



**MH-TCM: Recommendation for Action  
DTR (Denial, Reduction, or Termination of Service)**

**Note: All fields must be completed. If information is missing, the form will be sent back for completion.**

Fax form to SCHA, ATTN: MH/CH Manager: Fax Number: 507-431-6329

Date:	January 20, 2011
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**Member Information**

Member Name:	Jane Doe	SCHA ID:	G1234567801
Member Address:	123 Anywhere St City, State, Zip	SCHA Product:	PMAP - MA12
Member DOB:	2/7/99	PMI:	12345678
Date(s) of Service:	10/1/09 - 1/31/11	Date of most recent Diagnostic Assessment:	3/15/09
Parent/Guardian Name:	John Doe		
Parent/Guardian Address:	123 Anywhere St City, State, Zip		

**Case Manager/Provider Information:**

MH-TCM Case Manager:	Brandon Bailey	MH-TCM CM Phone:	555-555-5555
		MH-TCM CM Fax:	555-555-7777
Primary Care Clinic:	ABC Medical Center	Primary Care Physician:	Dr. Rickety Bones
Primary Care Clinic Address:	11 Main St Middleville, MN 55555		
Primary Mental Health Agency:	Region Ten Mental Health	Primary Mental Health Professional/Psychiatrist Name:	Dr. Fred Psyche
Primary Mental Health Agency Address:	456 Street Middleville, MN 55555	MH Professional Phone:	444-444-4444
		MH Professional Fax:	444-444-2222
MH-TCM Service Provider Agency Name:	Brandon Bailey		
MH-TCM Service Provider Address:	Region Ten Mental Health 456 Street Middleville, MN 55555		

**Recommendation for DTR Information**

Date of discussion with member or legal representative regarding potential denial, termination or reduction of service: <i>Notification to SCHA MUST be within (1) business day of this date</i>	1/20/11
Recommended Date of Action ( <i>should be at least 10 days from date of discussion with member</i> ):	1/31/11
Recommended Action: <input type="checkbox"/> Denial of Service <input checked="" type="checkbox"/> Termination of Service <input type="checkbox"/> Reduction of Service	
Service code for the recommended action:	<input checked="" type="checkbox"/> 1206 Mental Health Targeted Case Management

Member Name: Jane Doe

PMI: 12345678

Reason Code for the recommended action: Check appropriate box		Supporting Citation/Statute/Rule
<b>Most commonly used for MH-TCM</b>		
<input type="checkbox"/>	<b>0316</b> You do not meet the coverage criteria for mental health targeted case management (MH-TCM) <b>0316: Explanation Code:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<u>Adults:</u> M.S. 245.461 to 245.486; <u>Children:</u> M.S. 245.487 to 245.4889 and 256B.0625, subd. 20 <input type="checkbox"/> 5 <input type="checkbox"/> 12
<input type="checkbox"/>	<b>0601</b> You were not in this health plan on the date of service.  <b>0601 Explanation Code:</b> <input type="checkbox"/> 4 <input type="checkbox"/> 12	M.S. 256B.031, subd. 5 – Enrollment process for prepaid medical plans. M. R., Part 9500.1452 – Eligibility to enroll in a health plan; M.R. 9505.0010 to 9505.0150 – Eligibility criteria for participation in a prepaid medical program.
<input type="checkbox"/>	<b>0602</b> You were not in this health plan on the date of service. Coverage ended on [insert date of termination]  <b>Date of coverage termination:</b> <b>0602 Explanation Code:</b> <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12	M.S. 256B.031, subd. 5 – Enrollment process for prepaid medical plans. M. R., Part 9500.1452 – Eligibility to enroll in a health plan; M.R. 9505.0010 to 9505.0150 – Eligibility criteria for participation in a prepaid medical program.
<input type="checkbox"/>	<b>0603</b> You were not in this health plan on the date of service. You were not covered from [insert termination date] to [insert date prior to new effective date]. <b>Dates not covered:</b> <b>0603 Explanation Code:</b> <input type="checkbox"/> 9 <input type="checkbox"/> 11 <input type="checkbox"/> 12	M.S. 256B.031, subd. 5 – Enrollment process for prepaid medical plans. M. R., Part 9500.1452 – Eligibility to enroll in a health plan; M.R. 9505.0010 to 9505.0150 – Eligibility criteria for participation in a prepaid medical program.
<input type="checkbox"/>	<b>1603</b> The request for services was withdrawn by your provider at your request. <b>1603 Explanation Code:</b> <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 12	M.S. 256B.69, subd. 6b
<input checked="" type="checkbox"/>	<b>1618</b> Mental health targeted case management services are ending at the member's request. <b>1618 Explanation Code:</b> <input checked="" type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 12	M.R. 9520.0924 (C)
<input type="checkbox"/>	<b>1619</b> Mental health targeted case management services are ending because you have had no face-to-face contact with your case manager for 90 days or more. ( <i>Children only</i> ) <b>1619: Last date of contact:</b>	M.R. 9520.0924 (D)
<input type="checkbox"/>	<b>1620</b> Mental health targeted case management services are ending because you have had no face-to-face contact with your case manager for 180 days or more. ( <i>Adults only</i> ) <b>1620: Last date of contact:</b>	M.R. 9520.0924 (E)
<b>SCHA USE ONLY</b>		
Date Recommendation Reviewed:		SCHA Agree with Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, explain:		
Checklist: DTR/Member Rights sent to: <input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Case Manager; <input type="checkbox"/> Z: drive DTR Grid updated; <input type="checkbox"/> Contact Note in CCM; <input type="checkbox"/> Copy DTR letter sent to MMSI; <input type="checkbox"/> MMSI notified of date to stop claims payment MH-TCM DTR Reviewed with Medical Consultant: <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
SCHA Staff Signature:		Date:

Member Name: Jane Doe

PMI: 12345678

**MH-TCM DTR Recommendation for Action**

**Corresponding Explanation codes associated with reason codes**

**Please select one of the following explanation codes to go with above reason code specified. If a different explanation is needed, state explanation in item 12 below.**

1. Your diagnosis does not qualify you to be in this program. **[Re code: 0316]**
2. Information supplied to us by your provider does not meet the requirements for Mental Health Targeted Case Management. **[Re code: 0316]**
3. We requested information from your provider and your provider has not provided it. **[Re code: 0316]**
4. You have moved out of South Country Health Alliance’s service area. **[Re code: 0316; 0601]**
5. You no longer qualify for Mental Health Targeted Case Management as you had a break in service. **[Re code: 0316]**
6. Your case manager told us that you met your goals and no longer need this service. Please work with your case manager for any other help needed. **[Re code: 1603 or 1618]**
7. Your case manager told us you no longer want to receive this service. Please contact your case manager if you have questions. **[Re code: 1603 or 1618]**
8. The information we got from your case manager states you are not currently working with them on your goals. **[Re code: 1618]**
9. Please contact your case manager, as you may be able to receive this service through your new health coverage. **[Re code: 0602 or 0603]**
10. Coverage ended on \_\_\_\_\_ **[Re code: 0602]**
11. You were not covered from \_\_\_\_\_ to \_\_\_\_\_ **[Re code: 0603]**
12. Other (Specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_