __________________________________ Relationship _________________
(last) (first) (relationship to patient)

Guardian's address
____
(number and street) (apt no) (city) (state) (zip code)

Guardian's Telephone Number ( ) _______________________

Health Insurance

☐ No health coverage
☐ Medicaid/MassHealth Card #: _________________ RID #:______________________________

MassHealth Provider ☐ HMO __________________________☐ PCC ☐ Psych Under 21 ☐ Other
(name of HMO)

☐ Medicare
☐ Other Insurance Name of Insurance: __________________ Policy #:_________________

Name of Policy Holder: ____

Has eligibility for DMH continuing care services already been determined for this patient? ☐ Yes ☐ No

****Note: Please use this form when applying for transfer when the patient is already a DMH client.**

Patient name:

HOSPITAL INFORMATION

Referring Hospital:____

Name of Treating Physician: ________________ Telephone: ( )____________________

Address:

____
(number and street) (apt no) (city) (state) (zip code)

PHYSICIAN'S STATEMENT

I have reviewed the clinical criteria for referring patients to DMH for continuing care inpatient or intensive residential services and believe this patient requires this level of continuing care treatment. If the patient is accepted for transfer, the transfer will comply with M.G.L. c. 123, § 3, except for transfer to a CIRT program (children 6-12), which will be handled as a discharge.

____, MD
Signature of Treating Physician (☐ check if child/adolescent specialist)

Date:_________________________________

INSTRUCTIONS:

Initiate a transfer request mailing a copy of the completed form and the following attachments to the Child/Adolescent Screening contact for the Area. (See Appendix E)

1. Admission history ☐ Attached
2. Physical exam ☐ Attached
3. Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V) ☐ Attached
4. Any other initial assessments (psychosocial, medication, etc.) ☐ Attached
5. Hospital course, including treatment plan, barriers to discharge, somatic therapies and compliance, alternative therapies considered, need for Section 7, 8 and 8b, estimate of response to continued treatment, reason why any recommended treatments were not tried (if applicable) ☐ Attached
6. Last 10 days of progress notes ☐ Attached
7. Current medications; history, changes & rationale ☐ Attached
8. Copies of any relevant guardianships, including Rogers Order ☐ Attached

RESPONSE TO REQUEST FOR TRANSFER TO A DMH CONTINUING CARE INPATIENT FACILITY, IRTP OR CIRT PROGRAM

Level II Medical Review

Patient Name: ____

RID# (if Medicaid): ____

Hospital Name: ____

Name, DMH Area M.D. (or designee) reviewer:______________________________

Date of Review: ____

DMH Review Determination

[ ] Transfer Request Accepted

[ ] Transfer Request Denied (see below)

The determination to deny transfer to a DMH continuing care inpatient facility or intensive residential program is based on the following criteria:

____

____

The following recommendations were made to the treating physician:

____

____

The treating physician:

_____ Agreed to accept the determination and recommendations and understands that a request for admission to a DMH continuing care inpatient facility or intensive residential program can be re-initiated as needed.

_____ Disagreed with the determination and recommendations and plans to appeal to the Third Level Medical Review.

________________________________	________________________________
DMH Area Medical Director/designee	Signature
________________________________	________________________________
Telephone	Date of Determination

Form T2-99

TRANSFER REQUEST APPEAL

Request by DMA MH/SAP MCO Regional Manager or Other Insurer's Medical Director for Behavioral Health for Third Level Medical Review

Patient Name: ______________________________

RID# (if Medicaid): ______________________________

Hospital Name: ______________________________

MCO Regional Mngr./Insurer Medical Director Name: ______________________________

Telephone: ______________________________

Date of Appeal: ______________________________

The appeal of the decision to deny transfer of the patient to a DMH continuing care inpatient facility or intensive residential program is based on the following rationale (attach additional pages as needed):

____

____

____

Note: MCO Regional Manager or Other Insurer's Medical Director for Behavioral Health should call the DMH Area Medical Director or designee to complete the following section.

It is determined by the MCO Regional Manager/designee or Other Insurer's Medical Director for Behavioral Health and DMH Area Medical Director/designee that this case:

_____ Requires a third level of medical review because there are unresolved clinical concerns.

_____ The request is not solely based on clinical concerns and warrants an administrative review (e.g., bed availability, legal issues).

Initiate appeal by signing below and faxing completed form to the DMH Deputy Commissioner for Clinical and Professional Services at 617-626-8058. Attach a copy of original application and denial and any other pertinent written information you want considered in the review.

______________________________ ______________

MCO Regional Manager/designee or Insurer Medical Director/designee Date Completed

Form T3-99

DMH RESPONSE TO APPEAL

Level III Medical Review

Patient Name: ______________________________

RID# (If Medicaid): ______________________________

Hospital Name: ______________________________

MCO Regional Mngr./Insurer Medical Director Name: ______________________________

Telephone: ______________________________

Date of Request: ______________________________

The DMH Deputy Commissioner for Clinical and Professional Services and MCO Medical Director or Other Insurer's Medical Director for Behavioral Health has reviewed the information. The review resulted in the following determination:

____ Agree with request to transfer patient to a DMH continuing care inpatient facility or intensive residential program

____ Uphold determination to deny transfer of patient to a DMH continuing care inpatient facility or intensive residential program

  ____ The MCO/Other Insurer *agrees* with the determination and recommendations

  ____ The MCO/Other Insurer *disagrees* with the determination and recommendations

The determination is based on the following rationale:

____

____

The following recommendations were made to the MCO Regional Manager or Other Insurer's Medical Director and the Treating Physician:

____

____

______________________________ ______________________________

Signature, DMH Deputy Commissioner for Clinical and Professional Services — Date

______________________________ ______________________________

MCO Medical Director/Other Insurer's Medical Director — Date

Form/T4-99