

Twenty-One Day Service Tracking Bi-Monthly Report REFERRAL LOG LAYOUT FOR PROVIDERS

Revised 11/12/2024

All fields are required unless otherwise noted

Purpose of Report: Mercy Care requires that ALL children receive their first and subsequent medically necessary services within the access to care standards timeframes according to the clinical needs of the person, through the determination of medical necessity as recommended by an assessor, added to an assessment, added to a service plan, or agreed upon within a Child and Family Team (CFT). If not scheduled to begin within 14 days after the request was documented on the service plan, escalation of a medically necessary service must be made to Mercy Care by emailing the information to DCS@mercycares.org. This report is meant to track services that have been escalated to Mercy Care, trend service timelines, inform network throughput and needs and bring awareness to leadership at the Provider agency. Refer to ACOM 449, ACOM 417, and the Mercy Care Provider Manual.

When to Submit: The 5th and 20th of each month to DCS@mercycares.org

* Note: A Report does not need to be submitted if Provider has secured services for youth to begin within 21 days OR for the time agreed upon/requested by guardian. (Example: If guardian requests services to begin in 30 days and a provider will be in place, you can monitor internally but do not submit to Mercy Maricopa).

Steps to be completed prior to submitting escalation report to Mercy Care:

1. Submit and document referrals to all applicable providers that provide the medically necessary service (See DSP and Specialty Directory);
2. Exploration of all Internal resources;
3. Follow-up phone calls to ALL providers that provide recommended service;
4. Double check that referrals were submitted to all providers that provide the recommended service;
5. Review by Leadership.

Field Name	Definition	Format	Entering Instructions
Internal Escalation Required	INTERNAL ESCALATION REQUIRED: Include your agency's internal escalation process, supervisor recommendations to the BHH case manager, communication attempts and any follow-up actions taken to ensure service delivery. Additional, document the barriers encountered	TEXT FORMAT	
Name of Service Recommended	Medically Necessary service recommendation from the Child and Family Team.	TEXT FORMAT	
Date of Service Recommendation (ISP date)	(ISP date)	TEXT FORMAT	

Referrals Submitted	INCLUDE Name of provider, Date of referral, and outcome of referral)	TEXT FORMAT	
Member's location	(City/where in city)	TEXT FORMAT	
Is Virtual or Tele-Health an option for this member Y/N (if yes, indicate type?)		TEXT FORMAT	
Child's First Name and Last name		TEXT FORMAT	
Date of Birth		DATE FORMAT: mm/dd/yyyy	
AHCCCS ID# (if available) (text format)	Assigned AHCCCS ID	TEXT FORMAT: 6 characters	6 digit AHCCCS ID number
Line of Business	DCS CHP, DDD or ACC RBHA	TEXT FORMAT: 3 characters	Y = Yes, N = No
Adopted Y/N	Is member adopted?	TEXT FORMAT: 3 characters	Y = Yes, N = No
Date of Escalation to Mercy Care	If medically necessary service is not scheduled to begin within 21 days of the service being documented on the Service Plan, enter the date staff initiated escalation process to Mercy Care, not exceeding 14 days after service documentation on service plan. *Note: Providers should ONLY document youth that will not have services begin within 21 days OR the time agreed upon/requested by guardian. (Example: If guardian requests services to begin in 30 days and the service will be in place, provider to monitor internally but do not submit to Mercy Care)	DATE FORMAT: mm/dd/yyyy	
Has a Provider Accepted the Referral?	Name of Provider that accepted the referral and anticipated date of first service.	TEXT FORMAT AND DATE FORMAT: mm/dd/yyyy	
Resolution:	Date Service Provided, and Name of Provider *Note* Once service has been provided, name should be removed from report.	DATE FORMAT: mm/dd/yyyy	

Need Met Through Another Service, an Informal Support or in the Community	Description of informal/non-paid service that meets service plan need. *Note* This column is for internal Provider tracking ONLY; if member has need met, this should not be included in escalation to Mercy Care. (Example: Referred for behavior coaching through behavioral health but direct support was provided by the case manager).	TEXT FORMAT	
Behavioral Health CM and Supervisor's email address		TEXT FORMAT:	
DATE FIELDS: Format these fields BEFORE you enter the data. General formatting or Text formatting will not automatically change to a date unless it is re-entered.			
TEXT FIELDS: Format these fields BEFORE you enter the data. If the field is not formatted for text, it will drop leading zeroes.			

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