Title: Program Transfer and Referral Policy

Prepared By: Clinical Director

Purpose:

To define the process and protocols for referring and/or transferring consumers to services which more appropriately meet their individual treatment 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:

1. HBH makes every effort to place consumers in the most appropriate and least restrictive treatment possible and to meet the eligibility and medical necessity guidelines as defined in the Michigan Medicaid Provider Manual.
2. 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 individual's treatment needs and goals. As needs change throughout the course of treatment, additional services or reduced services may be appropriate. When the consumer is referred to another service, 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 in the EMR system. Specific cases should be discussed during clinical staff meetings or supervision meetings 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 discuss the referral/transfer and review the need for the transfer 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, when that is the most appropriate clinical option
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 thirty (30) calendar 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.

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

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 Planning 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 8th 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 8th 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.
I	11/03/23	Made several minor wording/grammatical changes/corrections throughout document without changing sentence content.
J	09/10/25	In "Information" section #1 added "eligibility and", in #2 changed "services change" to "the consumer is referred to another service", in "Policy" section #4 changed "30 days" to "thirty (30) calendar days", in "Acronyms" section removed "PCP", made several minor wording/grammatical changes/corrections throughout document without changing sentence content.