

Legislative Regulation Review Committee

2011-023

Department of Social Services

**REQUIREMENTS FOR PAYMENT OF
REHABILITATION SERVICES FOR
INDIVIDUALS UNDER 21 WITH
BEHAVIORAL HEALTH DISORDER**

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STATE OF CONNECTICUT
REGULATION
 OF

Name of Agency

Department of Social Services

Subject Matter of Regulation

**Requirements for Payment of Rehabilitation Services
 for Individuals Under Age 21 with Behavioral Health Disorders**

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-849 to 17b-262-861, inclusive, as follows:

(NEW) Sec. 17b-262-849. Scope

Sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for Medicaid coverage of rehabilitation services for individuals under 21 years of age with behavioral health disorders who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-850. Definitions

As used in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Admission" means an individual's initial participation in a rehabilitation services program;
- (2) "Allied health professional" or "AHP" means:
 - (A) a licensed or certified practitioner performing within his or her scope of practice in any of the professional and occupational license or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes; or
 - (B) a license or certification-eligible individual whose education, training, skills and experience satisfy the criteria for any of the professional and occupational licensure or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes;
- (3) "Authorization" means the approval of payment for services or goods by the department;
- (4) "Behavioral health condition" means mental disorders as defined in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, but excluding mental retardation, dementia and conditions designated with V codes;

- (5) "Behavioral Health Partnership" or "Partnership" or "BHP" means the integrated behavioral health service system developed by the Departments of Social Services, Children and Families, and Mental Health and Addiction Services for HUSKY Plan Parts A and B members; children enrolled in the Voluntary Services Program operated by the Department of Children and Families and, at the commissioners' discretion, may include other children, adolescents and families served by the Department of Children and Families; Medicaid recipients who are not enrolled in HUSKY Plan Parts A; and Charter Oak Health Plan members;
- (6) "Behavioral health services" means health care that is necessary to diagnose, correct or diminish the adverse effects of a behavioral health condition;
- (7) "Commissioner" means the commissioner of the Department of Social Services or the commissioner's agent;
- (8) "Complex behavioral health service needs" means behavioral health needs that require specialized, coordinated behavioral health services across several service systems; for example, school, mental health and court;
- (9) "DCF" means the Department of Children and Families or its agent;
- (10) "Department" or "DSS" means the Department of Social Services or its agent;
- (11) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT services" means the services provided in accordance with the requirements of 42 U.S.C. 1396a(a)(43), 42 U.S.C. 1396d (r) and 42 U.S.C. 1396d(a)(4)(B) and implementing federal regulations found in 42 CFR 441, Subpart B and section 17b-261(j) of the Connecticut General Statutes;
- (12) "Emergency" means a psychiatric or substance abuse condition manifesting itself by acute symptoms of sufficient severity (including severe distress) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate psychiatric attention may result in placing the health of the individual in serious jeopardy due to harm to self, harm to others or grave disability;
- (13) "Emergency Mobile Psychiatric Services" or "EMPS" means rehabilitation services provided by a DCF certified provider of such services in the home or other community setting to an individual under age 21 in response to a psychiatric or substance abuse related crisis in order to reduce disability, restore functioning and achieve full community integration and recovery;
- (14) "Extended day treatment program" or "EDT" means "extended day treatment" as defined in section 17a-147-1 of the Regulations of Connecticut State Agencies.
- (15) "Home and community-based rehabilitation services" means services provided by a DCF certified provider of such services in the home or other community setting to an individual under age 21 with psychiatric or substance abuse needs in order to reduce disability, restore functioning and achieve full community integration and recovery. Services may be provided in settings appropriate to the achievement of the rehabilitation goals and objectives, and as mutually agreed upon with the child and family. For example, service locations may include a local neighborhood community center, police substation, social service office or any other public or private community setting;
- (16) "HUSKY A" means the Connecticut program of managed health care authorized by Title XIX of the Social Security Act and operated pursuant to section 17b-266(b) of the Connecticut General Statutes;

- (17) "HUSKY B" means the federally subsidized program of managed health care for uninsured children up to the age of nineteen, established pursuant to Title XXI of the Social Security Act and sections 17b-289 to 17b-303, inclusive, of the Connecticut General Statutes;
- (18) "Individual" means a Medicaid eligible person under age 21 who receives covered rehabilitation services in accordance with sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies;
- (19) "Licensed clinician" means:
 - (A) a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;
 - (B) a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;
 - (C) a marital and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;
 - (D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;
 - (E) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;
 - (F) a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field;
 - (G) a professional counselor who is licensed under chapter 383c of the Connecticut General Statutes; or
 - (H) an alcohol and drug counselor who is licensed under chapter 376b of the Connecticut General Statutes;
- (20) "Medicaid program" means the program operated by DSS pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- (21) "Medical necessity" or "medically necessary" has the same meaning as defined in section 17b-259b of the Connecticut General Statutes;
- (22) "Office-based off-site rehabilitation services" means services provided by a DCF licensed outpatient psychiatric clinic operating within its scope of practice to an individual in a primary care setting, school setting or other office setting other than a primary or satellite office as provided for on the clinic's license;
- (23) "Prior authorization" means approval for the provision of service from the department before the provider actually provides the service;
- (24) "Provider" means a person, entity or organization that meets the requirements for participation specified in section 17b-262-851 of the Regulations of Connecticut State Agencies as a DCF licensed or certified entity that provides office-based off-site rehabilitation services, extended day treatment, emergency mobile psychiatric services or home and community-based rehabilitation services and participates in the Medicaid program as a qualified provider of rehabilitation services as evidenced by an executed provider agreement with the department;
- (25) "Provider agreement" means the signed, written contractual agreement between the department and the provider of rehabilitation services;

- (26) "Provider network" means the providers enrolled or contracted with the department;
- (27) "Quality management" means the process of reviewing, measuring and continually improving the processes and outcomes of care delivered;
- (28) "Registration" means the process of notifying the department of the initiation or continuation of a behavioral health service that includes information regarding the evaluation findings and plan of treatment. Registration may serve in lieu of authorization if a service is designated by the department as requiring registration only;
- (29) "Rehabilitation plan" means a written individualized plan of care developed by the performing provider in accordance with the applicable licensing requirements and section 17b-262-851(7) of the Regulations of Connecticut State Agencies;
- (30) "Rehabilitation services" means those services identified in section 17b-262-854 of the Regulations of Connecticut State Agencies when provided by a qualified provider on behalf of an individual with a behavioral health condition;
- (31) "Trainee" means an individual enrolled in an educational program or acquiring the supervisory experience necessary to obtain licensure or certification in any of the professional and occupational license or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes;
- (32) "Under the direct supervision" means that a licensed clinician operating within his or her scope of practice provides periodic supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitation services performed by the unlicensed staff; and
- (33) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity of the allocation of health care resources and services given, or proposed to be given, to an individual.

(NEW) Sec. 17b-262-851. Provider participation

In order to participate in the Medicaid program and provide rehabilitation services that are eligible for Medicaid reimbursement from the department, the provider shall:

- (1) Enroll with the department and have on file a valid provider agreement;
- (2) be licensed by DCF as an outpatient psychiatric clinic for children under section 17a-20-11 to 17a-20-61, inclusive, of the Regulations of Connecticut State Agencies, if providing office-based off-site rehabilitation services;
- (3) be licensed by DCF as an extended day treatment program under section 17a-147-1 to 17a-147-36, inclusive, of the Regulations of Connecticut State Agencies, if providing extended day treatment program services;
- (4) comply with any applicable DCF certification requirements necessary to be qualified to provide home and community-based rehabilitation services or emergency mobile psychiatric services;
- (5) comply with all Medicaid record keeping, documentation and other requirements including, but not limited to, those delineated in the department's administrative manuals, provider agreements and memoranda of understanding;
- (6) comply with all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to reimbursement for rehabilitation services;

- (7) except as noted below in subdivision (G) of this subsection, develop a written rehabilitation plan for each individual in accordance with section 17a-20-42 of the Regulations of Connecticut State Agencies not later than thirty days after the individual's admission to the program. This rehabilitation plan requirement applies to all providers of Medicaid-funded rehabilitation services for individuals under age 21, not just DCF psychiatric clinics that are the specific subject of section 17a-20-42 of the Regulations of Connecticut State Agencies. Such plan shall be developed by the provider, with input from the individual, individual's family or individual's legal representative and shall:
- (A) Specify the behavioral health disorder to be addressed;
 - (B) specify reasonable, individualized behavioral health goals and objectives based on each individual's behavioral health diagnosis and diagnostic and functional evaluation and be targeted toward the reduction of a client's behavioral health symptoms, restoration of functioning and recovery;
 - (C) identify the type, amount, frequency and duration of services to be provided;
 - (D) document that the services provided have been determined to be rehabilitation services consistent with section 17b-262-854;
 - (E) ensure the active participation of the individual and his or her family or the representative of the individual;
 - (F) contain a timeline, based upon the individual's assessed needs and anticipated needs, for reevaluation of the plan, not longer than one year; and
 - (G) providers of EMPS services to individuals under age 21 are not required to develop an individualized rehabilitation plan that meets the requirements of section 17a-20-42 of the Regulations of Connecticut State Agencies unless the services are provided for a period of more than 45 days. The Statewide Uniform Crisis Plan shall serve as the rehabilitation plan for the EMPS services until an individual rehabilitation plan for EMPS services is developed;
- (8) ensure that a licensed clinician operating within his or her scope of practice and employed by or under contract with the provider reviews and signs the individual rehabilitation plan. The first review and signature shall occur not later than thirty days after admission;
- (9) ensure that rehabilitation plans are reassessed by a licensed clinician at 90 day intervals as well as when a significant change in condition or diagnosis occurs. Reassessed rehabilitation plans shall be reviewed and signed by the supervising licensed clinician;
- (10) keep current service and progress notes in a permanent case record for each client in accordance with section 17a-20-54 of the Regulations of Connecticut State Agencies;
- (11) cooperate with the department in the rate setting process including, but not limited to, licensing or any quality assurance reviews or periodic audits to ensure compliance with rehabilitation service requirements defined in section 17b-262-849 to section 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies;
- (12) provide an initial orientation, training and periodic supervision to direct service staff responsible for the provision of rehabilitative services;

- (13) conduct ongoing assessment and service planning;
- (14) ensure that the program director is a licensed clinician operating within his or her scope of practice and with a minimum of three years of experience in a behavioral-health-services-related position;
- (15) ensure that the program director, or the program director's designee who shall be a licensed clinician, is accessible after hours, by telephone or pager, to staff on duty;
- (16) ensure that direct service staff of providers of office-based off-site rehabilitation services are physicians, allied health professionals or trainees;
- (17) ensure that direct service staff of providers of extended day treatment meet the minimum requirements established in 17a-147-1 to 17a-147-36;
- (18) ensure that direct service staff of providers of home and community-based rehabilitation services and emergency mobile psychiatric services are physicians, allied health professionals or trainees, or individuals who hold either a bachelor's degree in a behavioral-health-related specialty or have two years of experience in the provision of behavioral health services, provided such individuals meet the minimum requirements of any applicable certification authority;
- (19) ensure that all unlicensed staff work under the direct supervision of licensed clinical staff; and
- (20) ensure that direct service staff of providers of home and community-based rehabilitation services and emergency mobile psychiatric services be accessible to clients after hours, whether face-to-face or by telephone.

(NEW) Sec. 17b-262-852. Eligibility

Medicaid coverage for the cost of rehabilitation services is available for individuals with behavioral disorders when the service is medically necessary and is provided by a qualified and enrolled provider of rehabilitation services to an individual with a behavioral health disorder, subject to all of the qualifications, conditions and limitations contained in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-853. Need for services

Payment for rehabilitation services shall be made by the department only if all of the following conditions are met:

- (1) Medicaid payment for rehabilitation services may only be made to the extent that a covered rehabilitation service is provided by a qualified participating provider of such services and service is medically necessary for the client. Where a service is subject to prior authorization requirements in accordance with sections 17b-262-855 or 17b-262-856 of the Regulations of Connecticut State Agencies, eligibility for Medicaid payment is conditioned upon compliance with such requirements. Furthermore, all Medicaid payments, including payments for services that are prior authorized or registered, are subject to record keeping and post-payment review and audit requirements, and are subject to subsequent recoupment if it is subsequently determined that the service was not medically necessary or if record keeping or other requirements for payment are not satisfied;
- (2) for no more than thirty days after an individual's admission, rehabilitation services shall be provided in accordance with an initial assessment of need that is signed by a licensed clinician operating within his or her scope of practice. This assessment shall, for no more than thirty days after an individual's admission, be utilized as the individual's rehabilitation plan;

- (3) not later than thirty days after an individual's admission, the rehabilitation services shall be provided in accordance with the rehabilitation plan developed in accordance with section 17a-20-42 of the Regulations of Connecticut State Agencies. This plan shall include a progress note that describes the services that the individual has received to date, the individual's overall response, the individual's specific progress toward the goals and objectives listed in the rehabilitation plan and justification of the need for continued treatment. The progress note shall include discussion of any variance between the services listed on the rehabilitation plan and the services actually delivered. The progress note shall also include discussion of suggested changes, if any, to the rehabilitation plan. This plan shall be reviewed and signed by the licensed clinician employed by or under contract with the provider at least every ninety days thereafter; and
- (4) the individual is sufficiently stable to be able to function outside of a twenty-four hour medically managed setting and participate in community-based treatment services.

(NEW) Sec. 17b-262-854. Covered Services.

- (a) Rehabilitation services shall be recommended by a physician or other licensed clinician operating within his or her scope of practice.
- (b) Rehabilitation services are services designed to assist individuals in reaching an achievable level of independent functioning.
- (c) Rehabilitation services include office-based off-site rehabilitation services, home and community-based rehabilitation services, extended day treatment and emergency mobile psychiatric services when provided by a qualified and enrolled provider of such services.
- (d) Depending upon the particular needs of each individual and the rehabilitation plan, office-based off-site services may include any of the routine outpatient services listed on the department's fee schedule for behavioral health clinics.
- (e) Depending upon the particular needs of each individual and the rehabilitation plan, home and community-based rehabilitation services, extended day treatment program services and emergency mobile psychiatric services may include the following components:
 - (1) Intake and assessment, which means assessing and reassessing the individual's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the individual, the individual's family and through consultation with other professionals;
 - (2) development of an individual rehabilitation plan in accordance with sections 17b-262-851(7) and 17b-262-858 of the Regulations of Connecticut State Agencies;
 - (3) individual and group psychotherapy or counseling;
 - (4) family therapy or training;
 - (5) socialization skills development, which means individual-centered skill development activities that are provided to support the goals and objectives in the rehabilitation plan and that are directed at reducing individuals' psychiatric and substance abuse symptoms, restoring individuals to an achievable functioning level;
 - (6) behavior modification or management training and intervention;

- (7) supportive counseling directed at solving daily problems related to community living and interpersonal relationships;
- (8) psycho-educational services pertaining to the alleviation and management of psychiatric or substance abuse disorders;
- (9) teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem solving;
- (10) therapeutic recreation and other skill development activities directed at reducing disability, restoring client functioning and achieving independent participation in social, interpersonal or community activities and full community re-integration and independence as identified in the rehabilitation plan;
- (11) support with connecting individuals to natural community supports;
- (12) orientation to and assistance with accessing self-help and advocacy resources;
- (13) development of self-advocacy skills;
- (14) health education;
- (15) teaching of recovery skills in order to prevent relapse;
- (16) crisis response services either face-to-face or telephonic only when provided as part of a home and community-based rehabilitation service; and
- (17) consultation for persons responsible for the development of healthy social relationships and the promotion of successful interpersonal and community experiences.

(NEW) Sec. 17b-262-855. Coverage Limitations.

- (a) Coverage of rehabilitation services shall be subject to the following limitations:
 - (1) Rehabilitation services that do not meet medical necessity requirements or any applicable authorization or certification requirements are not eligible for Medicaid payment.
 - (2) Rehabilitation services shall be based on the rehabilitation plan developed pursuant to section 17b-262-851(7) of the Regulations of Connecticut State Agencies and the requirements of sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies, and shall be performed by or under the supervision of a licensed clinician employed by or under contract with the provider.
 - (3) Home and community-based rehabilitation services and emergency mobile psychiatric services may be provided in a facility, home, hospital or other setting, except as follows:
 - (A) When an individual resides in a facility or institution, the services may not duplicate services included in the facility's or institution's rate; or
 - (B) if the provider operates a clinic or practice for the provision of outpatient services, no more than 10 visits may be provided at the site of the outpatient clinic or practice per individual per episode of care, other than the initial assessment, that may be provided off-site. The services rendered under this exception are considered reimbursable rehabilitation services only if the services rendered are part of a rehabilitation service plan.

- (4) Extended day treatment programs shall meet the following requirements:
 - (A) Shall provide time-limited, active rehabilitation services within a clinic or off-site community setting;
 - (B) may employ an integrated, comprehensive and complementary schedule of treatment approaches;
 - (C) serve individuals with significant functional impairments resulting from a behavioral health condition, and further serve to avert hospitalization or increase the client's level of independent functioning;
 - (D) provide an adult escort to support the transportation of individuals under 16 years of age, transported by a Medicaid non-emergency medical transportation provider, unless the parent or guardian of a child between the ages of 12 to 15 years does not feel an escort is necessary for their child and has provided written consent for transportation of their child to the EDT program without an escort; and
 - (E) provide a minimum of three hours of scheduled, documented programming of which at least two and one half hours are rehabilitation services.
 - (5) Rehabilitation services may be provided indirectly through counseling of parents, other family members or other persons responsible for the care of the individual, regardless of the Medicaid eligibility of these individuals, only to the extent that the provision of such indirect treatment service is necessary and is intended to primarily benefit the individual.
 - (6) The department shall not pay for the following:
 - (A) Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
 - (B) programs, services or components of services that do not relate to the individual's diagnosis, symptoms, functional limitations or medical history;
 - (C) programs, services or components of services that are not included in the fee established by the department;
 - (D) programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms;
 - (E) programs, services or components of services provided solely for social or recreational purposes not in compliance with sections 17b-262-854(e)(5) or 17b-262-854(e)(10);
 - (F) time spent by the provider solely for the purpose of transporting clients;
 - (G) services that are solely educational or vocational;
 - (H) costs associated with room and board for individuals; and
 - (I) rehabilitation services that are provided out-of-state unless the services are not available within Connecticut.
- (b) Notwithstanding subsection (a)(3)(B) of this section, services that are provided at the primary or satellite site of a DCF-licensed clinic, as indicated on the clinic's license, do not qualify as rehabilitation services and may only be reimbursed by the Medicaid program to the extent that such services otherwise qualify for Medicaid reimbursement, for example, as covered clinic services.

(NEW) Sec. 17b-262-856. Non-billable Activities

The following activities are not billable:

- (1) Telephone contact with the department for the purpose of requesting or reviewing authorization;
- (2) completion of progress notes or billing documentation;
- (3) individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among participants of the rehabilitation team, including for the purpose of treatment planning;
- (4) travel to an appointment with an individual or family; travel to and from collateral appointments (e.g. school planning meeting, court appearance); or transportation of the individual to or from meetings or appointments unless the provider is also engaged in an activity that otherwise qualifies as a rehabilitation service;
- (5) time on-call that does not otherwise qualify as a rehabilitation service;
- (6) time spent performing routine services such as cleaning, cooking, shopping or child care designed to provide relief or respite for the family;
- (7) time spent waiting for an individual at their home when they have a scheduled appointment and the recipient has not arrived;
- (8) no shows, missed or cancelled appointments;
- (9) rehabilitation services of less than eight minutes duration for rehabilitation procedures whose billing codes are defined in 15-minute increments; and
- (10) time spent engaged in activities required by a credentialing or oversight entity such as gathering and submitting care plan or service data or other information.

(NEW) Sec. 17b-262-857. Authorization

- (1) Rehabilitation services for individuals with behavioral health disorders are subject to prior authorization or registration requirements to the extent required by this section. Where a service is subject to authorization or registration requirements, Medicaid payment for such service is not available unless the provider complies with such requirements.
- (2) Services that require authorization or registration will be designated as such on the provider's fee schedule or authorization and registration schedule published at www.ctdssmap.com.
- (3) The following requirements shall apply to all services that require authorization or registration under subdivisions (2) or (3) of this subsection:
 - (A) The initial authorization period shall be based on the needs of the individual.
 - (B) If authorization is needed beyond the initial or current authorization period, requests for authorization for continued treatment shall be submitted prior to the end of the current authorization.
 - (C) Except in emergency situations or for the purpose of initial assessment, authorization shall be received before services are rendered.

- (D) In order to receive payment from the department, a provider shall comply with all prior authorization and registration requirements. The department or its agent in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.
- (E) A provider shall present medical or social information adequate for evaluating medical necessity when requesting authorization. The provider shall maintain documentation adequate to support requests for authorization and registration including, but not limited to, medical or social information adequate for evaluating medical necessity.
- (F) Requests for authorization for the continuation of services shall include the progress made to date with respect to established treatment goals, the future gains expected from additional treatment and medical or social information adequate for evaluating medical necessity.
- (G) The provider shall maintain documentation adequate to support requests for continued authorization including, but not limited to, progress made to date with respect to established treatment goals, the future gains expected from additional treatment, and medical or social information adequate for evaluating medical necessity.
- (H) The department may require a review of the discharge plan and actions to be taken to support the successful implementation of the discharge plan as a condition of authorization.
- (I) A provider may request authorization from the department after a service has been provided for individuals who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service.
- (J) For individuals who are granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall be responsible for initiating this review to enable authorization and payment for services.
- (K) The department may deny authorization or registration based on non-compliance by the provider with utilization management policies and procedures.

(NEW) Sec. 17b-262-858. Documentation and record retention requirements

- (a) Providers shall comply with the following documentation and record retention requirements:
 - (1) An initial rehabilitation plan and all updated versions, including the current plan, shall be maintained.
 - (2) All rehabilitation service providers are required to develop a rehabilitation plan that meets the requirements of section 17a-20-42 of the Regulations of Connecticut State Agencies, except as provided for under subsection 17b-262-851(7) of the Regulations of Connecticut State Agencies. The rehabilitation plan shall include a medication plan, if the rehabilitation service includes medication management. The medication plan shall include an order and instructions for administration for each medication prescribed by a provider staff and a list of other medications that the patient is taking that maybe prescribed by non-clinic practitioners.

- (3) A case record that meets the requirements of section 17a-20-54 of the Regulations of Connecticut State Agencies, shall be maintained and shall include, at a minimum: identifying information; social and health history; the reason for admission to the rehabilitation program; copies of the initial and all subsequent orders for rehabilitation services; the rehabilitation plan; identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the client. This case record requirement applies to all providers of rehabilitation services for individuals under age 21 with behavioral health disorders, not just to DCF-licensed psychiatric clinics that are subject to section 17b-20-54 or the Regulations of Connecticut State Agencies.
 - (4) Encounter notes shall be maintained for each rehabilitative service provided. The notes shall include the service rendered, actual time the service was rendered, location of service, the goal and objective that is the focus of the intervention, a general description of the content of the intervention to provide evidence that it is a rehabilitative service as described in section 17b-262-854 of the Regulations of Connecticut State Agencies and the individual's response to the intervention. Encounter notes shall be signed, dated and indicate the credentials of the staff member who provided the service.
 - (5) For EDT programs the note shall document the duration of each distinct therapeutic session or activity and progress toward treatment goals.
 - (6) For the purpose of documenting the supervision of services provided by unlicensed direct care staff, licensed clinical staff shall document in the case record that they have reviewed the encounter notes corresponding to services provided by such unlicensed direct care staff at least once every 30 days. Documentation shall include the signature and credentials of the licensed clinical staff that reviewed the encounter notes.
- (b) Other documentation and record retention requirements:
- (1) The provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified individuals furnishing rehabilitation services.
 - (2) The provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.
 - (3) The provider shall maintain all required records for at least five years or longer as required by statutes or regulation. All required records shall be subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.
 - (4) All documentation shall be recorded in the eligible individual's case record in a complete, prompt and accurate manner. All documents shall be made available to authorized personnel of the department upon request.
 - (5) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(NEW) Sec. 17b-262-859. Billing requirements

- (a) Claims for office-based off-site rehabilitation services shall be billed with routine outpatient procedure codes and an off-site modifier or appropriate place of service code as designated by the department.

- (b) For home and community-based rehabilitation services that are delivered by more than one staff member, each staff member may bill for time spent engaged in rehabilitative services, whether the staff are working together or independently. When more than one staff member is in the home at the same time co-facilitating a family therapy or crisis intervention, each staff member may bill for the time spent engaged in this activity. The staff members may co-sign a single note that documents the rehabilitative activity that was conducted by the team. If the staff members worked with different family members, each staff member shall write a progress note in accordance with section 17b-262-858(a)(4) of the Regulations of Connecticut State Agencies.
- (c) For PHP, IOP and day treatment if the client is present for up to half of the program day and attends at least one individual, family or group session, the provider may bill half of the applicable Medicaid fee or rate. If the client is present for more than a half of the program day but less than a full day and attends at least two individual, family or group sessions, the provider may bill the full day charge on file. If the client does not attend at least one individual, group or family session the clinic is not entitled to any payment from the department.
- (d) A single per diem fee shall be billed for EDT inclusive of all medication evaluation or management services, treatment and rehabilitative services, administrative services and coordination with or linkages to other health care services. The agency may bill separately for medically necessary individual psychotherapy clinic services while the individual continues to receive extended day treatment services, if such services are rendered outside of the EDT program hours of operation, are provided by individuals other than EDT program staff and are necessary for the individual's transition or continuity of care.
- (e) For EDT if the client is present for up to half of the program day and attends at least one therapy session, the provider may bill for half of their fee on file. If the client is present for more than half of the program day but less than a full day and attends at least two therapy sessions, the provider may bill the full day charge on file. If the client does not attend at least one therapy session the clinic is not entitled to any payment from the department.
- (f) Claims for payment of rehabilitation services shall be on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment. All claims submitted to the department for payment of services covered under section 17b-262-854 of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the individual's permanent case record.

(NEW) Sec. 17b-262-860. Payment

- (a) In order to receive payment from the department, the provider shall be enrolled in the Connecticut Medical Assistance Program and comply with the requirements of sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.
- (b) The department shall establish rates for rehabilitation services. By enrolling in the program and providing covered rehabilitation services to eligible clients, the provider agrees to accept the department's rate as payment in full for rehabilitation services provided to eligible individuals.
- (c) Office-based off-site rehabilitation services provided by an entity that is not a Federally Qualified Health Center shall be reimbursed at the same rate applicable to such services when provided at a primary or satellite site as provided for on the clinic's DCF license.
- (d) Office-based off-site rehabilitation services provided by Federally Qualified Health Centers shall be reimbursed at the Federally Qualified Health Center's psychiatric encounter rate.

- (e) Home and community-based rehabilitation services and emergency mobile psychiatric services provided by Federally Qualified Health Centers shall be reimbursed at the same rates paid to non-Federally Qualified Health Center providers.
- (f) Rates for rehabilitation services include any associated travel costs.
- (g) Payment shall be made at the lowest of:
 - (1) The provider's usual and customary charge;
 - (2) the lowest Medicare rate; or
 - (3) the amount in the provider's rate letter or the amount on the applicable fee schedule as published by the department.

(NEW) Sec. 17b-262-861. Audit and Compliance Reviews

All supporting accounting and business records, statistical data and all other records relating to the provision of rehabilitation services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of the department.

Statement of Purpose: These regulations provide for community-based behavioral health rehabilitative services for individuals under the age of 21 eligible under the Connecticut Medical Assistance Program in accordance with section 17b-262 of the General Statutes of Connecticut.

IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

REGULATION

OF

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Payment of Rehab Services for

SECTION _____

Statement of Purpose: The purpose of the regulation is to set forth the department's requirements for payment of rehabilitation services for individuals under age 21 with behavioral health disorders who are eligible under the Connecticut Medicaid program. The problems, issues or circumstances that the regulation proposes to address are: to provide guidance to providers so that they may more easily distinguish between services reimbursable under the rehabilitation option and those reimbursable under the clinic option as specified in section 171.1 of the Medical Services Policy Manual. In addition, the regulation clearly sets forth the requirements under each area of Medicaid reimbursement and permits the department to enforce audit requirements.

(B) The main provisions of the regulation (1) establish three categories of rehabilitation services including office-based off-site rehabilitation services, home and community rehabilitation services and emergency mobile psychiatric services, (2) establish the requirements under which a provider can enroll in Medicaid for the purpose of providing these services; (3) indicate that reimbursement for provider services are limited to those services that are provided to Medicaid eligible persons under the age of 21 years; (4) define the services covered and the limitations on coverage; (5) specify services that are not covered by Medicaid; (6) outline billing procedures; (7) indicate payment procedures, rates, and limitations; and (8) reference necessary documentation and audit requirements.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The proposed regulation will update and clarify the policies regarding payment of rehabilitation services for children currently found in the Medical Services Policy Manual in regulation to reflect current practice.

CERTIFICATION

R-39 REV. 1/77

Be it known that the foregoing:

Page 2 of 2 pages

Regulations Emergency Regulations

Are:
 Adopted Amended as hereinabove stated Repealed

By the aforesaid agency pursuant to:
 Sections 17b-262 of the General Statutes.

Section _____ of the General Statutes, as amended by Public Act No. _____ of the _____ Public Acts.

Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on November 4, 2008, of the notice of the proposal to:

Adopt Amend Repeal such regulations

(If applicable): And the holding of an advertised public hearing on 2nd day of Dec., 2008

WHEREFORE, the foregoing regulations are hereby:

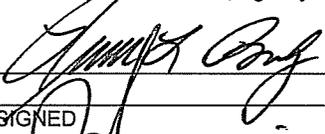
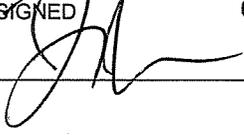
Adopted Amended as hereinabove stated Repealed

Effective:

When filed with the Secretary of the State.

(OR)

The _____ day of _____.

In Witness Whereof:	Date	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED
	<u>6/24/2011</u>		Commissioner
Approved by the Attorney General as to legal sufficiency accordance with sec. 4-169, as amended C.G.S.		SIGNED	OFFICIAL TITLE, DULY AUTHORIZED
		 <u>7/6/11</u>	ASSOC. ATTY. GENERAL

- Approved
- Disapproved
- Disapproved in part, (Indicate Section Numbers disapproved only)
- Rejected without prejudice

By the Legislative Regulation Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes.	Date	SIGNED (Clerk of the Legislative Regulation Review Committee)

Two certified copies received and filed, and one such copy forwarded to the Commission in Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY

INSTRUCTIONS

- One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
- Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
- Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
- Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.