



# HURON BEHAVIORAL HEALTH OPERATIONAL POLICY

Policy #: **SD.1.08**  
Issue Date: 02/17/05  
Rev. Date: 12/06/21  
Page: 1 of 2

## Title: Program Transfer and Referral Policy

Prepared By: Clinical Director

NOTE: This Document Copy is **Uncontrolled and Valid on this date only: January 12, 2022**. For Controlled copy, view shared directory I:\ drive

### Purpose:

To define the process and protocols for transferring consumers to services which more appropriately meet their individual needs and medical necessity.

### Scope:

This procedure applies to all employees (including full-time and part-time employees), contract clinical providers, volunteers, students, and/or interns of Huron Behavioral Health (HBH) and all consumers served.

### Information:

- HBH makes every effort to place consumers in the most appropriate and least restrictive services possible and to meet the medical necessity guidelines as defined in the Michigan Medicaid Provider Manual.
- A consumer's services are determined and authorized through the person-centered planning process (see also "[Person Centered Planning Policy](#)" QI.1.05 and "[Person Centered Planning Process and Individual Plan of Service \(IPOS\) Procedure](#)" QI.2.18). An Individual Plan of Service (IPOS) is developed which identifies the treatment needs. As needs change throughout the course of treatment, additional services or reduced services may be appropriate. When services change, the primary worker must complete a referral record in the Electronic Medical Record (EMR) to document the changes in service(s).

### Policy:

1. The primary worker is responsible for determining when a referral or transfer is appropriate and also for documenting all referrals and transfers in the consumer's case record. Specific cases should be discussed during clinical staff meetings and with the program supervisor, as well as with other program supervisors who are impacted by the referral/transfer. The primary worker, their supervisor, and the receiving program supervisor will typically meet to discuss the referral/transfer and to review the need based on the consumer's progress toward their goals and evaluate the need for:
  - Current services
  - Changing services to a more intensive service program
  - Changing services to a less intensive service program
  - Referring the consumer to services outside of the agency
2. If it is determined that a consumer no longer requires a current service, the treatment team will review the case, determine recommendations, and implement the necessary transition and follow-up activities.
3. Current services should continue until the consumer begins receiving the recommended services.
4. If services defined in the individual's IPOS are reduced, suspended, or terminated, Medicaid consumers must be notified in writing at least ten (10) calendar days prior to the proposed effective date (note – for General Fund consumers the requirement is 30 days before the action occurs) using the Adverse Benefit Determination Notice (see "Forms" section below). (See also "[Grievance and Appeals Procedure](#)" RR.2.36.)
5. The Primary Worker must complete a "Transfer/Referral Form" in the EMR system.

### Definitions/Acronyms:

#### Definitions:

*Referral* – is a term used when a consumer is referred to another program or service at HBH or an external provider.

# Title: Program Transfer and Referral Policy

Prepared By: Clinical Director

Procedure #: SD.1.08

Issue Date: 02/17/05

Rev. Date: 12/06/21

Page: 2 of 2

NOTE: This Document Copy is **Uncontrolled and Valid on this date only: January 12, 2022.** For Controlled copy, view shared directory I:\ drive

*Transfer* – is a term used when a consumer leaves the services of one program and begins services in a different program.

## Acronyms:

COA – Council on Accreditation  
EMR – Electronic Medical Record  
HBH – Huron Behavioral Health  
IPOS – Individual Plan of Service  
PCP – Person-Centered Planning

## **Forms:**

Transfer/Referral Form (in EMR)  
[90-709 Adverse Benefit Determination for Non-Medicaid Recipients Form](#)  
[90-710 Adverse Benefit Determination for Medicaid Recipients Form](#)  
Adverse Benefit Determination Form (Medicaid and Non-Medicaid) in EMR

## **Records:**

Records of transfers and referrals are retained in HBH's EMR system in the consumer case record in accordance with the ["HBH Record Retention & Storage Policy" \(QI.1.23\)](#).

## **Reference(s) and/or Legal Authority**

COA standards  
[QI.1.05 Person Centered Plan \(PCP\) Policy](#)  
[QI.1.23 HBH Record retention & Storage Policy](#)  
[QI.2.18 Person Centered Planning Process and Individual Plan of Service \(IPOS\) Procedure](#)  
[RR.2.36 Grievance and Appeals Procedure](#)

## **Change History:**

Change Letter	Date of Change(s)	Changes
None		Old procedure brought into new Controlled Documentation format with minimal content changes.
A	05/25/06	Added form numbers (#4 & "Forms" section) to reflect new regional Advance & Adequate forms (removed 90-267 & 90-268 and added 100-013, 100-014, 100-015, 100-016), added "AAM" to "Acronym" section.
B	09/11/07	Revised to include the new regional "Transfer/Program Change/Discharge Form" (90-1001) and removed all references to the old HBH forms (90-051 & 90-038), added "EMR" to "Acronym" and "Records" sections added "Definitions"
C	01/28/09	Reviewed and revised to comply with COA 8 <sup>th</sup> Edition Standards and present practices – removed COA chapter-specific reference (G9 & S5), reworded numerous sentences without changing content, added reference to RR.2.6 (Appeals & Grievance Procedure) 2 places.
D	06/05/13	Reviewed and revised to comply with 8 <sup>th</sup> edition COA standards – in #4 removed "standardized regional" and "from Access Alliance of Michigan (AAM)", in #5 changed "file it in" to "forward to be scanned into", in "Forms" section removed "(regional form)" from 90-1001, deleted second sentence in "Records" section which referred to Gallery/EMR and added "in EMR" to first sentence, removed "CMHC" and "AAM" from "Acronym" section.
E	05/31/16	Removed form numbers and changed names of forms to match current EMR form names, in "Policy" section #4 removed "the appropriate adequate or" and added "12 calendar days", #5 removed reference to scanning the document into the consumer's case record and entering CMHC demographic data, in "Forms" section removed "Adequate Notice Form" made several additional minor grammatical/wording changes/corrections throughout document without changing sentence content.
F	03/13/18	In "Policy" section #4 changed "twelve (12) calendar days prior to the change" to "at least ten (10) calendar days prior to the proposed effective date (note – for General Fund consumers the requirement is 30 days before the action occurs)", made several minor wording/grammatical changes/corrections throughout document without changing sentence content.
G	01/29/20	Changed "Person Centered Plan(PCP)" to "Individual Plan of Service (IPOS)" throughout document (3 places), changed "Advance Notice Form" to "Adverse Benefit Determination Notice" throughout document (2 places), in "Definitions" section removed "Discharge" & "Program Change" and added "Referral", in Acronyms" section added "IPOS", in "Forms" section added 90-709 & 90-710, corrected hyperlinks, made several minor wording/grammatical changes/corrections throughout document without changing sentence content.
H	12/06/21	Made several minor wording/grammatical changes/corrections throughout document without changing sentence content.