



**Action for Recommendation: Denial, Termination or Reduction (DTR) of a SCHA benefit by a Mental Health Targeted Case Management (MH-TCM) Services Provider**

South Country Health Alliance has contractual and regulatory responsibilities regarding member rights. South Country Health Alliance has responsibility for administering the Mental Health Targeted Case Management (MH-TCM) Services for eligible SCHA members. South County Health Alliance delegates to providers the case management/care coordination services for MH-TCM services.

South Country Health Alliance or MMSI acting on behalf of South Country Health Alliance will retain the authority to send out a Denial, Termination or Reduction (DTR) of service notice to SCHA members for all services, including Mental Health Targeted Case Management. County staff will not have the authority to send a DTR to members.

1. The provider will notify SCHA within one business day or 3 hours if expedited of a member determination to be ineligible for case management services or who refused or terminates from case management services.
2. For members found ineligible for MH-TCM services, the provider will provide SCHA with the SCHA MH-TCM Eligibility Determination Form and the Diagnostic Assessment.
3. The provider must notify SCHA within one business day or 3 hours if expedited, of their knowledge of an appeal.
4. Providers are not delegated the duties to determine benefits or provide DTR notifications on SCHA's behalf.
5. SCHA will send out the appeal information to the member based upon the notification received from the provider.
6. The provider must notify SCHA within one business day of the discussion they have with a SCHA MH-TCM member about a denial, termination or reduction of MH-TCM services.
7. Providers will make a recommendation to SCHA regarding the denial, termination or reduction of MH-TCM services by completing the MH-TCM DTR Recommendation for Action Form. The enrollee's service will not be denied, terminated or reduced by the case manager/care coordinator. The recommendation will include:
  - a. Date (*insert date form being submitted*)
  - b. Member Name (*insert first and last name*)

- c. Member Address (*street address, city, state, zip*)
  - d. Member Date of Birth (*month, date, year*)
  - e. SCHA ID Number (*example: G1234567801*)
  - f. SCHA Product (*example PMAP*)
  - g. PMI (*example: 12345678*)
  - h. Date(s) of Service (*dates you provided MH-TCM*)
  - i. Date of most recent Diagnostic Assessment (certifying either SED or SPMI) (*enter month, day, year*)
  - j. Parent/Guardian Name (*first and last name*)
  - k. Parent/Guardian address (*street address, city, state, zip*)
  - l. MH-TCM Case Manager (*first and last name*)
  - m. MH-TCM Case Manager Telephone (*area code plus 7 digit number; same for fax #*)
  - n. Primary Care Clinic (*name of clinic*)
  - o. Primary Care Clinic Address (*street address, city, state, zip*)
  - p. Primary Care Physician (*first and last name of physician*)
  - q. Primary Mental Health Agency (*name of agency providing MH Services*)
  - r. Primary Mental Health Agency Address (*street address, city, state, zip*)
  - s. Primary Mental Health Professional/Psychiatrist (*name of mh professional or psychiatrist who has provided ongoing mental health services to member or who completed Diagnostic Assessment*)
  - t. MH Professional Phone (*area code plus 7 digit number; same for fax #*)
  - u. MH-TCM Service Provider Agency (*enter name of agency providing MH-TCM service*)
  - v. MH-TCM Service Provider Address (*street address, city, state, zip*)
  - w. Date of discussion with member/legal representative regarding potential denial, termination or reduction of service (*enter month, day, year*)
  - x. Recommended Date of Action (***should be at least 10 days from date of discussion with member/legal representative; enter month, day, year***)
  - y. Recommended Action (denial, termination, reduction of service) (*select option*)
  - z. Description of the service that is being recommended to be denied/terminated/reduced (*Mental Health – Targeted Case Management*)
  - aa. Reason for the recommended action and explanation (***Select from list of reason codes and check box with corresponding explanation***)
  - bb. The legal authority for the proposed action (*legal authority matches to reason code selected*)
8. At the request of the adult or in the case of a child, the child and the child’s parent or legal representative, the child or adult shall continue to receive case management services pending the resolution of the appeal.
9. The MH-TCM DTR Recommendation of Action Form must be faxed to SCHA at 507-431-6329, Attention: MH/CH Manager.

10. If necessary, SCHA will contact the Case Manager upon receipt of the notice, to gather additional information.
11. SCHA will make a determination regarding the DTR and send the determination letter including member rights to the member. SCHA will also send notification to the case manager and the provider. The notification will include the service change and the effective date.
12. Once a determination letter is mailed out by SCHA, the member's services will not be reduced or terminated:
  - a. until 10 days after written decision is issued in response to Appeal, unless Enrollee withdraws Appeal;
  - b. if Enrollee has requested State Fair Hearing (SFH) with continuation of benefits, until SFH decision is reached;
  - c. or if an Enrollee files an Appeal with the health plan (SCHA) before date of the Action proposed on a DTR;
14. SCHA will make a determination regarding the DTR and send the determination letter including member rights to the member. SCHA will also send notification to the case manager and the provider. The notification will include the service change and the effective date.
15. Once a determination letter is mailed out by SCHA, the member's services will not be reduced or terminated:
  - a. Until 10 days after written decision is issued in response to Appeal, unless member withdraws Appeal;
  - b. If member has requested State Fair Hearing (SFH) with continuation of benefits, until SFH decision is reached; or
  - c. If a member files an Appeal with the health plan (SCHA) before date of the Action proposed on a DTR.

**\*\* The MH-TCM Recommendation for Action: Denial, Termination or Reduction of Service (DTR) form and the instruction for completion of the document are available on the South Country Health Alliance website. \*\***