



RODERICK L. BREMBY
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
MEMORANDUM

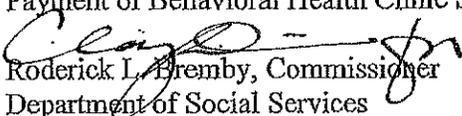
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To: Individuals Who Commented on the Proposed Regulation Regarding
Payment of Behavioral Health Clinic Services, DSS Reg. No. 09-03

From: 
Roderick L. Bremby, Commissioner
Department of Social Services
25 Sigourney St.
Hartford, CT 06106

Date: September 20, 2011

Re: Responses to Public Comment

The following are the Department of Social Services ("the Department") responses to comments received from the public concerning the proposed regulation referenced above. The Notice of Intent for this regulation was published in Connecticut Law Journal on August 18, 2009. A copy of the regulation with revisions based on public comment is enclosed. The Department anticipates submitting the proposed regulation to the Legislative Regulation Review Committee by November 1, 2011.

(1) **Audit Standards**

Comment: One Commentator suggested that the Department create an audit manual, develop a corporate compliance program and corresponding training schedule for the Medicaid program.

Response: Creating an audit manual, developing a corporate compliance program and corresponding training schedule is beyond the scope of this regulation; however, the Department's Medical Policy Unit has communicated this request to the Department's Quality Assurance Division.

(2) **Correlation with Existing Licensing Regulations**

Comment: A Commentator stated that the proposed Behavioral Health Clinic regulation contains references to other state regulations that are in conflict with one another.

Response: The Department has identified any apparent conflicts between the proposed regulation and existing regulations and addressed those conflicts accordingly.

(3) **Section 17b-262-818 (1)**

Comment: One Commentator states that the definition of “active treatment” found at 42 C.F.R. § 441.154 relates to inpatient services for individuals under age 21. The Commentator asks if the citation referenced in section 17b-262-818(1) is correct.

Response: The definition of “active treatment” has been removed because the term is not used elsewhere in the regulation and, therefore, does not need to be defined in the regulations.

(4) **Section 17b-262-818 (2)** (*See*, Attachment A, Section 17b-262-818(1))

(a) Comment: Several Commentators requested clarification of the meaning of the term “license-eligible” as it is used in the definition of “Allied Health Professional” in section 17b-262-818(2).

Response: “License-eligible” means that the individual’s education, training, skills and experience satisfy the criteria for any professional or occupational license categories pertaining to behavioral health under Title 20 of the Connecticut General Statutes except the individual has applied to take the licensure exam, but has not yet taken and passed the exam. A definition of the term “licensed-eligible” has been added to section 17b-262-818(21) of the Regulations of Connecticut State Agencies to provide clarification.

(b) Comment: A Commentator asked if the term “license-eligible” includes interns and individuals in training.

Response: No, interns and individuals in training are not “license-eligible.” Such individuals have not meet all of their licensure criteria as required in section 17b-262-818(21) of the Regulations of Connecticut State Agencies.

(c) Comment: A Commentator asked whether the definition of “Allied Health Professional” (“AHP”) includes BA level practitioners?

Response: An individual’s status as an AHP depends on whether the individual is a licensed practitioner or meets the definition of “license-eligible” as defined in section 17b-262-818(21).

(d) Comment: The Commentator asked if the definition of "Allied Health Professional" includes CT Alcohol & Drug Counselors ("CADC")?

Response: Yes, as long as the individual is certified as a CADC.

(5) **Section 17b-262-818 (7)** (*See, Attachment A, Section 17b-262-818(5)*)

(a) Comment: One Commentator suggested the definition of "behavioral health clinic services" be amended to include "prevention" and to reference "maintaining functioning." The Commentator proposed the following language be added:

... means health care that is necessary to prevent, diagnose, correct or diminish the adverse effects of a psychiatric or substance abuse disorder or to maintain functioning...

(b) Response: The Department has amended the regulation to include language regarding prevention. The concept of maintenance is integrated in the definition of "medical necessity"; therefore, the Department did not add maintenance to the definition of "behavioral health clinic service."

(6) **Section 17b-262-818 (6)** (*See, Attachment A, Section 17b-262-818 (4)*)

(a) Comment: One Commentator suggested the definition of "behavioral health clinic" include partial hospitalization program ("PHP").

Response: A "partial hospitalization program" is not a licensure category, but the federal designation given to a facility licensed as day or evening treatment program that provide services in a hospital or Community Mental Health Center ("CMHC"). §1861(ff)(1) of the Social Security Act.

(b) Comment: A Commentator suggested that the definition of "behavioral health clinic" include outpatient treatment service for substance abuse.

Response: The Department has amended the language of the definition of "behavioral health clinic" to include "an outpatient treatment facility for substance abuse." (*See, Attachment A, Section 17b-262-818(4)(F)*).

(c) Comment: A Commentator noted an inconsistent use of substance abuse terms found in sections 17b-262-818(6) defining "behavioral health clinic" and 17b-262-819(e) regarding provider participation.

Response: The Department has amended the regulation and changed the term "methadone maintenance" found in section 17b-262-819(e) to "chemical maintenance treatment" for consistency.

(d) Comment: One Commentator suggested that the Department adopt uniform names for services and facilities.

Response: The Department has modified definition of "behavioral health clinic" and the Provider Participation requirements in section 17b-262-819 to address the Commentator's concerns.

(7) **Section 17b-262-818(7)** (*See, Attachment A, Section 17b-262-818(5)*)

(a) Comment: A Commentator suggested that the definition of "behavioral health clinic services" be amended to include "psycho-educational services" and proposed the following language:

... means preventive, diagnostic, therapeutic, rehabilitative, psycho-educational or palliative items or services within the behavioral health clinic's scope of practice provided by ..."

Response: Psycho-educational services are a type of rehabilitative service, so it is already subsumed in the current definition which includes "rehabilitative services." No change will be made to the proposed language.

(b) Comment: One Commentator asked if "an individual in training for or obtaining supervisory hours" described in section 17b-262-818(7)(C) includes interns and non-licensed individuals?

Response: Yes, "an individual in training for or obtaining supervisory hours" includes interns and non-licensed individuals.

(c) Comment: A Commentator suggested the definition of "behavioral health clinic services" limits paraprofessionals to evidence-based services and that no other practitioner is limited in this way in the proposed regulation.

Response: To address the Commentator's concern, the regulation has been amended to remove the terms "paraprofessional" and "evidence-based practices."

(d) Comment: A Commentator asked if there are restrictions on what procedure codes may be billed by the clinic on behalf of the paraprofessionals.

Response: The regulation has been amended and the term "paraprofessional" has been replaced with "an unlicensed or non-certified individual who is otherwise qualified to perform the service." The expectation is that the licensing authority for the clinic will determine the appropriate services that can be performed and the qualifications of such unlicensed or non-certified individuals.

(e) Comment: One Commentator asked if a signature on the treatment plan is sufficient to demonstrate that the paraprofessional is "under the direction of a physician".

Response: See Response to Comment (15) below.

(8) Section 17b-262-818 (17)

Comment: Several Commentators had questions about or requested clarification regarding the term "evidence-based services."

Response: In response to the public comments received, the Department deleted the term "evidenced-based services."

(9) Section 17b-262-818 (20) (See, Attachment A, Section 17b-262-818(19))

Comment: A Commentator suggested that the definition of "intensive outpatient" or "IOP" include substance abuse services.

Response: The Department agrees and has amended the regulation to include the term "substance abuse" in the definition of "intensive outpatient."

(10) Section 17b-262-818 (22) (See, Attachment A, Section 17b-262-818(23)).

Comment: One Commentator suggested that the term "least costly" as used in the definition of "medical necessity" is subjective. The Commentator requested a definition of "equally-effective" as it relates to determining whether a service is the least costly. The Commentator also requested clarification regarding how many "multiple alternative treatments" or "diagnostic modalities" must be assessed to determine that a service was the least costly.

Response: Pursuant to section 107 of Public Act 09-7 of the September Special Session, a revised definition of "medical necessity" was developed by the Department and the Medical Inefficiency Committee. The new definition of "medical necessity," which was subsequently adopted pursuant to section 22 of Public Act 10-3, codified in section 17b-259b of the Connecticut General Statutes, addresses the Commentator's concerns.

(11) **Section 17b-262-818 (26)**

Comment: Several Commentators requested clarification regarding the “certificate” or “exam” referenced in the definition of “paraprofessional” that enables a paraprofessional to perform a particular service and who is considered to be a “paraprofessional.”

Response: See, Response (7)(c), above.

(12) **Section 17b-262-818 (29)**

(a) Comment: One Commentator suggested that the definition of “plan of care” include the term “maintenance.”

Response: The Department agrees and has amended the regulation to include the term “maintain” to the definition of “plan of care”.

(b) Comment: Another Commentator suggested that the definition of “plan of care” should explicitly state that “review periodically” means 90 days.

Response: The Department has amended the regulation and removed the reference to “review periodically.” Please refer to section 17b-262-824(g) of the Regulations of Connecticut State Agencies for the review requirements for a plan of care.

(c) Comment: One Commentator asked if the “plan of care” is equivalent to a “treatment plan” and requested clarification regarding how the initial plan of care and the treatment plan relate to each other. The Commentator also suggested the Department use consistent terminology if the two terms are the same.

Response: A treatment plan is one type of plan of care. The term “treatment plan” is used in section 17a-20-42 of the Regulations of Connecticut State Agencies to describe the care plan or treatment plan required for an outpatient psychiatric clinic for children.

(d) Comment: A Commentator suggested inserting the requirements of an “evaluation” described in section 17b-262-824(b) (now section 17b-262-824(c)) into section 17b-262-818 of the Regulations of Connecticut State Agencies.

Response: The *Manual for Drafting Regulations* prohibits the inclusion of substantive provisions within a definition. The substantive provisions, the requirements of a plan of care, have been removed from section 17b-262-818 for proper form.

(e) Comment: One Commentator suggested that the “plan of care” definition should include a statement that the “plan of care” is a required to be part of the client record.

Response: See, Response 12(d).

(13) Section 17b-262-818 (35)

Comment: One Commentator suggested that the definition of "rehabilitation services" include the term "maintain."

Response: The definition of "rehabilitation services" was deleted from the proposed regulation as it was not used elsewhere in the regulation and, therefore, did not require a definition.

(14) Section 17b-262-818 (36)

(a) Comment: A Commentator recommended that the Department use the same definition of "satellite site" as used by the Department of Children and Families (DCF) in section 17a-20-11 of the Regulations of Connecticut State Agencies.

Response: The regulation cross-references the definition of "satellite site" as it is defined in section 17a-20-11 of the Regulations of Connecticut State Agencies.

(b) Comment: Several Commentators asked whether services not provided at a satellite site, but provided "offsite" are covered by the Child Rehab regulation ("Rehab Option") or are some "offsite" services covered by the Behavioral Health Clinic ("Clinic Option") regulation?

Response: Off-site locations that do not meet the requirements of a "satellite site" under section 17a-20-11 of the Regulations of Connecticut State Agencies do not qualify for reimbursement under the Behavioral Health Clinic regulation. Off-site services may be reimbursable as rehabilitation services under the Child Rehab Option regulation which is also pending in the promulgation process.

(c) Comment: One Commentator asked if payment for Emergency Mobile Psychiatric Services ("EMPS") is included under these proposed Behavioral Health Clinic regulation or under proposed Child Rehab Option regulation.

Response: Emergency Mobile Psychiatric Services are not reimbursable under the Behavioral Health Clinic regulation. EMPS for children is reimbursable as child rehabilitation service under the Child Rehab Option regulation which is also pending in the promulgation process.

(15) Section 17b-262-818 (37)

Comment: One Commentator asked whether the term "under the direction" means that the physician is responsible for signing all documents.

Response: The Department has amended the regulation and removed the term "under the direction" and replaced it with the term "under the direct supervision." Documentation of physician direction is specified in section 17b-262-819(b) of the Regulations of Connecticut State Agencies. Under Federal law clinic services must be provided under the direction of a physician. 42 C.F.R. §440.90. In order to demonstrate that physician direction took place, the physician is responsible for signing the initial plan of care and all periodic reviews.

(16) Section 17b-262-819 (b)

(a) Comment: A Commentator asked for clarification regarding how the initial plan of care and the treatment plan relate to each other. The Commentator suggested that if the terms are the same for the Department to use consistent terminology.

Response: See, Response 12(c).

(b) Comment: A Commentator suggested that the current DSS requirements are not prescriptive about sign-off and this change in the proposed regulation makes providing services more expensive. Substance abuse providers are not currently required to have physician sign-off on all updates to plans of care and this requirement adds an additional responsibility for the physician and increases the need for additional hours and added expense. The Commentator suggested that the Department mirror the requirement used by the Department of Public Health ("DPH") and only require signature of the physician on the initial and annual treatment plans.

Response: As suggested by the Commentator, the Department amended the regulation and modified section 17b-262-819(b) of the Regulations of Connecticut State Agencies to require that the physician sign off on all "periodic reviews" for the plan of care rather than "all updates" to the plan of care. The Department also has modified the wording to require reviews with the same frequency as required by DPH licensure for the service rendered.

(17) Section 17b-262-819 (e)

Comment: One Commentator suggested that the reference to "Methadone Maintenance Service" should be removed from section 17b-262-819(e) because it is not one of the nine licensure classifications specified per section 19a-495-570(b)(1) to 19a-495-570(b)(9), inclusive of the Regulations of Connecticut State Agencies.

Response: The Department agrees and has amended the regulation and replaced the term "methadone maintenance" with "chemical maintenance."

(18) Section 17b-262-819 (f)

(a) Comment: A Commentator asked for clarification of the term "clinician" and asked which practitioners identified in sections 17b-262-818(2) or 17b-262-818(7) of the Regulations of Connecticut State Agencies are considered "clinicians"?

Response: The Department has amended the regulation and changed the term "clinician" in 17b-262-819(f) to "AHP" or "physician" for clarification.

(b) Comment: The Commentator suggests that the provision of 24/7 availability of a clinician is not a requirement for chemical maintenance licensure and that experience shows clients do not call when in a crisis.

Response: The Department has amended this provision to exclude facilities solely licensed as chemical maintenance programs from this requirement. The Department, however, believes it is important for clients to have access to a physician or AHP when there is an emergency rather than have their call go to a voice mail box.

(19) Section 17b-262-821 (a)

Comment: A Commentator asked for clarification regarding the process for authorization and payment for services provided under EPSDT in a clinic setting?

Response: The procedure is published in the provider manual located on the Connecticut Behavioral Health Partnership (CTBHP) website at www.ctbhp.com.

(20) Section 17b-262-821 (c)

(a) Comment: One Commentator suggested that the difference between a "satellite site" and "clinic off-site services" is unclear. The Commentator requested clarification of the distinction between a service that is "specified in the licensing process as locations where services are provided", as provided under the DCF Regulations regarding Licensure of Outpatient Psychiatric Clinics for Children, and a satellite clinic. The Commentator also requested clarification of the conditions under which a clinic can provide off-site services and be reimbursed.

Response: See, Response 14.

(c) Comment: One Commentator stated that there is no explanation regarding who is

permitted to bill for development testing (either limited or extended). The Commentator requested confirmation that these services can be provided by any level (BA, MSW, LCSW, or PhD).

Response: The determination of which professionals may bill for particular services depends on the licensed professional's "scope of practice" which is defined by DPH.

(c) Comment: One Commentator requested clarification regarding who can bill for services coded "90887" and the definition of this code for Medicaid clients.

Response: The definition of this code is universal across all providers and is defined in the Common Procedural Terminology ("CPT") manual. A physician, AHP or individual in training as described in section 17b-262-818(5)(A) to (C), inclusive, of the Regulations of Connecticut State Agencies, may bill CPT code 90887.

(21) Section 17b-262-822(a)(1)

(a) Comment: A Commentator requested a clarification regarding the term "same type" that is used in section 17b-262-822(a)(1). The Commentator also asked if individual, group and family psychotherapy are all considered the "same type" and if each provider in a clinic can provide each of these services in a day?

Response: Individual, group, family, and multiple family services are each considered different type of service. Section 17b-262-822(a)(1) allows a behavioral health clinic to provide each type of medically necessary therapy one time per client, per day.

(b) Comment: One Commentator asked if a provider can submit a bill for an individual therapy and a group therapy session, conducted separately, for the same client on the same day.

Response: The clinic, as the billing provider, may submit a claim for an individual therapy and group therapy sessions for the same client provided on the same day as long as each session is medically necessary and meets the minimum time requirements.

(22) Section 17b-262-822(a)(2)

(a) Comment: One Commentator suggested that the requirement that family and group psychotherapy sessions meet for a minimum of 45 minutes will affect staffing patterns, productivity and cost.

Response: The Department has revised section 17b-262-822(a)(5), increasing the permissible number of participants in group therapy sessions from 8 to 12 persons and believes that 45 minutes is the minimum amount of time necessary to achieve meaningful participation by all 12 participants.

(b) Comment: The same Commentator states that EDT and other milieus recommend 30 minute sessions to better meet needs of young children.

Response: A shorter duration session is permitted in an intermediate care program. The Department has amended the regulation to provide for sessions that are 30 minutes in duration when provided in an intermediate care setting (*See, Attachment A, Section 17b-262-822(a)(2)*).

(c) Comment: A Commentator suggested that evidence-based practices for adult services require 90 minute sessions. The Commentator suggests that running a longer session with a limited group size will increase the cost of providing the service. The Commentator asked if evidence-based practice group size can be increased to address this potential rate/reimbursement issue.

Response: Section 17b-262-822(a)(5) of the Regulations of Connecticut State Agencies has been amended, increasing the permissible group size of a group therapy session from 8 to 12 people.

(23) **Section 17b-262-822(a)(3)**

Comment: One Commentator requested clarification regarding the circumstances under which a second psychiatric diagnostic interview examination is permitted. The Commentator also questioned whether there is any discretion on the part of the provider when other circumstances may arise that would necessitate a second psychiatric diagnostic interview.

Response: Section 17b-262-822(a)(3)(A) and (B) of the Regulations of Connecticut State Agencies provides the circumstances under which more than one psychiatric diagnostic interview examination may be provided in a single episode of care.

(24) **Section 17b-262-822(a)(3)(B)**

Comment: One Commentator asked whether a clinic can bill for the second psychiatric diagnostic interview examination described in subdivision (a)(3)(B) of section 17b-262-822 with CPT code 90801.

Response: Yes.

(25) **Section 17b-262-822(a)(4)**

(a) Comment: A Commentator requested clarification regarding whether the limitation provided in section 17b-262-822(a)(4) should be interpreted to mean that clients that are not seen in 120 days shall be discharged. The Commentator also questioned whether reimbursement for services will cease after the 120 days.

Response: Discharge is not required after 120 days has elapsed. If 120 days have elapsed since the last contact with the client, and services are deemed medically necessary, the clinic may bill "90801".

(b) Comment: A Commentator asked if Medicaid will pay for a second evaluation if the client presents after 120 days.

Response: Reimbursement for a second evaluation may be available if the evaluation is medically necessary and meets the criteria specified in sections 17b-262-822(a)(3) or (4) of the Regulations of Connecticut State Agencies.

(c) Comment: One Commentator asked if a "complete intake" is necessary if a client presents to the clinic after 120 days has elapsed and the necessary information has already been gathered and is not likely to have changed.

Response: A re-evaluation is not required, but it is permitted if medically necessary. If a provider bills for an evaluation after 120 days, the evaluation must be medically necessary and meet the requirements of sections 17b-262-824(c)(1) to (7), inclusive of the Regulations of Connecticut State Agencies.

(d) Comment: The same Commentator asked, if another "complete intake" is not required after 120 days have elapsed, if a "clinical update" can be performed in lieu of a "complete intake." In addition, the Commentator asked what the minimum requirements are for a "clinical update".

Response: No, a "clinical update" performed in lieu of a full evaluation, cannot be billed as an evaluation unless it meets all the requirements of sections 17b-262-824(c)(1) to (7), inclusive, of the Regulations of Connecticut State Agencies.

(e) Comment: One Commentator asked if the clinic closes a case at 90 days and the client presents at the clinic again, whether a subsequent evaluation can be reimbursed.

Response: If a client has been discharged a new evaluation may be billed so long as the evaluation is medically necessary and meets the requirements of sections 17b-262-824(c)(1)-(7), inclusive, of the Regulations of Connecticut State Agencies.

(26) Section 17b-262-822(a)(5) (See, Attachment A, Section 17b-262-824(b))

(a) Comment: A Commentator asked why a CADC and BA level individuals are not permitted under the proposed regulation to perform “psychiatric diagnostic evaluation examinations” with a supervisor or AHP signoff, while “individuals in training” are permitted to do so.

Response: AHPs and individuals in training to become an AHP are only permitted to perform psychiatric diagnostic evaluation examinations to the extent permitted within the scope of practice of the applicable DPH licensure or certification category. The Department recommends that providers consult with DPH if they have specific questions regarding the scope of practice of any given DPH licensure or certification category. BA level individuals are not in training and thus do not have the experience, education and supervision necessary to prepare them for licensure and certification under one of the AHP categories recognized under this rule. Thus these individuals are not permitted to perform psychiatric diagnostic evaluation examinations.

(b) Comment: The same Commentator suggests that section 17b-262-822(a)(5) of the Regulations of Connecticut State Agencies appears to be at odds with section 17b-262-824(c) which references an “evaluation team.”

Response: The Department has amended the regulation and removed subsection 17b-262-824(c) and the reference to “evaluation team”.

(27) Section 17b-262-822(a)(6) (See, Attachment A, Section 17b-262-822(a)(5))

(a) Comment: The Commentator suggested that General Assistance Behavioral Health Partnership (“GABHP”) allows 12 participants in a group and Medicare allows 10 in a group so is 8 participants in group psychotherapy a Medicaid requirement?

Response: In response to this comment the Department amended section 17b-262-822(a)(6) of the Regulations of Connecticut State Agencies and increased the limit on the size of group psychotherapy from 8 to 12 participants.

(b) Comment: The same Commentator asked if the same group size requirement applies in IOP and PHP settings.

Response: Yes, except as provided in section 17b-262-822(d)(8) of the Regulations of Connecticut State Agencies.

(28) Section 17b-262-822(a)(7) (See, Attachment A, Section 17b-262-822(6)).

Comment: A Commentator suggested that limiting multiple-family groups to 12 participants is unrealistic based on the large sizes of many of the families served, including blended families and extended families.

Response: The Department agrees and has increased the maximum group size for multiple-family groups from 12 to 24 including the client and family members.

(29) Section 17b-262-822(b)(1) (See, Attachment A, Section 17b-262-822(b)(2))

(a) Comment: One Commentator points out that the provision of methadone services off-site is allowed by Medicare and DPH does not regulate the service location. The Commentator requests the Department's policy be changed to be consistent with the policy followed by Medicare and DPH.

Response: Federal conditions for reimbursement of clinic services require that services are provided at the clinic. The only exception is for an individual that "does not reside in a permanent dwelling or does not have a fixed home or mailing address." 42 C.F.R. §440.90. To receive payment for Medicaid services the service must be provided in accordance with Medicaid rules.

(b) Comment: A Commentator suggested that there are times when, for medical reasons, a client may be prohibited from coming to the clinic for daily medication. In these instances the clinic may send a counselor or a nurse to an individual's home to deliver the medication. The Commentator suggests that clinics should be able to bill for the services provided by the counselors and nurses under these circumstances. The following language was suggested:

"Payment for methadone maintenance provided on a weekly basis for all services included in the signed agreement between the Department of Social Services and the licensed treatment provider."

Response: Chemical maintenance (methadone maintenance) is a clinic based services that is billed on a weekly basis. Payment for chemical maintenance includes the services specified in section 17b-262-822(b)(3) of the Regulations of Connecticut State Agencies. In addition, the regulations require the client present on-site at the clinic a minimum of one time per week in order for payment to be made to the clinic. Home delivery of medication or services is not included in the weekly rate. If the client does not present at the clinic as required, chemical maintenance shall not be reimbursed.

(30) Section 17b-262-822(c)(2) (See, Attachment A, Section 17b-262-822(c)(3))

Comment: More than one Commentator suggested that a maximum limit of 21 days of ambulatory chemical detoxification services is too short a period of time to successfully transition an addict to methadone and successfully discharge the individual and avoid relapse. The Commentators both noted that the Department of Mental Health and Addiction Services ("DMHAS") has funded ambulatory chemical detoxification for more than 30 days. In addition, the Federal Guidelines for Treatment Improvement Protocols distinguishes between short-term services of less than 30 days, and long-term services of 30-180 days. One Commentator suggested that 60 days would be a more acceptable limit.

Response: In response to the Commentators' concerns the Department has amended the regulation to allow a maximum of 90 days of services.

(31) Section 17b-262-822(d)(2)

Comment: One Commentator suggested that the phrase "time-limited substance abuse treatment" be deleted from this provision because methadone treatment is not a time-limited treatment model.

Response: Subsection (d) of section 17b-262-822 does not apply to methadone treatment. This provision applies to day and evening treatment services, intensive outpatient treatment ("IOP") and partial hospitalization programs ("PHP").

(32) Section 17b-262-822(d)(3)

Comment: A Commentator suggested that treatment approaches employed by clinic programs be permitted to be broader than "evidence-based treatment approaches." Another Commentator requested clarification of the circumstances under which the Department would deem an intervention, approved by the clinic's Medical Director, to be insufficient or out of compliance with the standard articulated in section 17b-262-822(d)(3) of the Regulations of Connecticut State Agencies.

Response: The Department has removed the term "evidence-based" from the regulation in response to the Commentators' concerns.

(33) Section 17b-262-822(d)(4) (See, Attachment A, Section 17b-262-822(d)(3)).

Comment: One Commentator suggested that the phrase "significant functional impairment" or "significant" as used to describe the individuals that clinic programs shall be designed to serve is vague and requires further clarification.

Response: The Department agrees and in response amended the term "significant" to "serious." "Serious" is the terminology that is used in the DSM IV.

(34) **Section 17b-262-822(d)(5)** (*See, Attachment A, Section 17b-262-822(d)(4)*)

Comment: One Commentator requested clarification regarding: (1) the purpose of an adult escort; (2) the settings in which escorts are necessary; (3) whether the provision applies to transportation services; (4) if Medicaid will reimburse for escorts; and, if so, (5) the appropriate billing code.

Response: In response to the Commentator's questions the Department has amended the regulation to clarify this provision. The Department's intent is to require the behavioral health clinic to provide an adult escort, to and from the intermediate care program, if that client is between the ages of 12 and 16 and is transported by a Medicaid non-emergency medical transportation provider. This requirement is made in response to situations where safety of the driver or the client, or both, has been an issue. A client between 12 and 16 years of age may be transported without an adult escort if the provider has obtained written parental consent to do so. There is no procedure code or separate reimbursement for the provision of an escort.

(35) **Section 17b-262-822(d)(8)** (*See, Attachment A, Section 17b-262-822(d)(7)*).

(a) Comment: A Commentator asked if a provider of IOP or EDT offers additional hours of service during the treatment day, in excess of the three to four hours of programming required in subsection (d)(8), whether the provider will be paid the same rate as they would be paid for the three to four hours of programming.

Response: A per diem rate is paid for the services provided during an intermediate care program treatment day. The per diem rate is inclusive of all services provided on that date of service. The purpose of this provision is to set the minimum amount of time that shall be devoted to direct service provision in order for a provider to bill for services provided. The Department has amended the regulation to clarify the minimum requirement of 3 hours of scheduled, documented programming are required to receive the per diem rate.

(b) Comment: One Commentator asked if the range of "between three and four hours" provided in the proposed regulation was included to allow for the current practice of some IOP and EDT programs.

Response: See, Response 35(a) above.

(d) Comment: One Commentator requested an explanation regarding the reason why the regulation limits payment for partial hospitalization services to only partial hospitalization services provided in a Community Mental Health Center ("CMHC"). The Commentator suggested the following language:

The department shall pay for partial hospitalization services only when provided in a [CMHC] licensed Behavioral Health Clinic.

Response: Sections 1861(ff)(1) and 1861(ff)(3) of the Social Security Act, provide that partial hospitalization program services are payable only when "furnished by a hospital to its outpatients or by community mental health center." The suggested language is not consistent with the federal requirements.

(e) Comment: What reimbursement rate is provided under the proposed regulations for partial hospitalization services provided to individuals with addictions?

Response: Please refer to www.ctdssmap.com and www.ctbhp.com for the applicable reimbursement rates.

(36) **Section 17b-262-823(a)** (*See, Attachment A, Section 17b-262-823(1)*).

Comment: A Commentator suggested that the Behavioral Health Partnership allows provision of case management services over the phone and wants this reconciled with the limitation in subsection (a) of the regulation.

Response: This regulation addresses payment for behavioral health clinic services. These are services covered under the CT Medicaid State Plan as "clinic option services". It does not address those rehabilitative services which are provided by a clinic but which are covered as "rehab option services". Information or services provided to a client over the telephone are not covered as clinic option services. Case management services, which are not clinic option services, must comport with the Medicaid State Plan which only permits payment for case management services when provided to children under the age of 19. (*See, Attachment B, Medicaid State Plan*).

(37) **Section 17b-262-823(d)** (*See, Attachment A, Section 17b-262-823(4)*).

(a) Comment: The Commentator requested clarification of the use of the term "unproven" and recommended the following language:

any procedures or services of [an unproven, educational, social, research] a solely recreational or experimental nature, not approved by the supervising physician.

Response: The Department has modified section 17b-262-823(d) and eliminated the use of the term "unproven."

(b) Comment: One Commentator questioned whether the Department will pay for educational components of services for individuals with co-occurring disorders?

Response: Education is not a covered service under Connecticut Medicaid. Psycho-educational groups are considered rehabilitation and are permitted in intermediate care programs.

(38) **Section 17b-262-823(h)** (See, Attachment A, Section 17b-262-823(7)).

(a) Comment: A Commentator suggested that it is inappropriate for the proposed regulation to reference the Child Rehabilitation regulations, sections 17b-262-804 to 17b-262-816 of the Regulations of Connecticut State Agencies, because these regulations have not yet been made available to the public and have not been approved by the Legislative Regulation Review Committee.

Response: The proposed Child Rehabilitation regulation was made available to the public following the publication of the notice of intent on November 4, 2008. The Department will provide a copy of the Child Rehabilitation regulation to any member of the public upon request. It is anticipated that the Child Rehab Option regulations will be submitted to the LRRC and adopted before the Behavioral Health Clinic Regulations. However, if the Child Rehab Option regulations are not adopted by the time the Behavioral Health Clinic regulation is sent to the Attorney General's Office ("AGO"), the Department shall revise the regulation accordingly. The AGO will not approve a regulation as legally sufficient if it contains a citation to a regulation that has not been fully promulgated.

(b) Comment: The same Commentator suggests that subsection (h) which states, "Off-site services are services that are provided at a location other than the clinic or a satellite of the clinic" creates confusion between the definitions of "off-site" and "satellite clinic" and requests clarification regarding which services can be reimbursed under the Behavioral Health Clinic regulations.

Response: See. Response 14.

(d) Comment: The Commentator asked for clarification regarding which services are covered by the Child Rehabilitation regulation and which are covered by the Behavioral Health Clinic regulations?

Response: Services payable under the Behavioral Health Clinic Regulation are listed in section 17b-262-821 of the Regulations of Connecticut State Agencies and services covered under the Child Rehabilitation regulation are listed in proposed section 17b-262-854 of the Regulations of Connecticut State Agencies.

(e) Comment: The Commentator asked for confirmation of the regulations that cover Emergency Mobile Psychiatric Services ("EMPS") and Intensive In-home Child & Adolescent Psychiatric Services ("IICAPS")?

Response: EMPS is payable under the Child Rehabilitation regulation, section 17b-262-854 of the Regulations of Connecticut State Agencies. IICAPS are not reimbursed as clinic services. Although they are listed on the Behavioral Health Clinic fee schedule the expenditures are claimed under the Rehabilitation Option.

(39) Section 17b-262-824(a)

(a) Comment: The Commentator requested a definition for the term "periodically" as used when referring to the frequency of reviews for the need of continuing care.

Response: "Periodically" means no less than what is required by the applicable licensure requirements for the facility type.

(b) Comment: The Commentator requested clarification regarding at what point, during the authorization of care and periodic review of the need for continuing care, physicians are required to document records or sign records?

Response: The physician is required to sign the initial plan of care, at the time of each periodic review and when the plan of care is updated and there is a change in service. (See, Attachment, Section 17b-262-828(a)(3)). The physician's signature serves as attestation of agreement and physician direction.

(b) Comment: The Commentator requested clarification regarding which records must be signed by a physician.

Response: In addition to the requirements outlined in section 17b-262-828(a)(3) of the Regulations of Connecticut State Agencies, a physician shall sign an evaluation if treatment is not recommended and a plan of care is not developed, or a written note when a psychiatric office consultation is provided by an APRN.

(40) Section 17b-262-824(b) (See, Attachment A, Section 17b-262-824(c))

(a) Comment 1: One Commentator suggested adding a definition for "evaluation" under the definition section.

Response: *The Manual for Drafting Regulations* provides that definitions that merely repeat the dictionary meaning of a word or term are inappropriate. A definition for "evaluation" will not be added to section 17b-262-818 of the Regulations of Connecticut State Agencies.

(b) Comment: One Commentator recommended that the language of subsection (b) be modified as follows:

An evaluation [shall be part of the plan of the] should inform the plan of care and shall be completed for each client . . .

Response: The Department agrees and has amended the regulation as suggested.

(c) Comment: A Commentator asked if the evaluation is a separate document from the plan of care, is the physician's signature required on the evaluation or on the plan of care or on both documents.

Response: If treatment is recommended the physician is required to sign the plan of care. If treatment is not recommended the physician is required to sign the evaluation. (See, Attachment, Section 17b-262-824 (e) and (f)).

(d) Comment: A Commentator recommended modifying the components of the evaluation set forth in section 17b-262-824(c)(1) to (7) of the Regulations of Connecticut State Agencies to make it clear that not all components may be necessary.

Response: The Department has amended the regulation to clarify the components that are required to be included in the evaluation.

(e) Comment: The same Commentator recommended moving "medication evaluation" from subdivision (4) and "orders" from subdivision (5) to section 17b-262-818(29), the definition of "plan of care."

Response: The Department has amended the regulation and removed the terms "medication evaluation" and "orders" from subdivisions (4) and (5).

(41) **Section 17b-262-824(c)** (See, Attachment, Section 17b-262-824 (b))

(a) Comment: Several Commentators recommended modifying section 17b-262-824(c) to clarify who may conduct an evaluation and who is required to be part of the "evaluation team."

Response: The Department agrees that this provision creates confusion. In response to the comments received, the Department modified the regulation to clarify who may conduct an evaluation and eliminated former subsection (c).

(b) Comment: A Commentator states that 30 days is the current standard for reviewing a plan of care and recommends that "30 days" replace the "within two weeks" requirement.

Response: The Department has amended the regulation and changed the requirement to 30 days as requested (See, Attachment, Section 17b-262-828(a)(3)).

(c) Comment: The Commentator asked, if an AHP conducts the evaluation and no treatment is recommended, does the physician still have to sign something to evidence oversight, as there would be no plan of care.

Response: If treatment is not recommended, the physician must sign the evaluation, consistent with section 17b-262-824(f) of the Regulations of Connecticut State Agencies.

(42) **Sec. 17b-262-824 (d)**

Comment: The Commentator recommended clarification that "plan" means "plan of care."

Response: The Department has amended the regulation and changed "plan" to "plan of care" to provide clarity.

(43) **Sec. 17b-262-824 (e) (See, Attachment , Section 17b-262-824(h))**

(a) Comment: One Commentator asked for a definition of the term "consultation" as it is used in section 17b-262-824(e) of the Regulations of Connecticut State Agencies.

Response: The term "consultation" has the same meaning as provided in the CPT Manual. "Consultation" means a service provided at the request of another practitioner and includes a written report to the requesting provider. The requesting practitioner retains ongoing responsibility for management of the client's care.

(b) Comment: A Commentator requested the Department distinguish between a "psychiatric evaluation", which can be provided by an AHP, versus a "psychiatric office consultation", which is more restrictive and who can provide it.

Response: The Department has amended the regulation to provide clarification (See, Attachment, Section 17b-262-824 (b) and (h)).

(c) Comment: The Commentator requested clarification regarding whether to use an evaluation and management code ("E&M"), CPT code 90801, or another CPT code to bill for an office consultation.

Response: Office consultations are billable by Enhanced Care Clinics ("ECC") and the applicable codes are on the ECC fee schedule.

(d) Comment: The Commentator requested clarification as to why a physician signature is required as a co-signer for an APRN when the only documentation requirement is a written note, not a plan of care.

Response: 42 CFR §440.90 which addresses physician direction, requires physician oversight for every service.

(e) Comment: The Commentator asked whether an “office consultation” is designed to provide consultation to Primary Care Physicians or a medical clinic?

Response: Office consultations are billable only by an ECC and may be provided to any individual referred to the clinic by a medical provider.

(f) Comment: The Commentator asked whether “full medical records” are required.

Response: Full medical records are not required; however, there are requirements for medical records as they pertain to consultations as in the CPT manual.

(g) Comment: The Commentator requested clarification regarding whether consultations are a single session or ongoing for the purpose of providing medication and or PCP consultations?

Response: If a consulting provider continues to treat a client, after the initial consultation, the provider is no longer acting as a consultant, but instead assumes ongoing care of the client. Consultations may not be ongoing.

(44) Sec. 17b-262-824 (g) (See, Attachment, Section 17b-262-824(j)).

Comment: The Commentator recommended using the term “plan of care” instead of “treatment planning.”

Response: The Department has amended the regulation and changed the language as suggested:

(45) Sec. 17b-262-827 (a)

Comment: The Commentator requested for clarification of the services identified under the umbrella of clinic services which have Provider Specific Rates (“PSR”) rates. What is the significance of 17b-262-827(a) to PSR?

Response: All providers; in-state, border and out-of-state providers, are treated the same for fee schedule and rate purposes.

(46) Sec. 17b-262-827(b)

(a) Comment: The Commentator asked if there are new codes for billing half a fee for a PHP, IOP, or EDT day or is it documented only by time spent.

Response: There are no new codes. The provider is expected to bill half of the applicable Medicaid fee on file.

(b) Comment: The Commentator recommended using the term "behavioral health service" instead of the term "therapy session."

Response: The Department's expectation is that a client shall attend at least one "therapy session" in order for the provider to bill for a half day of an intermediate care program. The language of this subsection will remain unchanged.

(47) **Sec. 17b-262-827(c)**

(a) Comment: The Commentator asked why section 17b-262-827(c) allows for the provision of medically necessary individual psychotherapy services, but not family psychotherapy, substance abuse counseling or other services.

Response: The Department has amended the regulation to allow medically necessary family psychotherapy as well as individual psychotherapy. Substance abuse counseling is typically billed as individual psychotherapy services.

(b) Comment: The Commentator asked, if individual treatment is provided outside the program's hours, does this mean that individual therapy is considered to be unbundled from Extended Day Treatment ("EDT")?

Response: In response to public comment, EDT has been removed from the Behavioral Health Clinic regulation and included under the Child Rehab Regulation.

(48) **Sec. 17b-262-827(d)** (*See, Attachment, Section 17b-262-827(c)*)

(a) Comment: A Commentator questioned whether the payment limitation on individual and family psychotherapy provided in this subsection pertains only to outpatient clinics as it appears in subsection (c) that PHP, IOP, EDT can bill for additional services outside of the hours of program operation.

Response: The limit applies to the intermediate care programs (day or evening treatment services, IOP, PHP) provided by the behavioral health outpatient clinic.

(b) Comment: One Commentator noted that section 17b-262-822(a)(1) of the Regulations of Connecticut State Agencies may be in conflict with section 17b-262-827(d) of the Regulations of Connecticut State Agencies.

Response: Section 17b-262-822(a)(1) applies when the minimum requirements for each modality are met. The payment limitation in subsection (d) of section 17b-262-827

applies when different modalities are combined into one session and the minimum duration has not been met.

(49) Sec. 17b-262-828(a)(3)

Comment: A Commentator suggested that physicians not be required to sign off on plan updates.

Response: The Department has amended the requirement so that physician signature is not required on all updates, but is required for each periodic review and when the plan of care is updated with any change in type of service.

(50) Sec. 17b-262-828(a)(4)

(a) Comment: One Commentator states that currently only time and duration are required for documentation of a service. The requirement of providing a start and stop time, while a new requirement, serves to clarify the requirement and creates a clear standard.

Response: The Department is pleased that the requirement will assist by creating a clear standard for Behavioral Health Clinics.

(b) Comment: A Commentator asked if a clinic operates at only one site does the location need to be included in each documentation entry.

Response: The auditors will not know when reviewing records if a clinic operates one site, or more than one site. If a clinic operates only one site, the provider may indicate that the clinic has "only one site" instead of indicating the location of the site.

(51) Sec. 17b-262-828(c)

(a) Comment: A Commentator suggested that language be inserted that explicitly states that an "individualized plan of care [shall be] developed no later than 30 calendar days after admission."

Response: To ensure compliance with the DPH requirements for individualized care plans, now and in the future, the cross-reference to section 19a-495-550 of the Regulations of Connecticut State Agencies shall remain in the text of the proposed regulation.

(52) Sec. 17b-262-828(e)

(a) Comment: A Commentator states that this new requirement will add to the cost of providing services and recommended one integrated note for the day that document "*the duration of each distinct therapeutic session or activity & progress towards treatment goals.*"

Response: The Department has amended the regulation to include the language requested.

(b) Comment: The Commentator asked whether the documentation of duration includes break time.

Response: No.

(c) Comment: One Commentator suggested that unbundling services will not adequately capture the various interventions, including crisis management, behavioral interventions which may occur impromptu and outside a specific group. If those interventions occur and detract from the sum of the group time(s) required, what form of documentation will suffice to demonstrate the duration of all services was consistent with time stipulations for this level of care?

Response: The requirements include that the note documents each distinct therapy session provided during a program day in order to ensure that sufficient therapy is provided to meet the minimum requirements for an intermediate care program. A note is not needed for crisis management or impromptu interventions that occur outside of a group.

(d) Comment: The Commentator requested clarification whether the requirement for a separate note is met by one collective note for the day which contains the elements identified in section 17b-262-828(e).

Response: An integrated note would meet the documentation requirements if it includes duration and progress.

(53) Sec. 17b-262-828(g)

(a) Comment: A Commentator requested a definition for the term "individual in training."

Response 1: The definition of an "individual in training" may vary for different licensure categories. The Department recommends that the clinic contact the Department of Public Health for clarification.

(b) Comment: The same Commentator requested a definition of the term "monthly notes."

Response: The Department has amended the regulation and the term "monthly notes" has been removed.

(c) Comment: A Commentator recommended the following language be inserted: "*The supervisor's signature attests to having reviewed the documentation of the paraprofessional.*"

Response: In response, the Department has amended the regulation as requested.

(d) Comment: One Commentator states that JCAHO and CARF do not require supervisor sign-off on every document and recommends that a supervisor signature be required on treatment plans, but not client records or progress notes.

Response: The Department believes that when the treating practitioner is an individual in training a supervisor must sign-off on all documents to ensure quality. This sign-off is important not only for client safety and well-being, but also as an integral part of the mentoring/educational program.

(54) **Sec. 17b-262-828(h)**

Comment: One Commentator suggested the use of the term "order" be revisited and the following alternate language be used: "*shall include a list of medications the client is taking, both psychiatric and non-psychiatric, including dosage and schedule.*"

Response: The Department has amended the regulation and included language consistent with the request.

(55) **Sec. 17b-262-828(j)**

Comment: The Commentator suggested the addition of the following language: "*The extrapolation methodology utilized by the Department shall be statistically sound.*"

Response: The Department is drafting a stand-alone regulation for audit purposes. Provisions detailing the audit process and methodologies will be more appropriately covered in that regulation.

Enclosure

Cc: Mark Schaefer
Karen Andersson
Lois Berkowitz
Robert Plant
Jim McPherson
Barbara Fletcher
Nina Holmes
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Bill Halsey
File

R-39 REV. 04/04
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STATE OF CONNECTICUT
REGULATION
OF

Name of Agency

Department of Social Services

Subject Matter of Regulation

Payment of Behavioral Health Clinic Services¹

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 (21) of this section;
- (2) "Ambulatory chemical detoxification services" means "ambulatory chemical detoxification" as defined 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;

¹ Sent out with RTC 9/27/11.

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ATTACHMENT A

- (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 individual in training for or obtaining the supervisory hours for one of the professional or occupational categories referred to in subsection (1)(B) of this section; or
 - (D) an unlicensed or non-certified individual 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) "Chemical maintenance treatment" means "chemical maintenance treatment" as defined in section 19a-495-570 of the Regulations of Connecticut State Agencies;
- (7) "Client" means a person eligible for goods or services under Medicaid;
- (8) "Commissioner" means the Commissioner of Social Services or his or her designee;
- (9) "Community Mental Health Center" or "CMHC" means "community mental health center" as defined in section 1861(ff)(3)(B) of the Social Security Act;
- (10) "Day treatment facility" means "day treatment facility" as defined in section 19a-495-550 of the Regulations of Connecticut State Agencies;

- (11) "Day or evening treatment service" means "day or evening treatment" as defined in section 19a-495-570 of the Regulations of Connecticut State Agencies;
- (12) "Day treatment program" means a day treatment facility, or day or evening treatment service that provides services between four and twelve hours per day;
- (13) "Department" means the Department of Social Services or its agent;
- (14) "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;
- (15) "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;
- (16) "Fee" means the department's payment for services established by the commissioner and contained in the department's fee schedules;
- (17) "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;
- (18) "Group psychotherapy" means a type of behavioral health care in which clients meet with one or more allied health professionals at the same time for the purpose of discussing their mental or substance use disorders, the impact of these disorders upon the clients and the barriers that must be overcome in order to progress in their recovery;
- (19) "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;
- (20) "Intermediate care program" means a day or evening treatment service, IOP or Partial Hospitalization Program;
- (21) "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;
- (22) "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;
- (23) "Medical necessity" or "medically necessary" means medical necessity as defined in section 17b-259b of the Connecticut General Statutes;

- (24) "Off-site services" means services that are provided at a location other than the clinic or a satellite of the clinic;
- (25) "Outpatient Psychiatric Clinic for Children" or "OPCC" means "outpatient psychiatric clinic for children" as defined in section 17a-20-11 of the Regulations of Connecticut State Agencies;
- (26) "Outpatient treatment service for substance abuse" means "outpatient treatment" as defined in section 19a-495-570 of the Regulations of Connecticut State Agencies;
- (27) "Partial Hospitalization Program" or "PHP" means "partial hospitalization service" as defined in section 1861(ff)(1) of the Social Security Act;
- (28) "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;
- (29) "Plan of care" means a written individualized plan that contains the diagnosis, 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;
- (30) "Prior authorization" means approval of payment for a service from the department before the provider actually provides the service;
- (31) "Provider" means a behavioral health clinic enrolled in Medicaid;
- (32) "Provider agreement" means the signed, written contractual agreement between the department and the provider;
- (33) "Psychiatric outpatient clinic for adults" means "psychiatric outpatient clinic" as defined in section 19a-495-550 of the Regulations of Connecticut State Agencies;
- (34) "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;
- (35) "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;
- (36) "Satellite site" means "satellite site" as defined in section 17a-20-11 of the Regulations of Connecticut State Agencies;

- (37) "Under the direct supervision" means that a physician or licensed individual, as established in (1)(A) of this section, provides periodic supervision of the work performed by unlicensed clinical staff, certified or non-certified staff and individuals in training, and accepts primary responsibility for the behavioral health services performed by the unlicensed, certified or non-certified staff and individuals in training; and
- (38) "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 enroll in Medicaid and 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.
- (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.
- (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.
- (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 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

The department shall pay providers:

- (a) Only for those procedures listed in the department's fee schedule for the behavioral health clinic that are 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 or for EPSDT special services;
- (b) for services that are medically necessary to treat the client's condition; and
- (c) for services furnished in the clinic or a satellite site of the clinic.

(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 at least 45 minutes in length, except in an intermediate care program where family and group psychotherapy sessions shall be at least 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 subsection (d)(8) of this section.
- (6) 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.
- (7) 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 is available only for services provided at the clinic.
 - (3) Payment for chemical maintenance shall be a weekly rate that includes, but is not limited to: an intake evaluation; a physical examination; all medication; medication management; laboratory services 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 during the week for which payment is received. Payment shall not be made for weeks when none of these face-to-face services are provided even though a client may still be registered with the program and has received take-home medication for that week.
- (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 are 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 are 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 are documented behavioral health clinic services;
- (7) a treatment day at an IOP shall include a minimum of three hours of scheduled, documented programming of which two and one half hours are behavioral health clinic services;
- (8) psychotherapy and psycho-education group size in intermediate care programs is limited to 12 participants except that psycho-education group size for substance abuse related conditions is limited to 24 participants and may comprise no more than one and one-half hours of an intermediate care program; and
- (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 requiring authorization or registration for which the provider did not obtain such authorization or registration; or
- (7) 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, 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 only by an individual specified in section 17b-262-818(5)(A), (B) or (C) of the Regulations of Connecticut State Agencies.
- (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, the physician or AHP shall develop the plan of care.
- (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 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 is 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 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.
- (b) Services that require authorization or registration may 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 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 defined 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 a qualifications review no less often than annually. 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 within 30 days including 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, a non-certified individual or an individual in training, treatment notes entered pursuant to subsection (b) of this section shall be co-signed by the supervisor 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: 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

CASE MANAGEMENT SERVICES

A. Target Group:

Children with a behavioral health disorder under 19 years of age.

For case management services provided to individuals in medical institutions:

- Target group includes individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

B. Areas of state in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

C. Comparability of Services:

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount duration and scope.

D. Definition of Services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

- Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation;
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Development of a specific care plan that:

TN No. 08-002
Supersedes
TN No. _____

Approval Date 3/5/2009

Effective Date 7/1/08

HCPA ID: 1040P/0016P

ATTACHMENT B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

CASE MANAGEMENT SERVICES

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision-maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities:
 - To help an eligible individual obtain needed services including activities that help link an individual with
 - Medical, social, educational providers or
 - Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- Monitoring and follow-up activities:
 - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Case management may include:

- Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community: Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

CASE MANAGEMENT SERVICES

E. Qualification of Providers:

Qualified providers include:

1. Direct service staff within licensed outpatient psychiatric clinics for children (not including Federally Qualified Health Centers or general hospital outpatient clinics). Within such clinics, the state permits any of the following direct service staff to perform targeted case management:
 - a. a physician within the scope of practice as defined by Title 20 of the Connecticut General Statutes;
 - b. 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 General Statutes of Connecticut;
 - c. a license-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 General Statutes of Connecticut;
 - d. an individual in training for or obtaining the supervisory hours for one of the professional or occupational categories referred to in section 18b-262-x(2)(B) under the supervision of a physician or AHP; and
2. Direct service staff within community-based child rehabilitation programs. Within such clinics, the state permits any of the following individuals to perform targeted case management:
 - a. a physician within the scope of practice as defined by Title 20 of the Connecticut General Statutes;
 - b. 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 General Statutes of Connecticut;
 - c. a license-eligible individual whose education, training, skills and experience satisfy the criteria for any of the professional and occupational licensure or

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

CASE MANAGEMENT SERVICES

certification categories pertaining to behavioral health covered in Title 20 of the General Statutes of Connecticut;

- d. an individual in training for or obtaining the supervisory hours for one of the professional or occupational categories referred to in section 18b-262-x(2)(B) under the supervision of a physician or licensed/license eligible individual that meets the requirements of 2(a) or 2(b) above; and
 - e. a paraprofessional approved for the provision of community based child rehabilitation services under the supervision of a physician or licensed/license eligible individual that meets the requirements of 2(a) or 2(b) above.
3. Solo and group behavioral health practitioners enrolled in the Connecticut Medical Assistance Program. Practitioners include the following:
- a. Board eligible or board certified psychiatrist within the scope of practice as defined by Title 20 of the Connecticut General Statutes;
 - b. Psychologist licensed under Chapter 383, Section 20-186 through 195 of the Connecticut General Statutes;
 - c. Psychiatric nurse practitioners licensed pursuant to Chapter 379a of the Connecticut General Statutes (CGS), Section 20-87a through 20-102a;
 - d. Clinical social workers licensed under Chapter 383b, Section 20-195m through 195r of the Connecticut General Statutes;
 - e. Marital and family therapists licensed under Chapter 383b, Section 20-74c of the Connecticut General Statutes;
 - f. Professional counselors licensed under Chapter 376b, Section 20-74s through 74t of the Connecticut General Statutes; and
 - g. Alcohol and drug counselor services licensed under Chapter 383c, Section 20-195aa through 195cc of the Connecticut General Statutes.

F. Freedom of Choice Exception:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

CASE MANAGEMENT SERVICES

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Access to Services:

The State assures that:

1. Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
2. Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services;
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community, the State assures that:

1. The amount, duration, and scope of the case management activities would be documented in an individual's plan of care which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community.
2. Case management is only provided by and reimbursed to community case management providers.

H. Limitations:

Case Management does not include the following:

1. Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
2. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
3. Activities integral to the administration of foster care programs;
4. Activities for which third parties are liable to pay, except for the case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

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RODERICK L. BREMBY
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
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MEMORANDUM

To: Individuals Who Commented on the Proposed Regulation Regarding Payment of Behavioral Health Clinic Services, DSS Reg. No. 09-03

From: Roderick L. Bremby, Commissioner 
Department of Social Services
25 Sigourney St.
Hartford, CT 06106

Date: March 5, 2013

Re: Responses to Public Comment

The following are the Department of Social Services ("the Department") second set of responses to comments received from the public following the issuance of the first set of responses on September 20, 2011. The Notice of Intent for this regulation was published in Connecticut Law Journal on August 18, 2009. A copy of the regulation with revisions based on public comment is enclosed. The Department anticipates submitting the proposed regulation to the Legislative Regulation Review Committee by May 1, 2013.

1. Sec. 17b-262-818. (1) and (23) Definitions (formerly subsection (21))

Comment: A Commentator states that the proposed definitions of "AHP" and "license-eligible" hinder agencies following national best practices in hiring according to the principles of the "recovery model" of care promoted by DMHAS and SAMHSA. The Commentator explains that some agencies have hired many persons in recovery and persons who are bi-lingual and/or bi-cultural in order to enhance their cultural competency and recovery initiative, many of which are neither certified nor licensed. The Commentator notes that persons in recovery add an important dimension to service delivery, based on their deep understanding of the issues facing people in recovery.

Response: Clinics should follow their respective licensing regulation which addresses the provision of services by unlicensed and/or uncertified staff.

2. Sec. 17b-262-819(b). Provider Participation

Comment: One Commentator asked the Department to clarify the difference between a “periodic review” and an “update of the plan of care.”

Response: Clinics should follow their respective licensing regulation for specifics regarding plans of care and periodic review.

3. Sec. 17b-262-819(e)

Comment: Is inpatient detoxification included in this group of eligible programs?

Response: No, inpatient detoxification is not covered under this regulation.

4. Sec. 17b-262-822 (a) (2). Service Limitations

Comment: One Commentator requested confirmation regarding the length of time required for a family or group therapy session that is billable under this regulation.

Response: Under the proposed regulation, the length of time for a family or multi-family psychotherapy session shall be no less than 45 minutes (the CPT code for family/group therapy is not time based; but for Medicaid payment of these services the session shall be no less than 45 minutes), except for IOP where family and group therapy sessions shall not be less than 30 minutes.

Note: If the client is not present for the entire duration of the family therapy session, providers should bill using 90846 (family psychotherapy without the client present).

5. Sec. 17b-262-822 (a)(3)

Comment: A Commentator asked if, in order to meet medical necessity, initial diagnostic examinations (intakes) need to be signed by a physician on the same day that they are performed or before the next session (i.e. within 30 days of the intake).

Response: Initial diagnostic examinations shall be signed by a physician only if the physician personally performs the examination or if treatment is not recommended. The proposed regulation requires that the physician sign no more than 30 days after the diagnostic evaluation. If treatment is recommended, a plan of care shall be developed and the plan of care shall be signed by a physician no more than 30 days after the diagnostic evaluation.

6. Sec. 17b-262-822 (a)(4)

Comment: A Commentator asked if this section of the proposed regulation requires providers to close cases that have not received services in 120 days.

Response: The proposed regulation does not address the question of when a clinic must close a case. The proposed regulation defines an “episode of care.” The decision to close a case is one that is left to the clinic’s discretion.

Comment: The Commentator also asked if this section should be interpreted to mean that if there is a lapse of 120 days or more that a new assessment is required.

Response: Not necessarily. The decision regarding whether a new assessment is needed is at the discretion of the clinician. The proposed regulation merely provides that if there is an interruption of service lasting more than 120 days, clinics may bill for another intake if it is medically necessary.

7. Sec. 17b-262-822 (b)(2)

Comment: The Commentator states that the proposed language of this section creates an accessibility barrier to non-ambulatory patients on methadone who are in need of residential nursing home or medical rehabilitation services.

Response: Section 1905 of the Social Security Act requires that clinic services be provided at the clinic site for individuals who reside in a permanent dwelling or has a fixed home or mailing address. With regard to persons who reside in nursing homes, the nursing home is considered to be permanent dwelling for the period of time that an individual resides there.

8. Sec. 17b-262-822 (b)(3)

Comment: As proposed, this section would impose a significant financial burden on methadone maintenance providers by shifting the responsibility for laboratory services and medications other than methadone (for instance, prescription drugs for medical conditions) to methadone maintenance providers when these costs are not currently subsumed within the weekly rate paid to methadone maintenance providers. The weekly rate for chemical maintenance should not be designated as including “all medication” or “laboratory services.”

Response: The proposed language in this section has been modified to address this concern.

9. Sec. 17b-262-824 (d). Need for Service

Comment: A Commentator asked whether the language of this section means that non-licensed staff cannot develop plans of care.

Response: The plan of care is not required to be developed by a physician or AHP only. Clinics should follow their respective licensing regulation which indicates which practitioners are allowed to develop plans of care. The Department has changed the language in this section to read: “if treatment is recommended, a plan of care shall be developed.”

10. Sec. 17b-262-827(b). Payment

Comment: One Commentator asked how a FQHC can bill for half of an encounter since the FQHC rate-per-encounter is fixed.

Response: FQHCs do not have the ability to bill for half of an encounter.

11. Sec. 17b-262-828 (a)(3). Documentation and Audit Requirements

Comment: A Commentator asked, if the treatment plan and diagnostic evaluation are signed by a physician, do APRN evaluations and progress notes need to be signed off by a physician as well.

Response: No, APRN evaluations and progress notes do not need to be signed by a physician. The physician must demonstrate supervision of the case by signing off on initial plan of care and the subsequent periodic treatment plan reviews or when the plan of care is updated to reflect any change in the types of services.

12. Sec. 17b-262-828(g)

Comment: The Commentator states that the proposed requirement of this subsection will be a tremendous administrative burden for providers and asked whether the proposed requirement will be included in the final version of the proposed regulation.

Response: The Department has modified the regulation to address this concern.

Comment: The Commentator requested the definition of the term "treatment note" as used in section 17b-262-828(g).

Response: The term "treatment note" and "progress note" were being used interchangeably. For purposes of clarity and consistency the regulation has been revised and the term "treatment note" has been replaced with "progress note."

Comment: The Commentator asked if licensed staff signing the treatment notes of all unlicensed staff are required to sign each note or can notes be signed in the aggregate every 30 days.

Response: The regulation has been modified to provide guidance on this matter.

Comment: What is the required date of the signature? Can it be signed one week, one month or more after the note was made and the service rendered?

Response: The proposed regulation has been modified to provide guidance on this matter.

13. Miscellaneous Comments

Comment: One Commentator requested the Department provide the status of this regulation in the adoption process.

Response: The Attorney General's Office approved the proposed regulation as legally sufficient on February 20, 2013. The Department will file the proposed regulation with the Legislative Regulation Review Committee by May 1, 2013.

IMPORTANT: Read instructions on back of last page (Certification Page) before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations

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 be 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.

R-39 Rev. 03/2012
(Certification page—see Instructions on back)

CERTIFICATION

This certification statement must be completed in full, including items 3 and 4, if they are applicable.

- 1) I hereby certify that the above (check one) Regulations Emergency Regulations
- 2) are (check all that apply) adopted amended repealed by this agency pursuant to the following authority(ies): (complete all that apply)
- a. Connecticut General Statutes section(s) 17b-262.
- b. Public Act Number(s) _____
(Provide public act number(s) if the act has not yet been codified in the Connecticut General Statutes.)
- 3) And I further certify that notice of intent to adopt, amend or repeal said regulations was published in the **Connecticut Law Journal** on 8/18/09;
(Insert date of notice publication if publication was required by CGS Section 4-168.)
- 4) And that a public hearing regarding the proposed regulations was held on 10/15/09;
(Insert date(s) of public hearing(s) held pursuant to CGS Section 4-168(a)(7), if any, or pursuant to other applicable statute.)
- 5) And that said regulations are **EFFECTIVE** (check one, and complete as applicable)
- When filed with the Secretary of the State
- OR on (insert date) _____

DATE	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED Commissioner
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APPROVED by the Attorney General as to legal sufficiency in accordance with CGS Section 4-169, as amended

DATE	SIGNED (Attorney General or AG's designated representative)	OFFICIAL TITLE, DULY AUTHORIZED
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*Proposed regulations are **DEEMED APPROVED** by the Attorney General in accordance with CGS Section 4-169, as amended, if the attorney General fails to give notice to the agency of any legal insufficiency within thirty (30) days of the receipt of the proposed regulation.*

(For Regulation Review Committee Use ONLY)

- Approved Rejected without prejudice
- Approved with technical corrections Disapproved in part, (Indicate Section Numbers disapproved only)
- Deemed approved pursuant to CGS Section 4-170(c)

By the Legislative Regulation Review Committee in accordance with CGS Section 4-170, as amended	DATE	SIGNED (Administrator, Legislative Regulation Review Committee)
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Two certified copies received and filed and one such copy forwarded to the Commission on Official Legal Publications in accordance with CGS Section 4-172, as amended.

DATE	SIGNED (Secretary of the State)	BY
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(For Secretary of the State Use ONLY)

GENERAL INSTRUCTIONS

1. All regulations proposed for adoption, amendment or repeal, *except* emergency regulations, must be presented to the Attorney General for his/her determination of legal sufficiency. (See CGS Section 4-169.)
2. After approval by the Attorney General, the original and one electronic copy (in Word format) of all regulations proposed for adoption, amendment or repeal must be presented to the Legislative Regulation Review Committee for its action. (See CGS Sections 4-168 and 4-170 as amended by Public Act 11-150, Sections 18 and 19.)
3. Each proposed regulation section must include the appropriate regulation section number and a section heading. (See CGS Section 4-172.)
4. New language added to an existing regulation must be in underlining or CAPITAL LETTERS, as determined by the Regulation Review Committee. (See CGS 4-170(b).)
5. Existing language to be deleted must be enclosed in brackets []. (See CGS 4-170(b).)
6. A completely new regulation or a new section of an existing regulation must be preceded by the word "(NEW)" in capital letters. (See CGS Section 4-170(b).)
7. The proposed regulation must have a statement of its purpose following the final section of the regulation. (See CGS Section 4-170(b).)
8. The Certification Statement portion of the form must be completed, including all applicable information regarding *Connecticut Law Journal* notice publication date(s) and public hearing(s). (See more specific instructions below.)
9. Additional information regarding rules and procedures of the Legislative Regulation Review Committee can be found on the Committee's web site: <http://www.cga.ct.gov/rr/>.
10. A copy of the Legislative Commissioners' Regulations Drafting Manual is located on the LCO website at http://www.cga.ct.gov/lco/pdfs/Regulations_Drafting_Manual.pdf.

CERTIFICATION STATEMENT INSTRUCTIONS

(Numbers below correspond to the numbered sections of the statement)

1. Indicate whether the regulation is a regular or an emergency regulation adopted under the provisions of CGS Section 4-168(f).
2.
 - a) Indicate whether the regulations contains newly adopted sections, amendments to existing sections, and/or repeals existing sections. Check all cases that apply.
 - b) Indicate the specific legal authority that authorizes or requires adoption, amendment or repeal of the regulation. If the relevant public act has been codified in the most current biennial edition of the *Connecticut General Statutes*, indicate the relevant statute number(s) instead of the public act number. If the public act has not yet been codified, indicate the relevant public act number.
3. Except for emergency regulations adopted under CGS 4-168(f), and technical amendments to an existing regulation adopted under CGS 4-168(g), an agency must publish notice of its intent to adopt a regulation in the *Connecticut Law Journal*. Enter the date of notice publication.
4. CGS Section 4-168(a)(7) prescribes requirements for the holding of an agency public hearing regarding proposed regulations. Enter the date(s) of the hearing(s) held under that section, if any; also enter the date(s) of any hearing(s) the agency was required to hold under the provisions of any other law.
5. As applicable, enter the effective date of the regulation here, or indicate that it is effective upon filing with the Secretary of the State. Please note the information below.

Regulations are effective upon filing with the Secretary of the State or at a later specified date. See CGS Section 4-172(b) which provides that each regulation is effective upon filing, or, if a later date is required by statute or specified in the regulation, the later date is the effective date. An effective date may not precede the effective date of the public act requiring or permitting the regulation. Emergency regulations are effective immediately upon filing with the Secretary of the State, or at a stated date less than twenty days thereafter.