R-39 Rev. 03/2012
(Title page)

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State of Connecticut
**REGULATION**
of

NAME OF AGENCY

Department of Social Services

**Concerning**

SUBJECT MATTER OF REGULATION

Payment of Behavioral Health Clinic Services

**Section 1.** The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-817 to 17b-262-828, inclusive, as follows:

**(NEW) Sec. 17b-262-817. Scope**

Sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of accepted methods of treatment performed by behavioral health clinics for clients who are determined eligible to receive such services under Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

**(NEW) Sec. 17b-262-818. Definitions**

For the purposes of sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) "Allied Health Professional" or "AHP" means:

(A) A licensed or certified practitioner performing within their 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-eligible individual as defined in subsection (23) of this section;

(2) "Ambulatory chemical detoxification services" has the same meaning as in section 19a-495-570 of the Regulations of Connecticut State Agencies;

(3) "Authorization" means approval of payment for services by the department before payment is made;

(4) "Behavioral health clinic" or "clinic" means a facility that provides services to outpatients, is not part of a hospital and is licensed as one of the following:

(A) A day treatment facility;

(B) a psychiatric outpatient clinic for adults;

(C) an ambulatory chemical detoxification facility;

(D) a chemical maintenance treatment service;

(E) a day or evening treatment service;

(F) an outpatient treatment facility for substance abuse; or

(G) an outpatient psychiatric clinic for children;

(5) "Behavioral health clinic service" means preventive, diagnostic, therapeutic, rehabilitative or palliative items or services within the behavioral health clinic's scope of practice provided by:

(A) A physician within the scope of practice as defined by Title 20 of the Connecticut General Statutes;

(B) an AHP within the scope of practice of the AHP as defined in Title 20 of the Connecticut General Statutes;

(C) an unlicensed or non-certified individual, working under the direct supervision of a licensed AHP or a Certified Clinical Supervisor, who is otherwise qualified to perform services under the applicable licensure category in sections 17b-262-819(c) to 17b-262-819(e), inclusive, of the Regulations of Connecticut State Agencies;

(6) "Certified Clinical Supervisor" is an individual who is certified by the Connecticut Certification Board as a Certified Clinical Supervisor;

(7) "Chemical maintenance treatment" has the same meaning as in section 19a-495-570 of the Regulations of Connecticut State Agencies;

(8) "Client" means a person eligible for goods or services under Medicaid;

(9) "Commissioner" means the Commissioner of Social Services or his or her designee;

(10) "Community Mental Health Center" or "CMHC" has the same meaning as in section 1861(ff)(3)(B) of the Social Security Act;

(11) "Day treatment facility" has the same meaning as in section 19a-495-550 of the Regulations of Connecticut State Agencies;

(12) "Day or evening treatment service" has the same meaning as in section 19a-495-570 of the Regulations of Connecticut State Agencies;

(13) "Day treatment program" means a day treatment facility, or day or evening treatment service that provides services between four and twelve hours per day;

(14) "Department" means the Department of Social Services or its agent;

(15) "Drug abuse testing" means the taking of physical samples or specimens and the qualitative screening of these samples or specimens for substances of abuse;

(16) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services provided in accordance with section 1905(r)(5) of the Social Security Act, as amended from time to time;

(17) "Escort" means a person 21 years of age or older who accompanies a client under the age of 16 during transport in a motor vehicle from one location to another. The driver of a public transportation vehicle shall not be considered an escort. The escort accompanies the client for the purpose of the client's protection and safety;

(18) "Fee" means the department's payment for services established by the commissioner and contained in the department's fee schedules;

(19) "Formulation" means a clinical assessment of information obtained that is used to provide the framework for developing the appropriate treatment approach for a specific client;

(20) "Group psychotherapy" means a type of behavioral health care in which clients meet in groups facilitated for the purpose of discussing their psychiatric or substance use disorders, the impact of these disorders and the barriers that may be overcome in order to progress in their recovery;

(21) "Intensive Outpatient Program" or "IOP" means an integrated program provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance abuse or an outpatient psychiatric clinic for children;

(22) "Intermediate care program" means a day or evening treatment service, IOP or Partial Hospitalization Program;

(23) "License-eligible" means an individual whose education, training, skills and experience satisfy the criteria, including accumulation of all supervised service hours, for one of the behavioral health licensure categories of Title 20 of the Connecticut General Statutes, and has applied for but not yet passed the licensure exam;

(24) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(25) "Medical necessity" or "medically necessary" has the same meaning as in section 17b-259b of the Connecticut General Statutes;

(26) "Off-site services" means services that are provided at a location other than the clinic or a satellite of the clinic;

(27) "Outpatient Psychiatric Clinic for Children" or "OPCC" has the same meaning as in section 17a-20-11 of the Regulations of Connecticut State Agencies;

(28) "Outpatient treatment service for substance abuse" has the same meaning as section 19a-495-570 of the Regulations of Connecticut State Agencies;

(29) "Partial Hospitalization Program" or "PHP" has the same meaning as in section 1861(ff)(1) of the Social Security Act;

(30) "Physician" means an individual licensed or board-certified pursuant to section 20-10 of the Connecticut General Statutes and who has experience in the diagnosis and treatment of behavioral health or substance related conditions;

(31) "Plan of care" means a written individualized plan that contains the client's diagnosis; the type, amount, frequency and duration of services to be provided; and the specific goals and objectives developed subsequent to an evaluation and diagnosis in order to attain or maintain a client's achievable level of independent functioning;

(32) "Prior authorization" means approval of payment for a service from the department before the provider actually provides the service;

(33) "Provider" means a behavioral health clinic enrolled in Medicaid;

(34) "Provider agreement" means the signed, written contractual agreement between the department and the provider;

(35) "Psychiatric outpatient clinic for adults" has the same meaning as in section 19a-495-550 of the Regulations of Connecticut State Agencies;

(36) "Psycho-educational group" means a type of behavioral health care that utilizes a pre-determined and time limited curriculum that focuses on educating clients with a common diagnosis about their disorders, specific ways of coping and progressing in their recovery;

(37) "Registration" means the process of notifying the department of the initiation of a behavioral health clinic service that includes information regarding the evaluation findings and plan of care. Registration may serve in lieu of authorization if a service is designated by the department as requiring registration only;

(38) "Satellite site" has the same meaning as in section 17a-20-11 of the Regulations of Connecticut State Agencies;

(39) "Under the direct supervision" means that a physician, licensed AHP, as established in (1)(A) of this section, or a Certified Clinical Supervisor, provides weekly supervision of the work performed by unlicensed clinical staff or non-certified staff or individuals in training, and a minimum of monthly supervision for the work performed by certified staff; and accepts primary responsibility for the behavioral health services performed by the unlicensed, certified or non-certified staff or individuals in training; and

(40) "Usual and customary charge" means the fee that the provider accepts for the service or procedure in the majority of non-Medicaid cases. If the provider varies the fees so that no one amount is accepted in the majority of cases, "usual and customary" shall be defined as the median accepted fee. Token fees for charity patients and other exceptional charges are to be excluded.

**(NEW) Sec. 17b-262-819. Provider Participation**

(a) Providers shall meet and maintain all department enrollment requirements, as described in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies, to receive payment from the department.

(b) Clinic services shall be furnished by or under the direction of a physician as defined in 42 CFR §440.90. The physician shall sign the initial plan of care and all periodic reviews to the plan of care assuring that the services are medically necessary.

(c) Programs serving clients under 18 years of age that are primarily for the treatment of psychiatric conditions shall be licensed by the Department of Children and Families as an Outpatient Psychiatric Clinic for Children under section 17a-20 of the Connecticut General Statutes.

(d) Programs serving clients 18 years of age and older that are primarily for the treatment of psychiatric conditions shall be licensed by the Department of Public Health as a day treatment facility or psychiatric outpatient clinic for adults under section 19a-495-550 of the Regulations of Connecticut State Agencies.

(e) Programs that are primarily for the treatment of substance related conditions, regardless of the age of the client served, shall be licensed by the Department of Public Health as an ambulatory chemical detoxification service; a chemical maintenance service; a day or evening treatment program; or an outpatient treatment service for substance abuse under section 19a-495-570 of the Regulations of Connecticut State Agencies.

(f) All providers, except those licensed solely as a chemical maintenance provider, shall maintain the ability to respond to phone calls 24 hours a day, seven days a week and shall ensure that a client who is in crisis speaks with a physician or an AHP.

**(NEW) Sec. 17b-262-820. Eligibility**

Payment for behavioral health clinic services shall be available to all clients eligible for Medicaid subject to the conditions and limitations that apply to provision of the services.

**(NEW) Sec. 17b-262-821. Services Covered**

(a) The department shall pay providers for those procedures listed in the department's behavioral health clinic fee schedule, provided such services are:

(i) Within the clinic's scope of practice as defined by sections 19a-495-550, 19a-495-570, 17a-20-11 or 17a-147-1 of the Regulations of Connecticut State Agencies;
(ii) medically necessary to treat the client's condition; and
(iii)furnished in the clinic or a satellite site of the clinic.

(b) When a procedure or service requested by a provider is not on the department's behavioral health clinic fee schedule, prior authorization is required. In such instances the provider shall submit a prior authorization request to the department or its agent including, but not limited to documentation showing the medical necessity for the service or procedure.

(c) The department shall pay for behavioral health clinic services for EPSDT special services.

**(NEW) Sec. 17b-262-822. Service Limitations.**

(a) General

(1) Payment for individual, group, family or multiple-family psychotherapy is limited to one visit of each type per day, per provider, per client.

(2) Family and group psychotherapy sessions shall be no less than 45 minutes in length, except in an intermediate care program where family and group psychotherapy sessions shall be not less than 30 minutes.

(3) More than one psychiatric diagnostic interview examination shall only be provided in a single episode of care under the following circumstances:

(A) When it is necessary to have a psychologist perform an interview to initiate or determine the need for psychological testing; or

(B) when a client's presentation requires that a physician or a psychiatric advanced practice registered nurse evaluate the need for medication for a client who is in the care of a non-medical practitioner.

(4) An episode of care is a period of care that ends when the client has been discharged by the provider or there has been an extended cessation in treatment defined as 120 days from the last time the client was treated at the clinic.

(5) Group psychotherapy sessions, are limited in size to a maximum of twelve participants per group session regardless of the payment source of each participant, except as defined in subdivision (8) of subsection (d) of this section.

(6) Group psychotherapy sessions shall be facilitated by an individual qualified under the applicable licensure category in sections 17a-262-819(c) to (e), inclusive of the Regulations of Connecticut State Agencies.

(7) Multiple-family group psychotherapy sessions are limited in size to a maximum of 24 participants regardless of the payment source of each participant. Such sessions may be conducted with or without the client present.

(8) Family therapy shall be reimbursable for one identified client per encounter, without regard to the number of family members in attendance or the presence of behavioral health conditions among other family members in attendance.

(b) Chemical maintenance

(1) Services shall be billed as chemical maintenance when the goal is to stabilize a client on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance abuse. The induction phase of treatment, the maintenance phase and any tapering of treatment dosage downward, even to abstinence, shall be billed as chemical maintenance.

(2) Payment shall be available only for services provided at the clinic. Payment shall not be made for weeks when no face-to-face services are provided.

(3) A weekly rate payment for chemical maintenance shall be paid when opiate agonist medication and medication management services are provided to a client. Intake evaluation, initial physical examination; on-site drug abuse testing and monitoring; and individual, group and family counseling, are services that are also included in the weekly rate, if medically necessary.

(4) Intermediate care programs may be billed separately if medically necessary.

(c) Ambulatory chemical detoxification

(1) Services shall be billed as ambulatory chemical detoxification when the goal is to systematically reduce to abstinence a client's dependence on a substance. The goal of abstinence shall be documented in the client's initial plan of care.

(2) Ambulatory chemical detoxification treatment services shall be limited to one clinic visit per day, per client regardless of the number of times the client is seen in the clinic during any given day.

(3) Ambulatory chemical detoxification treatment services shall be limited to a maximum of 90 days from the date the client is admitted into the program.

(4) Payment for ambulatory chemical detoxification includes, but is not limited to: An intake evaluation; a physical examination; all medication; medication management; laboratory and monitoring; and individual, group and family counseling, with the exception of intermediate care programs that specifically address a substance abuse disorder and are provided by the clinic.

(5) Chemical maintenance and ambulatory chemical detoxification shall not be billed for the same time period.

(d) Intermediate care programs shall meet the following requirements:

(1) Care planning shall be individualized and coordinated to meet the client's needs.

(2) Clinic programs shall provide time-limited, active psychiatric or substance abuse treatment that offers therapeutically intensive, coordinated and structured clinical services within a stable therapeutic milieu.

(3) Clinic programs shall be designed to serve clients with serious functional impairments resulting from a behavioral health condition, and further serve to avert hospitalization or increase a client's level of independent functioning.

(4) The program shall provide an adult escort to support the transportation of clients under 16 years of age, transported by a Medicaid non-emergency medical transportation provider, unless the parent or guardian of the client between the ages of 12 to 15 years does not feel an escort is necessary for the client and has provided written consent for transportation of the client to the program without an escort.

(5) Clients may attend day treatment, IOP or PHP for a maximum of five days per week.

(6) A treatment day at a day treatment program or PHP shall include a minimum of four hours of scheduled programming, of which three and one half hours shall be documented behavioral health clinic services.

(7) A treatment day at an IOP shall include a minimum of three hours of scheduled programming, of which two and one half hours shall be documented behavioral health clinic services.

(8) Psychotherapy and psycho-education group size in intermediate care programs shall be limited to 12 participants except that psycho-education group size for substance abuse related conditions shall be limited to 24 participants and may comprise no more than one and one-half hours of an intermediate care program.

(9) The department shall pay for partial hospitalization services only when provided in a CMHC.

**(NEW) Sec. 17b-262-823. Services Not Covered**

The department shall not pay for the following:

(1) Information or services provided to a client over the telephone;

(2) cancelled services and appointments not kept;

(3) any services, treatment or items for which the provider does not usually charge;

(4) any procedures or services whose purpose is solely educational, social, research, recreational, experimental or generally not accepted by medical practice;

(5) any behavioral health clinic service in excess of those deemed medically necessary by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history;

(6) any service not included in the plan of care when treatment is recommended;

(7) any service requiring authorization or registration for which the provider did not obtain such authorization or registration; or

(8) off-site and certain other services, including but not limited to: Emergency mobile psychiatric services; home and community based rehabilitation services; and extended day treatment provided only under the Child Rehabilitation Option under sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies. Such services are

reimbursed as part of the rehabilitation option services rather than as a behavioral health clinic service.

**(NEW) Sec. 17b-262-824. Need for Service**

(a) Each client's care shall be under the direction of a physician directly employed by or under contract with the clinic. The physician shall authorize the care provided and periodically review the need for continuing care.

(b) Psychiatric diagnostic evaluations shall be provided by an individual who is permitted to conduct such evaluations under the applicable clinic licensure category.

(c) The evaluation shall inform the plan of care and shall be completed for each client. The evaluation shall contain the following components:

(1) Mental status;

(2) psychosocial history or updated psychosocial history for clients who have previously been in the provider's care;

(3) psychiatric or substance abuse history or updated psychiatric or substance abuse history for clients who have previously been in the provider's care;

(4) medication history and current status, if indicated, or updated medication history for clients who have previously been in the provider's care;

(5) orders for and medical interpretation of laboratory or other medical diagnostic studies, if indicated;

(6) the initial diagnosis, functional status and formulation; and

(7) treatment recommendations or further disposition of the client.

(d) If treatment is recommended, a plan of care shall be developed.

(e) The physician shall review the evaluation and plan of care and sign the plan of care and periodic reviews of the plan of care assuring that the services are medically necessary.

(f) If treatment is not recommended, the physician shall sign the evaluation.

(g) A plan of care shall be completed for each client admitted and shall be periodically reviewed and updated in accordance with the client's progress. The plan of care shall, at a minimum, meet the requirements of the individualized care plan as described in: section 19a-495-550 (k)(2)(C) of the Regulations of Connecticut State Agencies; individualized program plan described in section 19a-495-570 (m)(6) of the Regulations of Connecticut State Agencies; or individualized treatment plan as described in section 17a-20-42 of the Regulations of Connecticut State Agencies, as appropriate to the licensure of the service.

(h) A psychiatric office consultation shall be billed only by a physician or APRN. When a psychiatric office consultation is the only service provided by the clinic, only a written note is required as documentation and a plan of care is not necessary. If an APRN provides the

service, the written note shall be cosigned by a physician.

(i) The evaluation and plan of care shall be made a part of the client's medical record.

(j) Care planning shall be individualized and coordinated to meet the client's needs.

**(NEW) Sec. 17b-262-825. Prior Authorization and Registration**

(a) Behavioral health clinic services for clients with psychiatric and substance abuse disorders shall be 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 shall not available unless the provider complies with such requirements.

(b) Services that require authorization or registration shall be designated as such on the provider's fee schedule or authorization and registration schedule published at www.ctdssmap.com.

(c) The following requirements shall apply to all services that require authorization or registration under subsection (b) of this subsection:

(1) The initial authorization period shall be based on the needs of the client;

(2) 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;

(3) except in emergency situations or for the purpose of initial assessment, authorization shall be received before services are rendered;

(4) 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 and registration request. Prior authorization or registration does not, however, guarantee payment unless all other requirements for payment are met;

(5) 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;

(6) 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;

(7) the provider shall maintain documentation adequate to support requests for continued authorization or registration 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;

(8) the department may require a review of the discharge plan and actions taken to support the successful implementation of the discharge plan as a condition of authorization;

(9) a provider may request authorization from the department after a service has been provided for clients who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service;

(10) for clients 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; and

(11) the department may deny authorization or registration based on non-compliance by the provider with utilization management policies and procedures.

**(NEW) Sec. 17b-262-826. Billing Requirements**

(a) Claims shall be submitted on the department's designated 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.

(b) The provider shall bill its usual and customary charge for the services delivered, except as defined in section 17b-262-827(b) of the Regulations of Connecticut State Agencies.

**(NEW) Sec. 17b-262-827. Payment**

(a) The commissioner shall establish fees in accordance with section 4-67c of the Connecticut General Statutes. Fees shall be the same for in-state, border and out-of-state providers.

(b) If the client is present for up to half of the intermediate care 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 intermediate care 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.

(c) A single per diem fee shall be billed for intermediate care programs inclusive of all medication evaluation or management services, treatment and rehabilitative services, administrative services and coordination with or linkages to other health care services. A provider may bill separately for medically necessary individual or family psychotherapy services provided outside of the program hours of operation if such services are necessary for the purpose of client transition or continuity of care.

(d) If a session includes a combination of individual and family psychotherapy, the provider shall bill for the type that comprises the greater part of the session. Individual and family

psychotherapy shall not both be billed for the same date of service unless each type of session individually meets the minimum time requirement for the modality.

(e) Practitioners who are clinic-based either on a full-time or part-time basis are not entitled to individual payment from the department for services rendered to clients at the clinic. The clinic shall bill the services, except as provided in section 17b-262-460 (c) of the Regulations of Connecticut State Agencies.

(f) Payment for services provided to a client is contingent upon the client's eligibility on the date that services are rendered.

(g) The department shall pay the lower of:

(1) The amount in the applicable fee schedule;

(2) the amount on the provider's rate letter; or

(3) the amount billed by the provider.

(h) The department may establish higher reimbursement for providers that meet special requirements.

(1) The special requirements shall be established by the department and may vary by provider type and specialty. The department, in its sole discretion, shall determine whether a provider meets the requirements for the higher reimbursement.

(2) The special requirements shall be related to improvements in access, quality, outcomes or other service characteristics that the department reasonably determines may result in better care and outcomes.

(3) The department may grant provisional qualifications for higher reimbursement by means of an application process in which providers submit a plan that demonstrates the feasibility of meeting the requirements.

(4) The department shall conduct periodic qualifications reviews. If a provider fails to continue to meet the requirements, the department may grant a probationary period of not less than 120 days during which the provider continues to qualify for higher reimbursement and is permitted an opportunity to submit a corrective action plan and to demonstrate compliance.

(5) The department may conduct provider audits to determine whether a provider is performing in compliance with the special requirements.

**(NEW) Sec. 17b-262-828. Documentation and Audit Requirements**

(a) Providers shall maintain a specific record for all services rendered for each client eligible for Medicaid payment including, but not limited to:

(1) Client's name, address, birth date and Medicaid identification number;

(2) results of the initial evaluation and clinical tests, and a summary of current diagnosis, functional status, symptoms, prognosis and progress to date;

(3) the initial plan of care, signed by a physician not more than 30 days after the initial evaluation, that includes the types and frequencies of treatment ordered. The physician shall also sign the plan of care at the time of each periodic review and when the plan of care is updated to reflect any change in the types of service. When a physician signs off on the plan of care, the signature indicates that the plan of care is valid, conducted properly and based on the evaluation;

(4) documentation of each service provided by the clinician including types of service or modalities, date of service, location or site at which the service was rendered and the start and stop time of the service;

(5) the name and credentials of the individual performing the services on that date; and

(6) medication prescription and monitoring.

(b) For treatment services, the provider shall document the treatment intervention and progress with respect to the client's goals as identified in the plan of care.

(c) For providers licensed under section 19a-495-550 of the Regulations of Connecticut State Agencies, the medical record shall conform to the requirements of section 19a-495-550(k)(2) of the Regulations of Connecticut State Agencies.

(d) For providers licensed under section 19a-495-570 of the Regulations of Connecticut State Agencies, the medical record shall conform to the requirements of section 19a-495-570(m)(3) of the Regulations of Connecticut State Agencies.

(e) For intermediate care programs a note shall document the duration of each distinct therapeutic session or activity and progress toward treatment goals.

(f) For psychological testing, documentation shall include the tests performed, the time spent on the interview, the administration of testing and the completion of the clinical notes.

(g) For services performed by an unlicensed individual or a non-certified individual or an individual in training, progress notes entered pursuant to subsection (b) of this section shall be co-signed by the supervisor at least weekly for each client in care and shall contain the name, credentials and the date of such signature. For services provided by a certified individual, evidence of clinical supervision for each client in care shall be documented in the client's chart and shall contain the name, credentials and the date of such signature. The supervisor's signature means that the supervisor attests to having reviewed the documentation.

(h) The medication plan shall include instructions for administration for each medication prescribed by a clinic practitioner and a list of other medications that the patient is taking that may be prescribed by non-clinic practitioners.

(i) All required documentation shall be maintained in its original form for at least five years or longer by the provider in accordance with statute or regulation subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation

shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation whichever is longest.

(j) 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 or not provided to the department upon request.

(k) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(l) All documentation shall be entered in ink or electronically and incorporated into the client's permanent medical record in a complete, prompt and accurate manner.

(m) All documentation shall be made available to authorized department personnel upon request in accordance with 42 CFR §431.107.

**Section 2.** Sections 171.4 to 171.4 III, inclusive, and 173 to 173 I., inclusive, of the department's Medical Services Policy Manual, as they apply to behavioral health clinic services, are repealed.

## Statement of Purpose

*Pursuant to CGS Section 4-170(b)(3), "Each proposed regulation shall have a statement of its purpose following the final section of the regulation." Enter the statement here.*

**Statement of Purpose:** The purpose of the proposed regulation is to establish, in regulation form, the requirements for payment of behavioral health clinic services provided to clients covered by the Medicaid program. The problems, issues or circumstances that the regulation proposed to address: the current policy, found in the department's Medical Services Policy Manual, requires technical changes to accurately reflect current policy and practice. The main provisions of the regulation propose to: (1) add new definitions as necessary; (2) incorporate current practice; and (3) clarify the prior authorization process, documentation requirements and billing procedures. The legal effect of the regulation is to put in regulation form the department's current policies and procedures regarding the payment of behavioral clinic services under the Medicaid program.