Connecticut interChange MMIS

Provider Manual

Chapter 7 - Clinic

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Connecticut Department of Social Services (DSS)
55 Farmington Avenue
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DXC Technology
55 Hartland Street
East Hartford, CT 06108

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Freestanding Clinic Services Regulation/Policy
Chapter 7

Medical Services Policy 7.1

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to freestanding clinic and outpatient alcohol treatment center services. The Medical Services Policy for dental clinic services is included in the Dental Services Manual.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process.

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160 Free Standing Alcohol Abuse Treatment Centers

Free standing alcohol centers provide treatment and care for individuals who are dependent upon alcohol including and following the diagnosis of dependence and treatment of other related medical or psychological presenting problems.

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.130

II. Connecticut General Statutes: Section 17b-262

B. Definitions

I. Acute Treatment and Evaluation Program

An acute treatment and evaluation program provides medical management of detoxification and assessment of the individual's total situation in an inpatient milieu for the purpose of formulating and implementing a plan of care in addition to detoxification.

II. Detoxification

Detoxification from alcohol is the physiological process which results in the systematic reduction or elimination of alcohol from the body.

C. Provider Participation

I. Program Eligibility

Free standing, acute and evaluation alcohol abuse treatment programs which qualify for Medicaid reimbursement must

a. Submit acceptable materials in written form which include the program's organization and staffing structure.

b. Hold a current and active license issued by the Department of Public Health to operate a facility for Alcohol Dependent Persons.

c. Specify and describe services which are provided at the facility.

Services must be predominately focused on the medical and/or psychological management of alcohol abuse and other medical or psychological conditions, which impact upon or are related to alcohol abuse. Treatment and care must be provided under the direction of a physician within the scope of accepted medical practice.

II. Staffing Patterns

a. There shall be an administrator who shall be responsible for the overall management of the entire program.

b. There shall be a medical director who is responsible for clinical services and medical programming. The medical director shall be a duly licensed physician in the jurisdiction where the facility is located. The physician's hours and function at the facility shall be documented.

c. There shall be at least one nurse on duty at all times.

d. There shall be at least one full time counselor on staff who is qualified by virtue of training and/or experience according to guidelines set by the Department of Mental Health and Addiction Services (DMHAS).

e. There shall be other staff as required to adequately treat and care for individuals as specified under licensure and protocol standards.

D. Eligibility

Alcohol abuse services are available to all Medicaid eligible individuals.

E. Services Covered and Limitations

I. Services Covered

Services provided at free standing alcohol abuse centers are specified in the Licensure Requirement of Facilities for Alcohol Dependent Persons and further defined in the Protocol developed and followed by DMHAS. All services shall be equally available to each individual served.

a. Mandatory Services

Mandatory services include the following services:

1. Physical examination, assessment and on-going medical treatment and care

(a) Medical services shall include, at a minimum, a physical examination and assessment which is completed within twenty-four (24) hours of the individual's admission into an acute and evaluation program unless the individual was seen, examined and orders written by a physician immediately prior to admission. The physical examination and assessment is included as part of the basis for the formulation and implementation of ongoing treatment and is part of a total plan of care. The associated clinical services may include as appropriate but are not limited to

(1) Physician Services

(2) Nursing Services

(3) Laboratory Services

(4) Chemotherapy

(5) Pharmaceutical Services

(b) Medical services not directly related to alcohol abuse.

The program shall arrange medical services which are not directly related to the provision of alcohol abuse treatment services.

(c) Agreement with hospital

The program shall have a formalized, written agreement with a licensed hospital or hospitals in the community for the purpose of providing emergency, inpatient, and ambulatory medical services when needed.

(d) The program shall include in-program emergency medical and psychiatric services.

(1) The program shall formulate and implement a written plan to provide emergency medical and psychiatric services.

(2) The program shall make provisions for access to effective transportation between the facility and licensed hospital(s) as required.

(3) First aid procedures and supplies shall be regularly checked for adequacy and attended to if necessary.

(4) Staff shall be available who are trained in first aid procedures at a level equal to or better than Red Cross standards, multi-media training for OSHA (Occupational Safety and Health Administration) business and industry requirements and also including specialized CPR (Cardio-Pulmonary Resuscitation) training.

2. Psychological testing and evaluation

Each program shall provide psychological testing and evaluation as required.

3. Group and individual counseling

Each program shall provide counseling services. Services shall be provided by staff who are qualified to provide counseling services by virtue of training and/or experience. The frequency and content of the counseling sessions shall be within the guidelines set by DMHAS.

4. The program shall offer a therapeutic environment which provides an alcohol-free controlled group living experience.

b. Other Services

Other services may be provided if a medical and/or psychological rationale can be provided. Service provisions shall be subject to the approval of the Department's medical director.

II. Limitations

a. Phase of Treatment

The provision of services under the Medicaid program in free standing facilities for alcohol dependent individuals shall be limited to the acute and evaluation phase of the treatment program.

b. Length of Treatment

Treatment authorization in acute and evaluation treatment programs shall be limited to a ten (10) day period for each occurrence.

F. Need for Service and Authorization Process

I. Need for Service

The need for treatment during the acute and evaluation phase shall be documented and ordered by a duly licensed physician.

II. Individual's need for service

A Medicaid eligible individual may be eligible for the acute and evaluation program providing

a. A documentable diagnosis of alcohol ingestion can be substantiated;

b. The individual requires medical observation, treatment and/or protection as a result of the effects of alcohol ingestion and/or other related medical or psychological conditions.

c. The individual is willing and able to participate in a plan of care prescribed by the treatment staff as well as any other requirement of the program.

III. Authorization Process

a. Prior Authorization

Prior authorization is not required for the acute and evaluation treatment program.

G. Other Requirements

(Reserved)

H. Billing Procedures

Providers shall submit completed claims for payment on the HCFA 1500 to:

HP
P.O. Box 2941
Hartford, Connecticut 06104

I. Payment Rates

The per diem rate for care provided in a free standing alcohol abuse treatment center is determined periodically by the Committee on State Payments. Each rate is based upon the application of the State of Connecticut cost-based reimbursement formula to the latest annual (or initial cost projection, new facilities only) cost report of the facility as submitted.

171 Clinics

For the purposes of this section, clinics are facilities not associated with a hospital. They provide medical or medically-related services for diagnosis, treatment and care of persons with chronic or acute conditions.

This section is divided into four (4) subsections comprising the major fields of medical and medically-related provider groups associated with clinic-based services. The descriptions,citations, and definitions in Sections 171A. and 171B. below apply to all of the clinic types described herein.

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.2a, 440.90, 440.130

II. Connecticut General Statutes: Section 17b-262

III. Regulations of Connecticut State Agencies: Sections 17-134d2(9), 17-134d-56

B. Definitions

I. Free Standing Clinic

"Free Standing Clinic" means a facility providing clinic and off-site medical services by or under the direction of a physician or dentist, in a facility that is not part of a hospital.

II. Medical or Medically-Related Services

"Medical or Medically-Related Services" means services which are required in the diagnosis, treatment, care, or prevention of some physical or emotional problem which affects the health of an individual.

III. Clinic Services

"Clinic Services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that

a. Are provided to outpatients;

b. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

c. Are furnished by or under the direction of a physician or dentist.

d. Are performed at the clinic, a satellite site, school, or community center.

IV. Off-Site Medical Services

"Off-Site Medical Services" means diagnostic, preventive, and rehabilitative services furnished by or under the direction of a physician or dentist employed by or under contract to a free-standing clinic to a Medicaid eligible recipient at a location other than the locations listed elsewhere in this subsection. Such off-site locations are the recipient's home, acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded. Off-site services (as may be restricted by location in accordance with each clinic subsection herein) include: Behavioral Health Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Audiological Services, Physician's Services, Respiratory Therapy Services, Primary Care Services, and Dental Services.

V. All-inclusive fee

"All-inclusive fee" means a fee which covers any and all services provided by the clinic for a particular visit or program. No additional payment will be made by the Department for services rendered during that visit.

VI. Outpatient

"Outpatient" means a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, which is not providing him with room and board and professional services on a continuous 24 hour-a-day basis.

VII. Patient

"Patient" means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

VIII. By or Under the Direction of a Physician or Dentist

"By or under the direction of a physician or dentist" means a free-standing clinic's services may be provided by the clinic's allied health professionals (as defined in Sections 171.1 through 171.4) whether or not a physician is physically present at the time that medical services are provided. The physician

a. must assume professional responsibility for the services provided;

b. must assure that the services are medically appropriate, i.e., the services are intended to meet a medical need, as opposed to needs which are clearly only social, recreational or educational;

c. need not be on the premises, but must be readily available in person, by phone or electronically.

IX. Plan of Care

"Plan of Care" means a written individualized plan. Such plan shall contain the diagnosis, type, amount, frequency, and duration of services to be provided and the specific goals and objectives developed and based on an evaluation and diagnosis for the maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level.

X. Satellite Site

"Satellite Site" means a location separate from the primary clinic facility at which clinic services are furnished by clinic professionals on an ongoing basis meaning with stated hours per day and days per week.

XI. Home

"Home" means the recipient's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

Payment of Behavioral Health Clinic Services

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.

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 the practitioner's 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 subdivision (23) of this section;

(2) "Ambulatory chemical detoxification services" has the same meaning as provided 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. "Authorization" includes, prior authorization, registration and retroactive authorization;

(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 in chapter 370 of the Connecticut General Statutes;

(B) an AHP acting within the practitioner's scope of practice, 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, 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" has the same meaning as provided 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" has the same meaning as provided in section 1861(ff)(3)(B) of the Social Security Act;

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

(11) "Day or evening treatment service" has the same meaning as provided 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) "Drug abuse testing" means the taking of physical samples or specimens and the qualitative screening of these samples or specimens for substances of abuse;

(15) "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;

(16) "Episode of care" means 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;

(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 for the purpose of the client's protection and safety. "Escort" does not include the driver of a public transportation vehicle;

(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 (A) 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 (B) who 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 provided 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 provided in section 17a-20-11 of the Regulations of Connecticut State Agencies;

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

(29) “Partial Hospitalization Program” or “PHP” has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act;

(30) “Physician” means an individual licensed or board-certified pursuant to chapter 370 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) “Psychiatric outpatient clinic for adults” has the same meaning as provided in section 19a-495-550 of the Regulations of Connecticut State Agencies;

(35) “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;

(36) “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;

(37) “Satellite site” has the same meaning as provided in section 17a-20-11 of the Regulations of Connecticut State Agencies;

(38) “Under the direct supervision” means that a physician or licensed AHP 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

(39) “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. “Usual and customary charge” does not include token fees and other exceptional charges.

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, as defined in 42 CFR §440.90, shall be furnished by or under the direction of a physician. 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 as provided in 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 as provided in 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 treatment service; a day or evening treatment program; or an outpatient treatment service for substance abuse as provided in section 19a-495-570 of the Regulations of Connecticut State Agencies.

(f) All providers, except those licensed solely as a chemical maintenance treatment 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.

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.

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:

(1) Within the clinic's scope of practice as described in sections 19a-495-550, 19a-495-570, 17a-20-11 or 17a-147-1 of the Regulations of Connecticut State Agencies;
(2) Medically necessary to treat the client's condition; and
(3) 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 and for EPSDT special services.

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 not 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) 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 provided in subdivision (8) of subsection (d) of this section.

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

(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 treatment

(1) Services shall be billed as chemical maintenance treatment 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 treatment.

(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 treatment 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) Clinic programs 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-educational group size in intermediate care programs shall be limited to 12 participants except that psycho-educational 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.

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 as children’s rehabilitation services, as described in 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.

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 allied health professional who is permitted to conduct such evaluations under the applicable clinic licensure category.

(c) The psychiatric diagnostic evaluation shall be used in formulating the plan of care and shall be completed for each client. The evaluation shall contain the following components:

(1) The client's 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) Current medications, if indicated, medication history, 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) 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 to 17a-20-43, inclusive 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 advanced practice registered nurse. 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 advanced practice registered nurse 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.

Sec. 17b-262-825. Authorization

(a) Behavioral health clinic services for clients with psychiatric and substance abuse disorders shall be subject to authorization requirements to the extent required by this section. Where a service is

subject to authorization requirements, Medicaid payment for such service shall not be available unless the provider complies with such requirements.

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

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

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

(2) In order to receive payment from the department, a provider shall comply with all authorization requirements. The department or its agent, in its sole discretion, determines what information is necessary in order to approve an authorization request. Authorization does not, however, guarantee payment unless all other requirements for payment are met;

(3) 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 including, but not limited to, medical or social information adequate for evaluating medical necessity;

(4) 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;

(5) The provider shall maintain documentation adequate to support requests for continued authorization including, but not limited to: Progress made to date with respect to established treatment goals; the future gains expected from additional treatment; and medical or social information adequate for evaluating medical necessity; and

(6) 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.

(d) The following requirements shall apply to all services that require prior authorization:

(1) If prior authorization is needed beyond the initial or current authorization period, requests for prior authorization for continued treatment shall be submitted prior to the end of the current authorization period; and

(2) Except in emergency situations or for the purpose of initial assessment, prior authorization shall be received before services are rendered.

(e) The following requirements shall apply to all services provided to a client whose eligibility is granted retroactively:

(1) A provider may request retroactive authorization, for services provided during the period of retroactive eligibility, from the department for a client who is granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service;

(2) For a client who is granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall be responsible for initiating this review to enable retroactive authorization and payment for services; and

(f) The department may deny prior authorization, registration or retroactive authorization based on non-compliance by the provider with the department's utilization management policies and procedures.

Sec. 17b-262-826. Billing Requirements

(a) Claims shall be submitted by the providers 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 set forth in section 17b-262-827(b) of the Regulations of Connecticut State Agencies.

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 provider 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 of psychotherapy 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 for 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 to the department.

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

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 applicable statutes or regulations and 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.

171.2 Rehabilitation Clinics

Covered in this section are independent comprehensive rehabilitation facilities; speech, hearing and language clinics affiliated with health centers; and other independent rehabilitation clinics providing diagnostic, therapeutic and restorative services to injured, ill or disabled individuals. (Refer to opening Section 171. for other applicable clinic services policy).

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.90, 440.110, 440.130

II. Connecticut General Statute: Sections 17b-262, 17b-243, 17b-244, 17b-245

III. Regulations of Connecticut State Agencies: Section 17-134d-56

B. Definitions

I. Rehabilitation

"Rehabilitation" means the process of restoring an individual to useful life, who has been ill or, who is handicapped and has a potential for improvement.

II. Rehabilitation Services

"Rehabilitation Services" means medical and remedial services provided to an outpatient, the purpose of which is the maximum reduction of physical or mental disabilities and restoration of eligible recipients to their best possible functional level. The services are performed under the direction of a licensed physician (M.D.).

III. "By or under the direction of a physician"

"By or under the direction of a physician" means a free-standing rehabilitation clinic's services may be provided by allied health professionals, including audiologists, speech pathologists, physical therapists, occupational therapists, and other medical staff whether or not a physician is physically present at the time that medical services are provided.

The physician

a. must assume professional responsibility for the services provided;

b. must assure that the services are medically appropriate, i.e., the services are intended to meet a medical or medically-related need, as opposed to needs which are clearly only social, recreational or educational;

c. need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

IV. Medical and Remedial Services

"Medical and Remedial Services" mean those services ordered by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law and required for the diagnosis and treatment of some physical, psychiatric or psychological problem which affects the health of an individual.

V. Functional Therapy

"Functional Therapy" means a short term therapeutic rehabilitation program of which the major component is the treatment of a medical and/or psychological condition of disabled or handicapped adolescents or adults who have been determined to have no vocational objective. The program is individually planned and coordinated and includes participation in work activity services concurrent with the medical services and is designed to enhance the individual's daily living skills. The work activity services are provided in a medical sheltered workshop facility which performs such service.

VI. Speech Pathology Services

"Speech Pathology Services" means the application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions. Services are provided by a speech pathologist.

VII. Speech Pathologist

"Speech Pathologist" means a person who is licensed to practice speech pathology under Chapter 399 of the State Statutes.

VIII. Audiological Services

"Audiological Services" means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and the determination and use of appropriate amplification related to hearing and disorders of hearing, for the purpose of modifying communicative disorders involving speech, language, auditory function or other aberrant behavior related in hearing loss. Services are performed by an audiologist.

IX. Audiologist

"Audiologist" means a person who is licensed to practice audiology under Chapter 399 of the State Statutes.

X. Occupational Therapy Services

"Occupational Therapy Services" means services prescribed by a physician for the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by physical illness or injury, emotional disorder, congenital or development disability, using (1) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, (2) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped, (3) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities.

Services are performed by an occupational therapist to evaluate the patient's level of functioning and develop a plan of treatment. The implementation of the plan may be carried out by an occupational therapy assistant functioning under the general supervision of the occupational therapist.

XI. Occupational Therapist or Occupational Therapy Assistant

"Occupational Therapist or Occupational Therapy Assistant" means a person who is licensed to practice occupational therapy under Chapter 376a of the State Statutes.

XII. Physical Therapy Services

"Physical Therapy Services" means (1) diagnostic services to determine an individual's level of functioning, employing such performance tests as measurements of strength, balance, endurance, and range of motion; (2) treatment services which utilize therapeutic exercises and modalities of heat, cold, water, and electricity, for the purpose of preventing, restoring, or alleviating a lost or impaired physical function. Services are performed by a licensed physical therapist that develops a written individual program of treatment. The term "physical therapy" does not include the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes.

XIII. Physical Therapist

"Physical Therapist" means a person who is licensed to practice physical therapy under Chapter 376 of the State Statutes.

XIV. Partial Evaluation

"Partial Evaluation" means a re-evaluation or reassessment of a patient, in person, which will occur within one (1) year from the date a complete evaluation was performed by the same provider clinic. In order to receive payment for this procedure, the following medical developments must exist:

a. a significant change in the patient's condition which occurs in relation to the current treatment plan;

b. readmission to a treatment program interrupted by a period of hospitalization;

c. a new diagnosis requiring a new treatment plan for the same treatment modality.

XV. Medical Check-up

"Medical Check-up" means an evaluation of a patient, in person, who has received maximum benefits and has been discharged from a program of treatment and may require a medical status review by the discharging provider for the following medical developments only:

a. Degenerative conditions;

b. Assessment of a home program recommended and developed by a clinic health professional as part of the patient's discharge plan.

XVI. Traumatic Brain Injury (TBI) Day Treatment Program

"Traumatic Brain Injury (TBI) Day Treatment Program" means periodic short term, skilled medical rehabilitation services prescribed by a physician (M.D.) for individuals who have sustained injury which is neurologically-based and has resulted from the interaction of any single or repetitive external forces and the body resulting in any combination of focal and diffuse central nervous system (brain) dysfunctions, both immediate and delayed, occurring at the brain stem level and above. The injury results in a loss of living and working skills, in that the individual evidences cognitive, emotional, behavioral, physical, perceptual or language deficits which interfere with restoring the individual to their former living and work situations. Treatment employs a system of cognitive remediation, and other rehabilitative services as required: speech, language, psychological, occupational and physical therapies. These services are uniquely individualized for each participant as a part of a total plan of care. Services are provided on a one-to-one or group treatment basis following an individualized plan of care established by an interdisciplinary team.

XVII. Interdisciplinary Team - TBI Program

"Interdisciplinary Team - TBI Program" means medical rehabilitation professionals such as a speech pathologist; physical therapist; occupational therapist; qualified neuropsychologist; and social worker under the direction of a physician (M.D.) who is the primary member of the team. The physician provides medical supervision of the team professionals. The team is responsible for assessing the recipient's appropriateness for TBI program services and development of a coordinated individual treatment plan of care. The team is also responsible for the ongoing review of the plan of care, evaluating the continued need for medical rehabilitation services and adjusting the treatment goal as necessary.

XVIII. Cognitive Remediation

"Cognitive Remediation" means a rehabilitative treatment program designed to improve an individual's verbal and visual-perceptual abilities which are impaired. Specific areas that may require treatment include

a. Ability to sustain attention and mental focus on given tasks in order to work effectively in the completion of such tasks.

b. Ability to retain, retrieve and/or recognize information acquired through hearing.

c. Ability to organize information in a logical order to facilitate its analysis and comprehension.

d. Ability to organize visual information within a given physical space, in order to understand, comprehend, and make use of such information.

e. Ability to use fine motor muscles to perform such tasks as manipulation of small objects and/or writing.

f. Ability to integrate visual and fine motor stimuli to the extent that they apply to the scope of services provided by the rehabilitation clinic.

g. Ability to discriminate, visually, among different distracting stimuli.

h. The ability to formulate a problem within context, to analyze its conditions and to develop a strategy and a plan of approach to its solution and verification.

i. The ability to produce accurate retention and integration of verbal information and analysis of linguistic relationships.

j. The ability to evaluate and select appropriate alternatives of action to a given situation.

The individual suffering head trauma may evidence deficits in any or all of these areas. A program of cognitive remediation is constructed to address each participant's particular cognitive deficit(s). The goal of such a program is to improve the individual's function level of cognitive abilities, and/or to train the individual in appropriate compensations for permanent deficits.

Services are performed by a speech pathologist or occupational therapist in cognitive areas most applicable to their professional skills and training. Occupational therapy assistants may carry out the implementation of cognitive remediation functioning under the general supervision of the occupational therapist.

XIX. Home

"Home" means the recipient's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, or intermediate care facility.

XX. Physician's Follow-up Services Medical Rehabilitation

"Physician's Follow-up Services Medical Rehabilitation" means services by or under the direct supervision of an individual licensed under State law to practice medicine or osteopathy, to examine and/or treat a specific medical problem of a rehabilitation clinic client. For the purposes of this service, "under the direct supervision" means the physician must be available within five (5) minutes and the physician has actually seen the patient during that visit.

These services must comply with rehabilitation clinic services policy found herein and with Medical Services Policy Section 177 covering physician's services to the extent that they apply to the scope of services provided by the rehabilitation clinic.

XXI. Qualified Neuropsychologist

"Qualified Neuropsychologist" means a psychologist who:

a. documents completion of a Ph.D. or Psy.D. degree in clinical psychology from a program approved by the American Psychological Association with extensive pre- or post-doctoral coursework in basic neurosciences, neuroanatomy, neuropathology, clinical neurology, psychological assessment, clinical neuropsychological assessment, psychopathology and psychological intervention,

and

b. has completed one year of full-time supervised clinical neuropsychological experience at the post-doctoral level and at least one year of independent professional experience as a clinical neuropsychologist,

or

c. the equivalent of three years of unsupervised post-doctoral experience as a clinical neuropsychologist within the past ten years.

C. Provider Participation

I. The provider must meet all applicable licensing and certification requirements.

II. The provider must meet all Departmental enrollment requirements.

III. The following are requirements for satellite sites operated by rehabilitation clinics:

a. All satellite sites operated by rehabilitation clinics must meet Medicare standards for participation;

b. All clinics must document to the Department the names and titles of satellite clinical staff and scheduled hours of operation (hours per day/days per week) and description of services provided at such sites;

c. All such sites must otherwise comply with the provisions of this section of the Department's Medical Services Manual covering rehabilitation clinic services;

d. In cases in which the clinic has a special arrangement to provide services in another organized facility, the clinic must submit to the Department a copy of a written agreement between the clinic and such facility stipulating the services to be provided at such facility;

e. There must be adequate private office space in which to conduct direct patient care and treatment and administrative services.

IV. Functional therapy program providers who do not furnish the required medical services at the facility must contract with licensed and Department of Public Health recognized professionals in private practice or in clinics to treat the participant's medical need.

D. Eligibility

Payment for clinics providing rehabilitation services is available for all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

Except for the limitations and exclusions listed below, the Department will pay for rehabilitation services which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms or medical history.

I. Medical Rehabilitation Services Covered:

a. Physical Therapy

b. Speech and Language

c. Audiology

d. Hearing Aid

e. Occupational Therapy

f. Electronystagmography

g. Inhalation therapy

h. Psychological/Psychiatric

i. Physician

j. Functional therapy, must include at least one of the following:

   1. Physical therapy

   2. Speech therapy

   3. Occupational therapy

   4. Audiological services

   5. Psychiatric and/or psychological services

   6. Other medical services

   Social Services may also be covered with any of the above medial rehabilitation services. The Social Services must be included in the plan of treatment and contribute to the improvement of the individual's condition.

k. Early Childhood Intervention Programs

l. Traumatic Brain Injury Day Treatment Program

m. Neuropsychological Evaluation performed by a qualified neuropsychologist as defined in Section 171.2B.XXI. of this policy.

Assessment of perceptual/motor functions; language functions; attention, memory and learning; intellectual processes; and emotion, behavior, and personality by means of appropriate psychological procedures administered by a qualified neuropsychologist, such as the Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, the Halstead-Reitan Neuropsychological Battery, etc.

II. Limitations

a. Clinics providing medical day treatment programs must furnish such services at the clinic except for a home visit for the purposes of evaluating the recipient's home environment if required by the recipient's plan of care;

b. Evaluations and Diagnostic Testing:

1. Only one (1) complete evaluation per recipient will be paid for per year involving the same treatment modality for the same provider.

2. Only one (1) tympanometry test, full impedance battery, or electronystagmography per recipient will be paid for per year by the same provider. (Refer to Section H.)

c. Sheltered workshop services for individuals who are primarily diagnosed as developmentally disabled are covered only if their need for this type of program stems from an etiology readily identifiable as medical or psychological in origin.

d. Treatment services are limited to one (1) unit of service per day for the same procedure and the same patient, regardless of the length of time it takes to complete the procedure.

e. T.B.I. treatment programs are limited to individuals who have sustained injury from interaction of any external forces resulting in the central nervous system (brain) dysfunctions. Developmental impairment primarily contributing to brain dysfunction is not included. The impairment must be readily identifiable as having been sustained through injury.

f. The TBI program is primarily a medical rehabilitation program, however, vocational, social and educational services may be covered only when these services are (1) related to the individual's injury, (2) are reasonable and necessary for the diagnosis or treatment of the injury, (3) a part of the recipient's written individual plan of care.

g. Services covered are limited to those listed in the Department's Fee Schedule.

h. Programs relating to the learning of basic living or social skills, or other activities of daily living are limited to individuals who have lost or have had impaired functions of daily living and require retraining to maximize restoration of these skills.

III. Services Not Covered

a. Services provided by the facility's professional staff which are related solely to specific employment opportunities, workskills, work settings, and/or academic skills (reading, writing, mathematics) and are not reasonable or necessary for the diagnosis or treatment of an illness or injury are not covered.

b. Concurrent services for the same client involving similar services or procedures.

c. Periodic follow-up visits upon completion of treatment services except as limited to services involving "medical check-up" (see Section 171.2B.XV.).

d. Speech services involving non-diagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for the patient's general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicaid purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.

e. Services as described in Sections 171.2E.I. and II. are not covered if an individual's expected restoration potential would be insignificant in relation to the extent and duration of rehabilitation services required to achieve such potential.

f. Services which are provided in a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded which are deemed routine services for patients in such facilities are not covered. These services, whether furnished individually or as a part of a day treatment program, include but are not limited to occupational therapy services, physical therapy services, audiological services, speech services, respiratory therapy services, and primary care services.

g. When maximum benefits from any treatment program are reached, the service will no longer be covered; in other words, there is no payment for services providing maintenance at maximum functional levels.

h. Canceled visits or appointments not kept or other lack of attendance for services.

i. Services provided to a hospital inpatient.

j. Payment for hearing aid orientation services by persons licensed to dispense hearing aids. The dispensing fee includes this service.

k. Physician's follow-up services are not covered for visits for the sole purposes of the patient obtaining a prescription where the need for a prescription has already been established.

l. The Department will not pay for the treatment of obesity.

F. <u>Need for Service and Authorization Process</u>

I. Need for Service

a. Any Medicaid eligible person requiring medical or medically-related treatment necessary to improve daily functioning due to a disabling mental or physical condition may receive rehabilitation clinic or off-site services that are prescribed by a physician.

b. Functional Therapy Program

1. A recipient may participate in a functional therapy program at a medical sheltered workshop, if

(a) The recipient has a condition which is appropriate for the workshop, and

(b) The workshop is able to provide the services which the recipient's physician (M.D.) orders and which are deemed appropriate by the Department's Medical Consultant.

(c) The recipient has a substantial, documented, medical or psychological condition which can be expected to improve and provide functional improvement through services provided by the medical sheltered workshop.

2. For functional therapy participants, a written plan of care and a written agreement of participation must be executed by the recipient and/or the recipient's guardian or conservator, prior to the recipient's admission into the program.

(a) Plan of Care

The plan of care is based upon recommendations from the individual's physician, the individual's progress as determined by workshop staff, and other supportive services approved by the Department's Medical Consultant. The plan of care shall be coordinated with a total plan of care.

(b) The admission agreement shall include

(1) Any non-financial obligations of the individual to the workshop (e.g., a commitment from the individual to attend the workshop a specified number of days per week),

(2) The days and hours the program operates,

(3) A schedule of holidays when the workshop is closed, and

(4) The announcement procedures for unexpected closing due to disaster or inclement weather.

c. Traumatic Brain Injury Day Treatment Program

1. A recipient may participate in a TBI Day Treatment Program, if

(a) the recipient's impairment results in an identifiable medical, physical and psycho-social need for medical rehabilitation services to the extent that the recipient may be expected to be restored to a level of daily functioning that they may enter a traditional vocational program, and/or educational program, and/or have attained an optimal level of independent living as possible.

(b) The services are a part of an individual's plan of care which primarily includes any of the following skilled medical rehabilitation modalities: (1) physical therapy; (2) occupational therapy; (3) speech and language therapy; (4) cognitive retraining; (5) psychological/psychiatric services. Concurrent to the medical rehabilitative services, subordinate vocational, social and educational services may be provided as a part of the written plan of care. (See Subsections 171.2E.II. and III. for program limitations.)

(c) The plan of care must contain the diagnosis, the type, amount, frequency and duration of services to be given and the anticipated program goals.

(d) The plan of care must be reviewed by the interdisciplinary team under the direction of the team physician at least every sixty (60) days. Following the review, the team physician should certify that the plan of care is being followed and that the patient is making progress in attaining the established rehabilitation goals.

II. Prior Authorization

The following services require prior authorization from the Department regardless of the location where the service is performed:

a. Day treatment program services from the date of first treatment;

b. Individual, group, or family psychotherapy or counseling, in accordance with the Medical Services Policy for Behavioral Health Clinics, Section 171.1F.II.;

c. Physical therapy or speech, language or hearing therapy in excess of two (2) visits per consecutive seven (7) day period per patient per provider;

d. Occupational therapy in excess of one (1) visit per consecutive seven (7) day period per patient per provider;

e. Physical therapy, occupational therapy or speech, language or hearing therapy in excess of nine (9) visits per calendar year per patient per provider involving the following primary diagnoses:

1. All mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD-9-CM, 9th Revision, Clinical Modification) diagnosis code section 290-319, inclusive.

2. Cases involving musculoskeletal system disorders covered by ICD-9-CM diagnosis code section 722-724, inclusive.

3. Cases involving symptoms concerning nutrition, metabolism and development covered by ICM-9-CM diagnosis code section 783, inclusive.

f. Partial Evaluations in excess of one (1) in ninety (90) days from the date of a complete evaluation, medical check-up, or another partial evaluation, involving the same treatment modality and provider;

g. Medical check-up(s) in excess of one (1) in ninety (90) days from the date of a complete evaluation, partial evaluation or another medical check-up, involving the same treatment modality and provider;

h. Complete physical therapy, occupational therapy, speech, language or hearing therapy evaluation (1) when provided in excess of one (1) per calendar year per patient per provider; or, (2) which occur within ninety (90) days from the date of a partial evaluation or medical check-up involving the same treatment modality and provider;

i. Respiratory therapy from the date of first treatment.

III. Authorization Procedure

For services prior authorized, the procedure or course of treatment must be initiated within six (6) months of the date of authorization.

a. Form W-626 "Authorization Request for Professional Services" is used to obtain prior authorization and is submitted to

Department of Social Services
Utilization Review Unit
55 Farmington Avenue
Hartford, Connecticut 06105

b. The initial authorization period for ongoing rehabilitation services will be up to three (3) months except functional therapy and TBI treatment programs which shall be authorized for up to six (6) months.

All evaluation reports shall include the individual treatment goals, short and long term, and evidence of the medical need from rehabilitation services.

1. The authorization request shall include a copy of the written clinical evaluation report for each treatment modality for which prior authorization is requested.

2. The authorization request for a TBI day treatment program shall include the interdisciplinary team's written clinical assessment of the recipient's condition which evidences the need for medical rehabilitation services and any other clinical reports the team may deem to be important supportive evidence of need. Such reports must result from an evaluation by other rehabilitation professionals, clinics, or physicians, occurring within the immediate three (3) months prior to the date the recipient is to enter the TBI Day Treatment Program.

3. The authorization request for functional therapy shall include the clinical findings of a physical examination of the recipient by a licensed physician (M.D.) within the immediate three (3) months prior to admittance for functional therapy. The examination and medical history to be attached to the authorization request shall include at least the following:

(a) Temperature, pulse, reflexes, general appearance, weight, height, skin condition, eyes, ears, nose, throat, lips, teeth, tongue, mouth, gums, neck, lymph nodes, chest, heart, lungs, blood vessels, abdomen, genitalia, rectum, bones, joints, muscles, upper and lower extremities, breast (female), and neurological system. (If the individual has been hospitalized in the preceding three (3) months, a complete discharge summary may be used to fulfill the physical examination requirement);

(b) A list of current medications and treatments;

(c) A statement indicating any contraindications or limitations to the individual's participation in program activities; and

(d) Any other materials deemed appropriate at the discretion of the provider.

c. A reassessment by the rehabilitation professional or interdisciplinary team (for TBI program participants) evidencing continued need for treatment is required at least once during each period of departmental authorization.

If the findings of the reassessment disclose the need for further services, the reassessment, in written summary form, signed by a physician (M.D.) together with any other written clinical evidence relating to the recipient's need for further services, is attached to Form W-626, "Request for Prior Authorization for Professional Services". The new authorization request shall be submitted to the Department <u>not less than fourteen (14) days</u> prior to the expiration of the current authorization period. The reassessment shall describe the further treatment required, progress of the participant to date with goals achieved, and further treatment program goals, and is submitted to

Department of Social Services
Utilization Review Unit
55 Farmington Avenue
Hartford, Connecticut 06105

d. All requests requiring authorization must also include

1. The name of the physician, and/or clinic making the referral

2. The specific number of visits required

3. The period of time by dates covered by the request

4. The specific type of service required and a description of the service to be rendered

5. The complete diagnosis and other conditions for which the recipient needs services.

e. A request for a partial evaluation or medical check-up in excess of one (1) in a ninety (90) day period as described in Section 171.2F.II. shall document the specific medical need for such additional services.

f. To request additional services or other changes in the treatment plan within a period already authorized, a copy of the authorized Form W-626 for that time period must be submitted with justification for the additional request and the statement "Additional Services" should be written on the form.

G. Other

I. Payment to a Salaried Physician

Physicians who are fully or partially salaried by a clinic may not receive payment from the Department unless the physician maintains an office for private practice at a separate location from the clinic.

Physicians who are solely clinic-based either on full time or part time salary are not entitled to individual payment from the Department for services rendered to Title XIX recipients. Services are to be billed by the provider clinic.

Physicians who maintain an office for private practice separate from the clinic, may bill for services provided at the private practice location or for services provided to the physician's private practice patients at the clinic. If the patient is also a clinic patient, the physician may bill for private practice services only if the services are not provided for in the Department's clinic payment rate.

II. Rehabilitation services must relate directly and specifically to a written individualized treatment plan established by or under the direction of a licensed physician. The written plan of treatment shall be part of the individual's record on file in the clinic, and shall be reviewed periodically by the appropriate facility health professional(s) to reassess goals and objectives of treatment making changes in the treatment plan as necessary.

III. The functional therapy participant's record must contain at least the following:

a. Basic identifying information, e.g., name, address, date of birth, sex, source of referral, date(s) of admission into the workshop and Medicaid case number

b. Emergency contact (name and telephone)

c. The name and telephone number of the participant's physician or medical provider

d. A signed order by the physician specifying the need for medical sheltered workshop, with findings and recommendations

e. The prior authorization (W-626) for the initial and extended periods of attendance at the workshop beyond the initial authorization

f. A copy of the written agreement between the participant and the workshop.

IV. The functional therapy program and TBI Day Treatment shall be subject to periodic monitoring by the Department of Social Services staff. The purpose of monitoring shall be to

a. Assess the quality and appropriateness of participant's plan of care

b. Determine the effectiveness of the program

c. Determine adherence to provider eligibility requirements and other program requirements contained in the medical services policy.

V. Procedure for discharge from the functional therapy and TBI treatment programs.

The facility is required to document in writing the following information which shall be placed in the participant's record:

a. A discharge summary (final reassessment)

b. Recommendations for continuing sources of treatment, if appropriate

c. Referrals to other agencies or facilities for continuing treatment or service, if appropriate

d. Written notification to the participant and, if appropriate, to the participant's guardian or conservator if the facility's intent is to discharge the participant from the program.

VI. Documentation Requirements

a. A record of each service performed must be on file in the recipient's individual medical record. Such service record must include, but is not limited to

1. the specific services rendered;

2. the date the services were rendered;

3. for therapy services, the amount of time it took to complete the session on that date;

4. the name and title of the person performing the services on that date;

5. the site at which the services were rendered;

6. the recipient's individual medical record must contain at least a monthly summary documenting the progress made toward the goals and objectives in accordance with the recipient's plan of care.

b. All documentation must be entered in ink and incorporated into the patient's permanent medical record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by Federal Law.

c. In the case of off-site services, all individual medical records must be on file at the clinic.

H. Billing Procedures

I. Form HCFA 1500 "Health Insurance Claim Form" is used for billing all clinic services. The bill is mailed to the Department's fiscal agent:

HP
P.O. Box 2941
Hartford, Connecticut 06104

II. All claims submitted for payment which include prior authorized procedures must include the authorization number from the current authorization.

III. Claims submitted for services not requiring prior authorization must include the name of the physician or clinic making referral.

IV. All services must be billed indicating the appropriate site at which the services were performed according to the place of service coding required by the Department.

V. For an evaluation or test which is not completed on the same day, the provider should bill for services as of the date the evaluation or test has been completed.

I. Payment

I. Payment will be made at the lower of

a. the usual and customary charge to the public, or,

b. the Medicare rate, or

c. the fees as contained in the individual clinic's fee schedule published by the Department, or

d. the amount billed.

II. Payment Rate

a. In-State Clinics

The Commissioner of the Department of Social Services establishes the fees as contained in the in-state rehabilitation facility's individual fee schedule. The fees are based on reasonable costs in the respective facility where the service is rendered.

b. Out-of-State Clinics

The fees contained in the out-of-state rehabilitation facility's individual fee schedule are based on the Medicaid rate established by the appropriate rate setting agency in the respective state where the clinic is located.

c. Subject to the service limitations stated in this policy, rehabilitation clinics shall be reimbursed by the Department for services covered in accordance with the Department's fee schedule covering rehabilitation clinic services regardless of the site where the service is provided.

III. Payment Limitations

a. The rate is determined annually by the Commissioner of the Department of Social Services for the following facilities in accordance with Section 17-313 of the General Statutes:

1. Rehabilitation centers affiliated with the Easter Seal Society for Crippled Children and Adults of Conn., Inc.

2. The association affiliated with United Cerebral Palsy of Conn., Inc.

3. The facilities affiliated with the Association for Retarded Citizens.

4. Any private non-profit agency providing such programs for autistic or neurologically impaired persons for services to clients referred by any State agency.

b. The rates for the following medical rehabilitation programs are all-inclusive and represent the maximum amount payable for any recipient for all sources of necessary rehabilitation services. The all-inclusive rate is comprised of services which are (1) certified by a physician (M.D.) that the recipient requires skilled rehabilitation services, (2) furnished under a written plan of care developed by the facility's professional staff, and, (3) a service directly relating to the recipient's impairment and treatment goals as established by the staff. These services include, but are not limited to, therapy evaluations, psychological/psychiatric services, other medical rehabilitation services, transportation services, and physician's follow-up services (as defined in Subsection 171.2B):

1. Functional Therapy

2. Ripple Program

3. Early Childhood Intervention Programs

4. Traumatic Brain Injury Day Treatment Program

c. The fee for an evaluation of any individual treatment modality includes a written report.

d. The cost of electronystagmography includes interpretation unless otherwise approved by the Department.

e. No payment is made for periodic reassessment of an individual's treatment goals and objectives, except for partial evaluations and medical checkups as defined in Section 171.2B.

f. If a rehabilitation clinic facility provides transportation for recipients, the cost of which is included in the procedure rate, there is no separate payment for transportation.

g. Payment for TBI day treatment services will discontinue when the TBI program interdisciplinary team determines the recipient to be eligible for vocational training. A referral shall be made to an appropriate vocational training program by the team.

h. Travel costs incurred by clinic staff for covered services provided at covered sites are included in the Department's established rate for such covered services.

i. There is no separate reimbursement for medication reviews by a licensed physician. A medication review is a part of the ongoing treatment of an individual and these services are included in the fee for a treatment session.

j. The Department will not pay for a neuropsychological evaluation <u>and</u> any other psychodiagnostic evaluation (i.e., intellectual evaluation, scholastic achievement/group I.Q. test, personality diagnosis, evaluation of organic brain involvement, evaluation of aptitudes, interests, and educational adjustment) in any twelve (12) month period when performed by the same provider for the same recipient.

k. No payment will be made for neuropsychological evaluation for a recipient who (1) is enrolled in a day treatment program for the Traumatic Brain Injured as defined in Section 171.2B.XVI. of the Department's Medical Services Policy for Rehabilitation Clinics - the cost of such testing is made a part of the fees for such programs; or (2) was discharged from a TBI program within twelve (12) months from the date of the TBI program's evaluation.

171.4 Medical Clinics

For the purposes of this section, medical clinics are free-standing facilities providing medical care, services and supplies deemed by the Department to be necessary for the prevention, diagnosis and treatment of illness, disease, injury or infirmity to an outpatient. Included in this section are: Medical Clinics affiliated with Community Health Centers, One Day Ambulatory Surgical Centers, Family Planning Clinics and other free-standing clinics providing medical services. (Refer to Section 171. for other applicable clinic services policy).

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.20(b), 440.90, 440.130

II. Connecticut General Statute: Sections 17b-262

III. Regulations of Connecticut State Agencies: Sections 17-134d-2(3), (9), (11), (12), (13) and (15); 17-134d-56

B. Definitions

I. Medical Clinic Services

"Medical Clinic Services" means services provided by or under the direction of a licensed physician in a facility not associated with a hospital and licensed by the State to provide such services.

II. "By or under the direction of a physician"

"By or under the direction of a physician" means a free-standing medical clinic's services may be provided by allied health professionals, including nurse practitioners, physician's assistants, registered nurses, and other medical staff whether or not a physician is physically present at the time that medical services are provided. The physician

a. must assume professional responsibility for the services provided;

b. must assure that the services are medically appropriate, i.e., the services are intended to meet a medical or medically-related need, as opposed to needs which are clearly only social, recreational or educational.

c. need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

III. Mobile Health Unit

A Mobile Health Unit provides medical services including examination, diagnosis, and treatment in the community by a physician for those who would have difficulty reaching other medical services. For the purposes of this section, these units are considered to be clinics, either a separate independent unit, or affiliated with an independent clinic facility.

IV. Family Planning Services

Family Planning Services include any medically approved diagnostic procedures, treatment, counseling, drugs, supplies or devices which are prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children. Family Planning services are performed in a free-standing clinic and shall comply with Section 173 of the Medical Services Policy, "Family Planning, Abortions and Hysterectomies".

V. Clinic Visit

"Clinic Visit" means a face-to-face encounter between a clinic patient and any health professional employed by or under contract to a medical clinic subject to Section 171.4 of the Department's Medical Services Manual. Encounters with more than one health professional and multiple encounters with the same health professional employed by or under contract to the same clinic provider that take place on the same day, regardless of the location, constitute a single visit, except when the patient, after the first encounter, suffers a new illness or injury requiring additional diagnosis or treatment.

C. Provider Participation

I. The provider must meet all applicable state licensing and certification requirements.

II. Mobile health units must meet the same licensing and certification requirements as other medical clinic facilities.

III. The provider must meet all Departmental enrollment requirements.

IV. The following are requirements of satellite sites operated by medical clinics:

a. All satellite sites operated by clinics licensed by the Department of Public Health (DPH) must also be approved by the Department of Public Health to provide clinic services at such locations, and document to the Department DPH approval of such sites.

b. All clinics must document to the Department the names and titles of satellite clinical staff and scheduled hours of operation (hours per day/days per week) and description of services provided at such sites.

c. All such sites must otherwise comply with the provisions of this section of the Department's Medical Services Manual covering medical clinic services.

d. In cases in which the clinic has a special arrangement to provide services in another organized facility, the clinic must submit to the Department a copy of a written agreement between the clinic and such facility stipulating the services to be provided at such facility;

e. There must be adequate private office space in which to conduct direct patient care and treatment and administrative services.

D. Eligibility

Payment for clinics providing medical care are available for all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

Except for limitations and exclusions listed below, the Department will pay for clinic medical services which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms or medical history.

I. Medical Clinic Services include:

a. Physician's care

b. Pediatric services

c. Respiratory therapy, such as:

1. Intermittent positive pressure breathing

2. Ultrasonography

3. Aerosol

4. Sputum induction

5. Percussion and Postural Drainage

6. Arterial puncture, withdrawal of blood for diagnosis

d. One day ambulatory surgical centers (refer to Section I.III.)

e. Family planning services as described in Section J.I. of this policy.

f. Dialysis treatment (refer to Section I.III.)

g. Health screening services for the elderly.

h. Abortion services as described in Section J.I. of this policy.

II. Limitations

a. Only one (1) form of birth control will be paid for per recipient at any one time.

b. Reimbursement of a visit to a clinic patient is limited to one (1) per day for the same clinic provider to the same patient involving the same treatment modality, illness or injury regardless of the location at which the service is furnished, except as otherwise defined in the Subsection 171.4B.V. of this policy, “Clinic Visit”.

c. The Department will pay for an initial comprehensive examination to a family planning clinic or abortion clinic only once per patient and provider. Initial visits refer to the clinic’s first contact with a new patient or when the clinic-patient relationship has been discontinued for two or more years and is then reinstated.

d. The comprehensive reexamination of an established patient receiving family planning clinic services is limited to one (1) per year, per provider, for the same patient.

e. The comprehensive reexamination of an established patient receiving abortion clinic services is limited to recipients who have more than one abortion in a year and the examination is preparatory to performing an abortion.

f. Other medical procedures are limited as stipulated in the manual section covering such medical procedures.

g. Services covered are limited to those listed in the independent clinic’s fee schedule as published by the Department.

h. Continuous Ambulatory Peritoneal Dialysis training period is limited to fifteen (15) days.

III. Services Not Covered

a. Transsexual surgery or a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis

b. Treatment of obesity

c. Any immunizations, biological products and other products available to the clinic free of charge from the Connecticut State Department of Public Health

d. Any examinations and laboratory tests for preventable diseases which are furnished free of charge by the Connecticut State Department of Public Health

e. Information provided to a patient over the telephone

f. Cosmetic surgery

g. A visit for the sole purpose of a patient obtaining a prescription where the need for the prescription has already been determined

h. Canceled visits or for appointments not kept

i. Services which are provided in a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded which are deemed routine services for patients in such facilities are not covered. These services include, but are not limited to, occupational therapy services, physical therapy services, audiological services, speech services, respiratory therapy services, and primary care services.

F. Need for Service and Authorization Process

I. Need for Service

Any Medicaid eligible person requiring medical treatment may receive clinic and off-site services for a condition which comes within the scope of the clinic's license and the service is recommended by a physician.

II. Prior Authorization

For respiratory treatment centers, prior authorization is required for respiratory therapy procedures regardless of the location where the therapy is performed.

III. Authorization Procedure

For services prior authorized, the procedure or course of treatment must be initiated within six (6) months of the date of authorization.

a. Form W-626 "Authorization Request for Professional Services" is used to obtain prior authorization and is submitted to:

Department of Social Services
Utilization Review Unit
55 Farmington Avenue
Hartford, Connecticut 06105

b. The initial authorization period for ongoing medical need will be up to three (3) months. If the need exceeds the authorization period, a request for the extension of the authorization period using Form W-626 must be submitted to the Department and must include the progress made to date and the future gains expected through additional treatment.

IV. Requests for authorization of treatment must be submitted and approved prior to the onset of services for which authorization is requested.

G. Other

I. Payment to a Salaried Physician

a. Physicians who are fully or partially salaried by a clinic may not receive payment from the Department unless the physician maintains an office for private practice at a separate location from the clinic.

b. Physicians who are solely clinic-based either on full time or part time salary are not entitled to individual payment from the Department for services rendered to Title XIX recipients. Services are billed by the provider clinic.

c. Physicians who maintain an office for private practice separate from the clinic, may bill for services provided at the private practice location or for services provided to the physician's private practice patient in the clinic. If the patient is also a clinic patient, the physician may bill for private practice services only if the services are not provided for in the Department's clinic payment rate.

II. Documentation Requirements

a. A record of each service performed must be on file in the recipient's individual medical record. Such service record must include, but is not limited to

1. the specific services rendered;

2. the date the services were rendered;

3. for therapy services, the amount of time it took to complete the session on that date;

4. the name and title of the person performing the services on that date;

5. the site at which the services were rendered;

6. the recipient's individual medical record must contain a progress note for each encounter.

b. All documentation must be entered in ink and incorporated into the patient's permanent medical record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by Federal law.

c. In the case of off-site service, all individual medical records must be on file at the clinic.

H. <u>Billing Procedures</u>

I. Form HCFA 1500 "Health Insurance Claim Form" is used for billing all clinic services. The bill is mailed to the Department's claims processing agent:

HP
P.O. Box 2941
Hartford, Connecticut 06104

II. All claims submitted for payment which include prior authorized procedures must include the authorization number from the current authorization.

III. Claims submitted for services not requiring prior authorization must include the name of the physician or clinic making the referral.

IV. The fee for a Pap test is to billed by the laboratory facility doing the pathological examination.

V. For one-day ambulatory surgical centers, surgeons', anesthesiologists', and pathologists' fees are billed separately to the Department.

VI. One-day ambulatory surgical centers performing abortions and sterilizations must bill the specific abortion and/or sterilization procedure code as shown in the Clinic Fee Schedule.

VII. All services must be billed indicating the appropriate site at which the services were performed according to the place of service coding required by the Department.

I. Payment

I. Payment will be made at the lower of

a. the usual and customary charge to the public, or

b. The Medicare rate, or

c. the fee as contained in the individual clinic's fee schedule as published by the Department, or

d. the amount billed.

II. Payment Rate

a. In-State Clinics

The Commissioner of the Department of Social Services establishes the fees as contained in the in-state medical clinic's individual fee schedule. The fees are based on reasonable costs in the respective facility where the service is rendered.

b. Out-of-State Clinics

The fees as contained in the out-of-state medical clinic's individual fee schedule are based on the Medicaid rate established by the appropriate rate setting agency in the respective state where the clinic is located or, if that state uses a different rate setting method, the rate will be set by the Department at its basic encounter fee for medical clinics.

c. Subject to the service limitations stated in this policy, a medical clinic shall be reimbursed by the Department for services covered at its individual clinic visit rate(s) in accordance with the Department's fee schedule for medical clinic visits regardless of the site where the service is provided.

III. Payment Limitations

a. The fee established for a clinic visit is "all-inclusive", except as authorized by the Department in writing, and represents the maximum amount payable for any recipient for all sources of care at the clinic for that visit.

b. The clinic rate for dialysis treatment includes routine laboratory blood studies, drugs and surgical supplies.

c. The fee for obtaining a tissue sample for a pap test is included in the fee for a clinic visit.

d. The rate for one-day ambulatory surgical centers includes

1. preoperative examination

2. operating and recovery room services

3. all required drugs and medicine.

e. There is no payment for an initial family planning or abortion clinic visit after a follow-up or annual clinic visit for the same provider clinic and recipient except as provided for under Section E.II. of these regulations.

f. The fee established for an abortion includes local anesthesia, supplies and drugs.

g. Travel costs incurred by clinic staff for covered services provided at covered sites are included in the Department's established rate for such covered services.

h. The composite rate for Continuous Ambulatory Peritoneal Dialysis (CAPD) includes routine solutions, equipment, laboratory services, support services, and supplies and is reimbursed on a per day basis.

i. The fee for the physician's supervision of a CAPD patient is paid as a monthly fee regardless of the number of times the physician sees the patient during the month.

173 Family Planning, Abortions and Hysterectomies

This section contains policies and procedures which must be followed when providers request payment for family planning, abortion and hysterectomy procedures and services provided for Title XIX patients.

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 441.20, 441.200 through 441.208, and 441.250 through 441.259

II. Connecticut General Statutes: Section 17b-262

B. Definitions

I. Family Planning Services

"Family Planning Services" include any medically approved diagnostic procedures, treatment, counseling, drugs, supplies or devices which are prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

II. Informed Consent

For the purposes of this section, "Informed Consent" means the knowing, voluntary assent from the individual on whom the sterilization is to be performed after he or she has been given, as evidenced by the document signed by the individual, the following information:

a. an objective explanation of the procedures to be followed;

b. a description of the attendant discomforts and risks;

c. a description of the benefits to be expected;

d. counseling concerning appropriate alternative methods and the result of the sterilization including the fact that it must be considered an irreversible procedure;

e. instruction that the individual is free to withhold or withdraw his or her consent anytime prior to the sterilization without prejudicing future care and without loss of any other program benefits to which the individual might otherwise be entitled; and

f. answers to any inquiries concerning the procedures.

III. Institutionalized Individual

For the purposes of this section, "Institutionalized Individual" means an individual who is (a) voluntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of behavioral health disorder; or (b) confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of behavioral health disorder.

IV. Mentally Incompetent Individual

"Mentally Incompetent Individual" means an individual who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for the purposes which include the ability to consent to sterilization.

V. Shortly Before

For the purposes of this section, the phrase "shortly before" as used in the Physician's Statement section of the Sterilization Consent Form means seven (7) days or less. This applies to the requirement that the physician performing the sterilization explain the procedure to the patient shortly before the operation is performed.

VI. Sterilization

"Sterilization" means any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

C. Provider Participation

In order to participate in the Medicaid program, providers must meet all applicable State licensing and certification requirements. Providers must also meet all Departmental enrollment requirements.

D. Eligibility

Payment for family planning services, abortions and hysterectomies is available to all persons eligible for Medicaid, subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

I. Family Planning

The Department will pay for family planning services for individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

II. Sterilizations

a. The Department will not pay for sterilizations for patients who are under age twenty-one (21) or who are under age twenty-one (21) at the time of consent.

b. The Department will not pay for sterilizations performed on mentally incompetent individuals.

c. The Department will not pay for sterilizations performed on institutionalized individuals.

III. Hysterectomies

The Department will not pay for hysterectomies when

a. The hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or

b. If there was more than one purpose to the procedure, the hysterectomy would not have been performed, but for the purpose of rendering the individual permanently incapable of reproducing.

IV. Abortions

The Department will pay for an abortion only when

a. The attending physician has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term, or

b. Effective October 9, 1981, the attending physician has certified in writing that the abortion is medically necessary for the patient's health.

V. Laboratory Services

Payment for any laboratory service is limited to services provided by Medicaid providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

VI. Services covered are limited to those listed in the Department's fee schedule.

F. <u>Need for Service and Authorization Process</u>

I. Need for Service

Medicaid recipients of child-bearing age who indicate a need for family planning services must be free from coercion or mental pressure and free to choose the method of family planning to be used.

II. Prior Authorization

None of the services covered in this section require prior authorization.

G. Other

I. Requirements for Sterilization

a. Informed Consent

Informed consent has been given only if the person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure and provided a copy of the consent form to the individual to be sterilized.

The person obtaining consent has met the informed consent requirements if all of the following information or advice was provided orally (unless otherwise indicated):

1. The individual has been advised that he or she is free to withhold or withdraw consent to this procedure at any time before sterilization. This decision would not affect the individual's right to future care or treatment nor would it cause the loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

2. The individual has been given a description of available alternative methods of family planning and birth control.

3. The individual has been advised that the sterilization procedure is considered to be irreversible.

4. The individual has been given a thorough explanation of the specific sterilization procedure to be performed, verbally and in writing.

5. The individual has been advised of the discomforts and risks that may accompany or follow performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

6. The individual has been given a full description of the benefits or advantages that may be expected as a result of the sterilization.

7. The individual has been advised that the sterilization will not be performed for at least thirty (30) days, except in the circumstances specified under Premature Delivery or Emergency Abdominal Surgery.

8. In case of a blind, deaf or otherwise handicapped individual, suitable arrangements were made to ensure that the information listed above, under Informed Consent, was effectively communicated.

9. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.

10. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.

11. The requirements of Form W-612, "Consent Form" (Sterilization) were met.

b. Restrictions on Obtaining Informed Consent

Informed consent may not be obtained from an individual under the following conditions:

1. The individual is in labor or childbirth.

2. The individual is seeking to obtain or is obtaining an abortion.

3. The individual is under the influence of alcohol or other substances that effect the individual's state of awareness.

c. Consent Form

1. The Department must receive a completed original of Form W-612 "Consent Form" (Sterilization) before payment for any sterilization procedure can be made. The form must be fully and accurately completed in all areas. Forms must be clearly written and legible. Form W-612 is the only acceptable form that can be submitted. The only reproduction of this form allowed for the purpose of obtaining consent is a photocopy. All other facsimiles, even with identical wording, will be denied for payment.

d. Premature Delivery

In the case of a premature delivery, Form W-612 must be signed and dated by the patient at least seventy-two (72) hours prior to the sterilization and at least thirty (30) days prior to the expected date of delivery. The physician must include the patient's expected date of delivery as part of the Physician's Statement in cases of sterilization with premature delivery.

e. Emergency Abdominal Surgery

Form W-612 must be completed and signed by the patient at least seventy-two (72) hours prior to surgery in cases where sterilization is performed in conjunction with emergency abdominal surgery.

f. Submission of Consent Form

Providers should submit Form W-612 along with their standard billing form. When two or more providers bill for services rendered in connection with the same sterilization, only one provider is required to submit the original completed Consent Form. It is suggested that hospitals submit the original W-612 with their bill since hospitals frequently bill earlier than physicians. This is not mandatory. An original Form W-612 must be on file before any provider will be paid.

II. Requirement for Hysterectomies

a. Medical Necessity

The Department will pay only for hysterectomies which are medically necessary. The diagnosis must be clearly written on the face of the claim. The Department reserves the right to review the medical necessity of all hysterectomies for which reimbursement is being requested.

b. Hysterectomy Acknowledgment Requirement

The Department will pay for a medically necessary hysterectomy which was performed for a reason other than sterilization only when

1. The person who secured authorization to perform the hysterectomy informed the patient and her representative, if any, both orally and in writing prior to the surgery that the hysterectomy would make the patient permanently incapable of reproducing. The patient or her representative, if any, must sign and date Form W-613, "Hysterectomy Information Form," acknowledging receipt of this information.

   For dates of service on of after July 1, 1983, the patient or her representative may sign and date form W-613 before or after the surgery is performed provided that the person who secured authorization for the surgery informed the patient and her representative, if any, both orally and in writing prior to the hysterectomy;

2. The physician certifies in writing that the patient was already sterile at the time of the hysterectomy and states the cause of the sterility. Form W-613 must be completed by the physician when this situation applies. The patient or her representative is not required to complete Form W-613 when the patient was already sterile at the time of the hysterectomy; or

3. The physician certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The physician must include a description of the nature of the emergency. Form W-613 must be completed by the physician when this situation applies.

A completed Form W-613 must be submitted with the billing form in order for payment to be made.

c. Retroactive Eligibility

For dates of service on or after July 1, 1983, the Department will pay for a medically necessary hysterectomy which was performed during a period of retroactive eligibility if the physician who performed the hysterectomy certifies in writing that

1. The patient was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;

2. The patient was already sterile at the time of the hysterectomy and the physician states the cause of sterility; or

3. The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The physician must include a description of the nature of the emergency.

Form W-613A, "Physician Hysterectomy Certification Form - Retroactive Eligibility" must be completed by the physician and submitted with the billing form in order for payment to be made.

III. Requirements for Abortion

a. Medical Necessity

The Department will pay for an abortion only when

1. The attending physician has certified in writing on form W-484, "Physician's Certification for Abortion (Title XIX)," that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term, or

2. The attending physician has certified in writing on Form W-484 that the abortion is medically necessary for a patient's health.

b. Submission of Certification

Form W-484 must be filled out completely including the name and address of the patient. An original Form W-484 must be on file with the Department before any provider will be paid. Providers should submit Form W-484 along with their standard billing form for the services provided.

IV. The Department must have an accurate original certification form on file before any provider will be paid for a sterilization, hysterectomy or abortion. The first certification form submitted by a provider for a particular claim will be the one which is reviewed for payment purposes.

V. The Department will not pay for canceled office visits, for appointments not kept, or for information provided by telephone.

VI. Obtaining Consent, Information and Certification Forms

Providers may obtain forms W-612, "Consent Form" (Sterilization); W-613, "Hysterectomy Information Form"; W-613A, "Physician Hysterectomy Certification Form - Retroactive Eligibility"; and W-484, "Physician's Certification for Abortion (Title XIX)", by sending a written request to

Department of Social Services
Supervisor, Duplicating
55 Farmington Avenue
Hartford, Connecticut 06105

H. Billing Procedures

I. Providers should use the standard billing form for their provider type when billing for family planning services, abortions and hysterectomies (e.g. physicians use the HCFA 1500). All family planning procedures should be indicated as such on the billing form using the method appropriate for the billing form.

NOTE: Abortions and hysterectomies should not be listed as family planning services.

II. Providers of family planning services, abortions and hysterectomies should submit claims to the Department's fiscal agent:

HP
PO Box 2941
Hartford, Connecticut 06104

Providers should use the post office box number appropriate for their provider type.

I. Payment

Payment will be made in accordance with the payment policy established for each provider group.

Requirements for Payment of Dialysis Services

Sec. 17b-262-651 Scope

Sections 17b-262-651 through 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of dialysis services provided by physicians, general hospitals, and freestanding dialysis clinics for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

Sec. 17b-262-652 Definitions

For the purposes of sections 17b-262-651 through 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Border Hospital" means an out-of-state general hospital which has a common medical delivery area with the State of Connecticut and is deemed a border hospital by the department on a hospital by hospital basis.

(2) "Client" means a person eligible for goods or services under the department's Medicaid Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to section 17b-1(a) of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Dialysis" means dialysis as defined in 42 CFR 405.2102.

(6) "Freestanding Dialysis Clinic" means those centers licensed by the Department of Public Health (DPH) and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

(7) "General Hospital" means a short-term acute care hospital having facilities, medical staff, and all necessary personnel to provide diagnosis, care, and treatment of a wide range of acute conditions, including injuries. This includes a children's general hospital. It shall also include a border hospital.

(8) "HealthTrack Services" means the services described in section 1905(r) of the Social Security Act.

(9) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and behavioral health disorders and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(10) "Home" means the client's place of residence which includes a boarding home or residential care home. Home does not include a hospital, chronic disease hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

(11) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(12) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).
(13) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.
(14) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.
(15) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or behavioral health disorder; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.
(16) "Medical Record" means medical record as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.
(17) "Physician" means a physician licensed pursuant to section 20-1 of the Connecticut General Statutes or a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes.
(18) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.
(19) "Provider" means:
- **(A)** a physician;
- **(B)** a general hospital--inpatient or outpatient; or
- **(C)** a freestanding dialysis clinic licensed by the Department of Public Health (DPH) and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

(20) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.
(21) "State Plan" means the document which contains the services covered by the Connecticut Medicaid Program in compliance with 42 CFR(430)(B).

Sec. 17b-262-653 Provider Participation

In order to enroll in the Medicaid Program and receive payment from the department, providers shall:
- **(1)** meet and maintain all applicable licensing, accreditation, and certification requirements;
- **(2)** meet and maintain all departmental enrollment requirements; and
- **(3)** have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medicaid Program. This agreement, which will be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

Sec.17b-262-654 Eligibility

Payment for dialysis services shall be available on behalf of all persons eligible for the Medicaid Program subject to the conditions and limitations which apply to these services.

Sec.17b-262-655 Services Covered and Limitations

Subject to the limitations and exclusions listed below and those set forth in the Regulations of Connecticut State Agencies dealing with physicians, general hospitals, and freestanding dialysis clinics, the department shall pay for dialysis services which conform to accepted methods of diagnosis and treatment.

(a) The department shall pay for the following:

(1) for services provided by an enrolled provider in a home, clinic, hospital, or institution having an organized and approved dialysis program; and

(2) for HealthTrack Services and HealthTrack Special Services.

(b) The department shall not pay for the following:

(1) cancelled office visits and appointments not kept;

(2) information or services provided to a client by a provider over the telephone;

(3) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge; and

(4) for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

Sec.17b-262-656 Need for Service and Authorization Process

(a) The department shall pay for medically necessary and medically appropriate dialysis services for Medicaid Program clients, in relation to the diagnosis for which care is required, provided that:

(1) the services are within the scope of the provider's practice;

(2) a physician documents the need in writing and orders the service; and

(3) the services are made part of the client's medical record.

(b) Prior authorization, on forms and in a manner as specified by the department, is required for HealthTrack Special Services:

(1) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(2) the request for HealthTrack Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her scope of practice as defined under state law, justifying the need for the item or services requested;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(c) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(d) The initial authorization period shall be up to three months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(f) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(g) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies to only those services which normally require prior authorization.

(h) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

Sec.7b-262-657 Billing Procedures

Claims from providers 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.

Sec.17b-262-658 Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;
(2) the lowest Medicare rate;
(3) the amount in the applicable fee schedule as published by the department;
(4) the amount billed by the provider; or
(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) Not with standing the provisions of subsection (a) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual enrollee without affecting the amount paid by the department for the same or substantially similar goods or services.

Sec.17b-262-659 Payment Rate

(a) The commissioner establishes the fees contained in the provider's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Payment rates for physicians and physician groups are found in the department's fee schedule for physicians' services.

(c) Payment rates for dialysis services performed by freestanding dialysis clinics shall be based on the fee published by the department and contained in the department's fee schedule for clinics.

(d) Payment rates for dialysis services performed in a hospital on an inpatient basis are paid through the inpatient hospital interim per diem rate and published in the department's fee schedule for general hospital inpatient services.

(e) Payment rates for dialysis services performed in a hospital on an outpatient basis are paid as published in the department's fee schedule for general hospital outpatient services.

Sec. 17b-262-660 Documentation

(a) Providers shall maintain a specific medical record for all services received for each client eligible for Medicaid Program payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file 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 or five years, whichever is greater.
(c) 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 provided to the department upon request.

State of Connecticut
Regulation of
Department of Social Services
Concerning
Requirements for Payment to Behavioral Health Clinics

Section 1. Sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies are amended as follows:

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] behavioral health clinic services for CMAP members.

Sec. 17b-262-818. Definitions

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

(1) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes and who has experience and expertise in the diagnosis and treatment of behavioral health conditions;

(2) "Allied Health Professional" or "AHP" means an individual who works within such individual's scope of practice under state law and who is:

(A) [A licensed or certified practitioner performing within the practitioner's 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] A psychologist, a licensed clinical social worker, a licensed marital and family therapist, a licensed professional counselor, a licensed alcohol and drug counselor, a certified alcohol and drug counselor, advance practice registered nurse or physician assistant; or

(B) [a] an individual who is license-eligible [individual as defined in subdivision (23) of this section];

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

[(3)] (4) "Authorization" means approval for delivery of and payment for services by the department before payment is made. ["Authorization"] It includes[,] prior authorization, registration and retroactive authorization. It does not, however, guarantee payment unless all other requirements for payment are met;

(5) "Autism spectrum disorder" has the same meaning as provided in section 17b-262-1052 of the Regulations of Connecticut State Agencies;

(6) "Autism spectrum disorder services" has the same meaning as provided in section 17b-262-1052 of the Regulations of Connecticut State Agencies;

[(4)] (7) "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:

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(A) A day treatment facility;
(B) A psychiatric outpatient clinic for adults;
(C) An ambulatory chemical detoxification facility;
(D) A facility licensed to provide chemical maintenance treatment;
(E) A facility licensed to provide day or evening treatment;
(F) An outpatient treatment facility for substance [abuse] use; or
(G) An outpatient psychiatric clinic for children;

[(5)] (8) "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 one or more of the following individuals employed by or under contract to the behavioral health clinic, each of whom shall work within such individual's scope of practice:

(A) A physician [within the scope of practice as defined in chapter 370 of the Connecticut General Statutes];

(B) [an] An AHP [acting within the practitioner's scope of practice, as defined in title 20 of the Connecticut General Statutes];

(C) An LMSW working under the direct supervision of an individual qualified to supervise the LMSW in accordance with section 20-195s of the Connecticut General Statutes;

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

[(6)] (9) "Case management" means services provided by the provider that (A) are related to other behavioral health clinic services performed by the provider, (B) assist the member in gaining access to needed medical, social, educational and other services, as defined in the plan of care and (C) are reimbursed only when they are provided to members under age twenty-one;

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

(11) "Children's Health Insurance Program" or "CHIP" means the federally subsidized program of health care for uninsured, low-income children authorized by Title XXI of the Social Security Act and operated by the department pursuant to sections 17b-289 to 17b-307, inclusive, of the Connecticut General Statutes, also known as HUSKY B;

[(7)] ["Client" means a person eligible for goods or services under Medicaid;]

[(8)] (12) "CMS" means the U.S. Centers for Medicare and Medicaid Services;

(13) "Commissioner" means the Commissioner of Social Services or [his or her] the commissioner's designee;

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

(15) "Connecticut Medical Assistance Program" or "CMAP" means all of the medical assistance programs administered by the department pursuant to state and federal law, including, but not limited to, Medicaid and CHIP";

[(10)] (16) "Day or evening treatment" has the same meaning as provided in section 19a-495-570 of the Regulations of Connecticut State Agencies;

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

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

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

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[(13)] (19) "Department" means the Department of Social Services or its agent;

[(14)] (20) "Drug [abuse testing] use screening" means the taking of physical samples or specimens and the qualitative screening of these samples or specimens for substances [of abuse] used;

[(15)] (21) "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;

[(16)] (22) "Episode of care" means a period of care that ends when the [client] member has been discharged by the provider or there has been [an extended] a cessation in treatment [defined as] of not less than 120 days [from the last time] after the [client] member was treated at the clinic;

[(17)] (23) "Escort" means a person [21 years of] age twenty-one or older who accompanies a [client] member under [the] age [of 16] sixteen during transport in a motor vehicle from one location to another for the purpose of the [client's] member's protection and safety. ["Escort"] It does not include the driver of a public transportation vehicle;

[(18)] (24) "External toxicology laboratory test" or "external toxicology test" means quantitative drug testing performed by a laboratory that is separate and independent from the behavioral health clinic;

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

[(19)] (26) "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] member;

[(20)] (27) "Group psychotherapy" means a type of behavioral health care in which [clients] membersmeet in [groups] facilitated groups 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)] (28) "Intensive Outpatient Program" or "IOP"means an integrated program of outpatient psychiatric services or outpatient substance use disorder services that are designed for more intensive treatment than routine outpatient psychiatric services or outpatient substance use disorder services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance [abuse] use or an outpatient psychiatric clinic for children;

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

[(23)] (30) "License-eligible" means an individual (A) whose education, training, skills and experience satisfy the criteria, including accumulation of all supervised service hours, for one of the [behavioral health] following licensure categories: [of title 20 of the Connecticut General Statutes,] psychologist, licensed clinical social worker, licensed marital and family therapist, licensed professional counselor, licensed alcohol and drug counselor, advanced practice registered nurse or physician assistant and (B) who has qualified and applied for but not yet [passed] taken the applicable licensure exam;

(31) "Licensed alcohol and drug counselor" or "LADC" means an individual who (A) is licensed pursuant to section 20-74s of the Connecticut General Statutes and (B) engages only in the practice of alcohol and drug counseling, as defined by section 20-74s of the Connecticut General Statutes;

(32) "Licensed clinical social worker" or "LCSW" means an individual licensed pursuant to subsection (c) or subsection (e) of section 20-195n of the Connecticut General Statutes;

(33) "Licensed marital and family therapist" or "LMFT" means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;

(34) "Licensed master social worker" or "LMSW" means an individual who (A) is licensed

pursuant to subsection (b) or subsection (d) of section 20-195n of the Connecticut General Statutes and (B) complies with such individual's scope of practice under state law, including, but not limited to, the requirements in section 20-195s of the Connecticut General Statutes concerning professional supervision under a licensed practitioner specified therein and consultation regarding mental health diagnoses with a licensed practitioner specified therein;

(35) "Licensed professional counselor" or "LPC" means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;

[(24)] (36) "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)] (37) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(38) "Medical record" means the behavioral health clinic's records of services provided to each member, including, but not limited to identification data, progress notes, orders, services provided and other necessary information, including, but not limited to, information required by the Department of Public Health to be included in a medical record and information required to be included in accordance with sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies;

(39) "Member" means an individual who is eligible to receive goods and services under CMAP;

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

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

[(28)] (42) "Outpatient treatment [service] facility for substance [abuse] use" [has the same meaning as provided in] means a facility that is licensed to provide outpatient treatment for a substance use disorder in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies;

[(29)] (43) "Partial Hospitalization Program" or "PHP" has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act;

[(30)] (44) "Physician" means an individual licensed [or board-certified] pursuant to [chapter 370] section 20-13 of the Connecticut General Statutes and who has experience and expertise in the diagnosis and treatment of behavioral health [or substance related] conditions;

(45) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes and who has experience and expertise in the diagnosis and treatment of behavioral health conditions;

[(31)] (46) "Plan of care" means a written individualized plan that contains the [client's] member'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] member's achievable level of independent functioning;

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

[(33)] (48) "Provider" means a behavioral health clinic enrolled in [Medicaid] CMAP;

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

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

(51) "Psychologist" means an individual licensed pursuant to section 20-188 or section 20-190 of

the Connecticut General Statutes;

(52) "Registered nurse" means an individual licensed pursuant to section 20-93 or section 20-94 of the Connecticut General Statutes;

[(36)] (53) "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 in writing by the department as requiring registration only;

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

[(38)] (54) "Under the direct supervision" means that a physician or licensed AHP provides weekly supervision of the work performed by LMSWs, unlicensed clinical staff or [non-] any other clinical staff not certified [staff] by the Department of Public Health or individuals in training, and a minimum of monthly supervision for the work performed by staff certified [staff] by the Department of Public Health; and accepts primary responsibility for the behavioral health services performed by the LMSW or the unlicensed, certified or non-certified staff or individuals in training; [and]

[(39)] (55) "Usual and customary charge" means the fee that the provider accepts for the service or procedure in the majority of non-[Medicaid] CMAP cases. If the provider varies the fees so that no one amount is accepted in the majority of cases, "usual and customary charge" [shall be defined as] means the median accepted fee. "Usual and customary charge" does not include token fees and other exceptional charges[.]; and

(56) "Utilization management" means the evaluation of the medical necessity, quality and timeliness of behavioral health clinic services. Utilization management may be conducted on a prospective, concurrent or retrospective basis and includes, but is not limited to, prior authorization, registration, concurrent review and retrospective review.

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, as defined in] In accordance with 42 CFR [§]440.90, as amended from time to time, all behavioral health clinic services shall be furnished by or under the direction of a physician. [The] A qualified physician, APRN, physician assistant, psychologist, LCSW, LMFT, LPC or LADC shall sign the initial plan of care and all [periodic reviews to the plan of care assuring] updates thereto not later than thirty days after the initial plan or update is written, in order to ensure that the services are medically necessary.

(c) Programs serving [clients] members under [18 years of] age eighteen 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 as provided in section 17a-20 of the Connecticut General Statutes.

(d) Programs serving [clients 18 years of] members age eighteen 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] as provided in section 19a-495-550 of the Regulations of Connecticut State Agencies.

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

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

Sec. 17b-262-820. Eligibility

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

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:

(1) Within the clinic's scope of practice as described in sections 19a-495-550, 19a-495-570, 17a-20-11 or 17a-147-1 of the Regulations of Connecticut State Agencies, as applicable to the clinic;

(2) Medically necessary to treat the [client's] member's condition; and

(3) Furnished in [the clinic or a satellite site] a licensed location 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] with supporting documentation, 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 and for EPSDT special services subject to sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies.

(d) An appropriate qualified physician or AHP shall supervise each LMSW, unlicensed clinical staff, non-certified staff, individual in training and license-eligible staff not less than weekly and shall supervise certified staff not less than monthly. The supervising physician or AHP shall accept primary responsibility for services performed by LMSWs, unlicensed, noncertified, license-eligible and certified staff; and shall supervise all staff in accordance with applicable scope of practice requirements.

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] member.

(2) [Family] Each session of family, multi-family and group psychotherapy [sessions] shall be not less than [45] forty-five minutes [in length], except in an intermediate care program, where each session of family, multi-family and group psychotherapy [sessions] shall be not less than [30] thirty 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] member's presentation requires that a qualified physician, [or a psychiatric] advanced practice registered nurse or physician assistant evaluate the need for medication for a [client] member who is in the care of a non-medical practitioner.

(4) [Group] Each session of group psychotherapy [sessions, are] is limited in size to a maximum of twelve participants per group session regardless of the payment source of each participant, except

as provided in subdivision (8) of subsection [(d)] (e) of this section.

(5) [Group] Each session of group psychotherapy [sessions] shall be facilitated by an individual qualified as provided in the applicable licensure category in sections [17a-262-819(c)] 17b-262-819(c) to (e), inclusive, of the Regulations of Connecticut State Agencies.

(6) [Multiple-family] Each session of multiple-family group psychotherapy [sessions are] is limited in size to a maximum of 24 participants regardless of the payment source of each participant. [Such sessions] Each such session may be conducted with or without the [client] member present.

(7) Family therapy shall be reimbursable only for one identified [client] member 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) Case Management.

(1) The behavioral health clinic shall bill for case management in the manner specified in writing by the department and shall meet all applicable time and clinical criteria for billing.

(2) Case management shall be for the benefit of a member and shall directly support the member's access to medical, dental, behavioral health, educational and other services that affect the member's health. Services shall be provided pursuant to a behavioral health evaluation and shall be included in the plan of care. The plan of care or separate case management care plan shall be in writing and shall specify the goals and actions necessary to address the medical, behavioral health, social, educational and other services needed by the member to benefit the member's health and functioning. Each case management service that is billed shall document how it supports the goals of the member's plan of care.

(3) Payment for case management is available only for members under age twenty-one.

(4) Case management does not include routine documentation of treatment sessions, missed appointments or direct behavioral health clinic services provided to the member. Case management shall not duplicate any other CMAP services, including, but not limited to, services provided as targeted case management, behavioral health home services or any other services. The behavioral health clinic shall not bill for any case management services that duplicates any other CMAP covered service. The department shall not pay for any case management services that duplicates any other CMAP covered service.

[(b)] (c) Chemical [maintenance treatment] Maintenance Treatment. Each behavioral health clinic that provides chemical maintenance services shall comply with all applicable requirements, including, but not limited to, 42 CFR 8, as amended from time to time, and the requirements of this subsection.

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

(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.] Payment for chemical maintenance shall be a weekly rate that includes at least one unit of the following categories of service per day for seven days: in-person medication administration, take-home medication doses or any in-person clinical service provided at the clinic that meets the billing code clinical and minimum time definitions for individual, group or family psychotherapy or any combination thereof. On each claim, in a form and manner specified by the department, the clinic shall specify the number of daily units of each service that are actually provided to each member in each week. For any week for which such a service is provided on fewer than seven days, the department shall prorate the rate to pay only for the number of days in the week during which such a service was provided. The behavioral health clinic shall

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ensure that the total number of services billed equals the number of services actually provided and is in no case more than seven days of services per week.

(3) [A weekly rate payment for chemical maintenance treatment 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.] The rate for chemical maintenance treatment includes all of the following, to the extent medically necessary for each member: intake evaluation; initial physical examination; medication administration, including face to face medication administration or take-home medication; on-site drug use screening and monitoring; and all routine individual, group and family substance use disorder counseling services. The behavioral health clinic shall perform or make arrangements for the provision of all routine drug use screening and monitoring, which is included in the weekly rate and the behavioral health clinic shall ensure that no separate payment by the department is made to any provider for such services. Any laboratory work other than routine drug use screening may be provided by a laboratory other than the behavioral health clinic and such services are not included in the rate for chemical maintenance treatment. The provider shall not bill separately for the services described in this subdivision and the department shall not pay separately for the services described in this subdivision outside the weekly rate described in subdivision (2) of this subsection.

(4) Intermediate care programs may be billed separately from chemical maintenance services if both services are medically necessary for a member and all applicable requirements for both categories of services are met.

(5) Chemical Maintenance Treatment Laboratory Testing. Each provider of chemical maintenance services shall ensure that external laboratory testing related to such services is provided only to the extent medically necessary for each member. The department may recoup payment made to a clinic for chemical maintenance services by the amount of payment made by the department to one or more laboratories based on orders for laboratory tests referred by the clinic in violation of this subdivision.

(A) The provider shall perform all routine drug use screening and monitoring, which is included in the weekly rate. Typical urine drug samples shall be screened on-site by the provider, except as otherwise specifically authorized by subdivision (3) of this subsection. If the results of such on-site screening are atypical or there is a suspicion that the results are invalid or tainted, urine samples may be tested by an external, independent lab.

(B) External toxicology laboratory tests are not included in the department's weekly rate for chemical maintenance services provided by the behavioral health clinic. All external toxicology laboratory tests ordered shall be medically necessary for each member. No more than eight external toxicology laboratory tests may be provided under a single standing order in any calendar year, not to exceed one test per calendar month. In no instance shall more than one external toxicology laboratory test shall be ordered in a calendar month unless it is medically necessary for each member based on that member's plan of care. Each external toxicology laboratory test in excess of one per calendar month or eight in a calendar year requires a specific order from a qualified physician, physician assistant or APRN that is documented in the behavioral health clinic's medical record of the member and explains why such additional external toxicology laboratory test or tests is medically necessary. In each member's medical records, the provider shall include clinical documentation demonstrating the need for any external laboratory testing ordered or referred by the provider. The provider shall also include documentation in each member's medical records that appropriate medical personnel at the provider have reviewed and interpreted external laboratory tests and explain in the medical records how such interpretation of the tests has affected the member's plan of care.

(6) Each provider for which rates are determined under this subsection shall submit a cost report to the department in accordance with this subdivision annually not later than 180 days after the end of

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the provider's fiscal year. Each provider shall complete such cost report in compliance with the format and requirements specified by the department. If a provider fails to submit a complete and accurate cost report on or before the deadline specified in this subdivision, the department shall notify such provider of such failure and the provider shall have thirty days from the date the notice was issued to submit a complete and accurate cost report.

(7) The commissioner may reduce the applicable rate for chemical maintenance services in effect for a provider that fails to submit a complete and accurate cost report in accordance with subdivision (6) of this subsection by an amount not to exceed ten percent of such rate. Any rate reduction imposed pursuant to this subdivision shall take effect immediately upon the expiration of the thirty days following the notice issued pursuant to subdivision (6) of this subsection.

[(c)] (d) Ambulatory [chemical detoxification] Chemical Detoxification.

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

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

(3) Ambulatory chemical detoxification treatment services shall be limited to a maximum of [90] ninety days from the date the [client] member is admitted into the program per episode of care.

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

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

[(d)] (e) Intermediate Care Programs. Intermediate care programs shall meet the following requirements:

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

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

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

(4) Clinic programs shall provide an adult escort to support the transportation of [clients] members under [16 years of] age sixteen, transported by a [Medicaid] CMAP non-emergency medical transportation provider, unless the parent or guardian of [the client between the ages of 12 to 15 years] a member who is not less than age twelve but not more than age fifteen does not feel an escort is necessary for the [client] member and has provided written consent for transportation of the [client] member to the program without an escort.

(5) [Clients] Members 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 not less than three and one half hours shall be documented behavioral health clinic services as defined in section 17b-262-818 of the Regulations of Connecticut State Agencies.

(7) A treatment day at an IOP shall include a minimum of three hours of scheduled programming, of which not less than two and one half hours shall be documented behavioral health clinic services

as defined in section 17b-262-818 of the Regulations of Connecticut State Agencies.

(8) [Psychotherapy] Each psychotherapy or [and] psycho-educational group [size] in an intermediate care [programs] program shall [be limited to 12] not exceed twelve participants, regardless of payer, except that psycho-educational group size for substance [abuse] use disorder related conditions shall [be limited to 24] not exceed twenty-four participants, regardless of payer, 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.

(f) Autism Spectrum Disorder Services.

(1) Pursuant to and to the extent authorized by sections 17b-262-1051 to 17b-262-1065, inclusive, of the Regulations of Connecticut State Agencies, a behavioral health clinic may bill the department for providing autism spectrum disorder services that are performed by individuals employed by or under contract to the behavioral health clinic.

(2) The behavioral health clinic shall ensure that all autism spectrum disorder services described in subdivision (1) of this subsection comply with sections 17b-262-1051 to 17b-262-1065, inclusive, of the Regulations of Connecticut State Agencies, including required qualifications for practitioners performing the services.

(g) Individual Tobacco Cessation Counseling. Individual tobacco cessation counseling services may be provided by any physician, registered nurse, APRN, physician assistant or AHP.

(h) Group Tobacco Cessation Counseling.

(1) Group tobacco cessation counseling services are scheduled professional counseling sessions designed to assist a member in ceasing the use of tobacco and shall include:

(A) Education on evidence-based methods for stopping the use of tobacco;

(B) Collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco and to prevent relapse;

(C) A plan for continued care following initial treatment; and

(D) Information and advice on the benefits of nicotine replacement therapy or other appropriate evidence-based pharmaceutical or behavioral adjuncts to quitting tobacco.

(2) A member may receive up to twenty-four group tobacco cessation counseling sessions from a behavioral health clinic in any 365-day period, which may be exceeded with prior authorization based on medical necessity.

(3) Each group tobacco cessation counseling session shall:

(A) Have not less than three and not more than twelve participants in the group, regardless of each participant's payment source;

(B) Last not less than forty-five minutes; and

(C) Be provided by an individual who complies with subdivision (4) of this subsection.

(4) Provider Qualifications.

(A) Individuals who provide group tobacco cessation counseling shall be trained in the specific counseling model that is used by the provider and that is approved by the department.

(B) Supervision of staff and progress notes written by the group facilitator shall comply with applicable licensure and accreditation requirements and other requirements applicable to the behavioral health clinic.

(5) Documentation. All tobacco cessation counseling services shall be documented accurately in the behavioral health clinic's medical record for each member who receives such services. The plan of care for group tobacco cessation counseling shall include an order for tobacco cessation services. The progress note for each group participant in group tobacco cessation counseling shall include the date of the group, the duration of the group, the actual start and stop time that the member attended the group, a summary of the content of the group session and the group facilitator's name and credentials.

Sec. 17b-262-823. Services not covered

The department shall not pay for the following:

(1) Information or services provided to a [client] member electronically or over the telephone, except for case management provided in accordance with section 17b-262-822 of the Regulations of Connecticut State Agencies or as otherwise specifically approved in writing by the department;

(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] member's condition; or for services not directly related to the [client's] member's diagnosis, symptoms or medical history;

(6) Any service not included in the plan of care [when treatment is recommended] , except for an initial evaluation and any covered crisis services on the behavioral health clinic fee schedule, if applicable;

(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 as children's rehabilitation services, as described in 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.

Sec. 17b-262-824. Need for service

(a) [Each client's care] In accordance with 42 CFR 440.90, as amended from time to time, behavioral health clinic services shall be provided by or under the direction of a physician directly employed by or under contract with the clinic. [The] A physician or other qualified licensed allied health professional working within such individual's scope of practice shall authorize the care provided and periodically review the need for continuing care.

(b) Psychiatric diagnostic evaluations shall be provided by [an] a qualified physician or allied health professional who is permitted to conduct such evaluations under the applicable clinic licensure category and within such individual's scope of practice.

(c) The psychiatric diagnostic evaluation shall be used in formulating the plan of care and shall be completed for each [client] member. The evaluation shall contain the following components:

(1) The [client's] member's mental status;

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

(3) Psychiatric or substance [abuse] use disorder history or updated psychiatric or substance [abuse] use disorder history for [clients] members who have previously been in the provider's care;

(4) Current medications, if indicated, medication history, or updated medication history for [clients] members 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 of the plan of care; and

(7) Treatment recommendations or [further disposition of the client] other recommendations for the member, including other services, if applicable.

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

(e) [The] A qualified physician, APRN, physician assistant, psychologist, LCSW, LMFT, LPC or

LADC shall review the evaluation and plan of care and sign the plan of care and [periodic reviews of the plan of care assuring] updates thereto not later than thirty days after such evaluation and plan of care or updates thereto are developed to ensure that the services are medically necessary.

(f) If treatment is not recommended, the physician, APRN, physician assistant, psychologist, LCSW, LMFT, LPC or LADC shall sign the evaluation. If treatment was recommended, any physician or AHP may sign the evaluation.

(g) The plan of care shall, at a minimum, meet the requirements, as applicable, of the individualized care plan as described in: section 19a-495-550 (k)(2)(C) of the Regulations of Connecticut State Agencies; the individualized program plan described in section 19a-495-570 (m)(6) of the Regulations of Connecticut State Agencies; or the individualized treatment plan as described in [section] sections 17a-20-42 to 17a-20-43, inclusive, of the Regulations of Connecticut State Agencies, as appropriate to the licensure of the service.

(h) A psychiatric office consultation shall be [billed] provided only by a qualified physician, [or] advanced practice registered nurse or physician assistant. When a psychiatric office consultation is the only service provided by the clinic, only a [written] note in the member's chart is required as documentation and a plan of care is not necessary. If an advanced practice registered nurse or physician assistant provides the service, the written note in the member's chart shall be [cosigned] co-signed by a physician not later than thirty days after the service is provided, except when the APRN is authorized to practice independently in accordance with section 20-87a of the Connecticut General Statutes or when a physician signature is not required in accordance with an APRN's collaboration agreement with a physician.

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

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

Sec. 17b-262-825. Authorization

(a) Behavioral health clinic services for [clients] members with psychiatric and substance [abuse] use disorders shall be subject to authorization requirements to the extent required by this section. Where a service is subject to authorization requirements, [Medicaid] CMAP payment for such service shall not be available unless the provider complies with such requirements.

(b) Services that require authorization shall be designated as such on the provider's fee schedule published [at www.ctdssmap.com] on the department's website or other designated location that is accessible to providers.

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

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

(2) In order to receive payment from the department, a provider shall comply with all authorization requirements. The department [or its agent], in its sole discretion, determines what information is necessary in order to approve an authorization request. Authorization does not, however, guarantee payment unless all other requirements for payment are met;

(3) 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 including, but not limited to, medical or social information adequate for evaluating medical necessity;

(4) 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;

(5) The provider shall maintain documentation adequate to support requests for continued authorization including, but not limited to: Progress made to date with respect to established

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treatment goals; the future gains expected from additional treatment; and medical or social information adequate for evaluating medical necessity; and

(6) 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.

(d) The following requirements shall apply to all services that require prior authorization:

(1) If prior authorization is needed beyond the initial or current authorization period, requests for prior authorization for continued treatment shall be submitted prior to the end of the current authorization period; and

(2) Except in emergency situations or for the purpose of initial assessment, prior authorization shall be received before services are rendered.

(e) The following requirements shall apply to all services provided to a [client] member whose eligibility is granted retroactively:

(1) A provider may request retroactive authorization, for services provided during the period of retroactive eligibility, from the department for a [client] member who is granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service; and

(2) For a [client] member who is granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall be responsible for initiating this review to enable retroactive authorization and payment for services[; and].

(f) The department may deny prior authorization, registration or retroactive authorization based on non-compliance by the provider with the department's utilization management policies and procedures.

Sec. 17b-262-826. Billing requirements

(a) [Claims shall be submitted by the providers on the department's designated form or electronically transmitted to the department's fiscal agent] The provider shall submit claims to the department in a form and manner specified by the department and shall include all information required by the department to process the claim for payment.

(b) The provider shall bill as instructed in writing by the department. The provider shall bill for a service only after having met the applicable requirements for payment for such service.

[(b)] (c) The provider shall bill its usual and customary charge for the services delivered, except as otherwise specified in writing by the department, including as set forth in section [17b-262-827(b)] 17b-262-827 of the Regulations of Connecticut State Agencies.

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] member is present for up to half of the intermediate care program day and attends [at least] not fewer than one individual, family or group session, the provider may bill half of the applicable [Medicaid] CMAP fee or rate. If the [client] member is present for more than a half of the intermediate care program day but less than a full day and attends [at least] not fewer than two individual, family or group sessions, the provider may bill the full day charge on file. If the [client] member does not attend [at least one] any individual, [group or] family or group session, the provider 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 medically necessary for the purpose of [client] member transition or continuity of care, as documented in the member's plan of care.

(d) If a session includes a combination of individual and family psychotherapy, the provider shall bill for the type of psychotherapy 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] each such category of psychotherapy.

(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] members at the clinic. [The] Only the clinic shall bill for the services, except as otherwise specifically provided in section [17b-262-460 (c)], 17b-262-460(c), 17b-262-475(a) and 17b-262-922(a) of the Regulations of Connecticut State Agencies.

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

(g) The department shall pay at the [lower] lowest 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[.];

(4) The provider's usual and customary charge to the public; or

(5) For laboratory services provided by the provider, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

(h) Enhanced Care Clinics. 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 provider submits a plan to the department that demonstrates the [feasibility of meeting] provider's ability to meet the special requirements for enhanced care clinics.

(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 to the department. If the department determines that the provider fails to comply with all applicable requirements after completing the probationary period and corrective action plan described in this subdivision, then the department shall remove the provider from eligibility for the higher payments described in this subsection.

(5) The department may [conduct provider audits] audit a provider to determine [whether a] if the

provider is [performing in compliance] complying with the [special] requirements of this subsection.

Sec. 17b-262-828. Documentation and audit requirements

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

(1) [Client's] Member's name, address, birth date and [Medicaid] CMAP 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[,] shall be signed by a qualified physician, APRN, physician assistant, psychologist, LCSW, LMFT, LPC or LADC not more than [30] thirty days after the initial evaluation[, that includes] and shall include the types and frequencies of treatment ordered. The qualified physician, APRN, physician assistant, psychologist, LCSW, LMFT, LPC or LADC shall also sign each update to the plan of care [at the time of] not more than thirty days after each periodic review [and when the plan of care is updated to reflect any change in the types of service]. When a physician, APRN, physician assistant, psychologist, LCSW, LMFT, LPC or LADC signs [off on] the plan of care or an update thereto, the signature indicates that the plan of care or update, as applicable, is valid, conducted properly and based on the evaluation and recommends services that are medically necessary;

(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 and the date the documentation was entered;

(5) The name and credentials of [the] each individual performing the services on that date; and

(6) Medication prescription and monitoring.

(b) The provider shall complete all necessary documentation related to providing a service, including, but not limited to, notes in the member's medical records, as soon as possible after providing the service, but in all cases, not more than thirty days after providing the service.

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

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

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

[(e)] (f) For intermediate care programs, a note shall document the duration and start and end times of each distinct therapeutic session or activity and progress toward treatment goals.

[(f)] (g) 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)] (h) For services performed by an unlicensed individual, [or] a non-certified individual, an LMSW or an individual in training[, progress notes entered pursuant to subsection (b) of this section shall be co-signed by the supervisor at least] evidence of weekly supervision for each [client] member in care [and] shall be documented in the member's chart and shall contain the name[,] and credentials of the supervisor, [and] the date of such [signature] supervision and the date signed. [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.] For members who attend therapy less frequently than weekly, supervision shall be documented for each scheduled treatment session.

[(h)] (i) For services provided by a certified individual, evidence of supervision for each member in care shall be documented in the member's chart at least monthly and shall contain the name, credentials and signature of the supervisor, the date of such supervision and the date signed. For members who attend therapy less frequently than monthly, supervision shall be documented for each scheduled treatment session.

(j) A supervisor's signature means that the supervisor attests to having provided supervision of the member's treatment in accordance with subsection (h) or subsection (i) of this section. The supervisor shall sign the document confirming that supervision occurred not later than thirty days after the supervision occurred.

(k) 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] member is taking that may be prescribed by non-clinic practitioners.

[(i)] (*l*) [All] The provider shall maintain all required documentation [shall be maintained] in its original electronic or hard copy form, as applicable, for [at least] not less than five years or longer [by the provider] in accordance with applicable statutes or regulations and subject to review by authorized department personnel. In the event of a dispute between the provider, the department, a third party or any combination thereof concerning a service provided, the provider shall maintain documentation [shall be maintained] concerning such service until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

[(j)] (m) [Failure] If the provider fails to maintain all required documentation, [shall result in the disallowance and recovery by] the department [of] shall disallow and recover any amounts paid to the provider for which the required documentation is not maintained or not provided to the department upon request.

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

[(*l*)](o) All documentation shall be entered legibly in ink or electronically and incorporated into the [client's] member's permanent medical record in a complete, prompt and accurate manner. All electronic signatures shall comply with applicable requirements and policies, including the department's policies contained as part of the provider's enrollment package with the department.

[(m)] (p) All documentation shall be made available to authorized department personnel upon request in accordance with [42 CFR §431.107] all applicable federal and state requirements, including, but not limited to, 42 CFR 431.107, as amended from time to time.

Statement of Purpose

The purpose of this regulation is to update the department's regulations regarding payment to behavioral health clinics.

(A) The problems, issues or circumstances that the regulation proposes to address: CMS informed the department that the payment methodology for chemical maintenance services provided by behavioral health clinics no longer complied with applicable federal Medicaid requirements. In order to implement the changes necessary to bring that methodology into compliance, the behavioral health clinic regulation needed to be amended. In addition, the regulation also needs to be updated to conform to changes in the clinical environment, including the addition of a new licensure category of LMSWs and the addition of new covered services of group tobacco cessation counseling services and autism spectrum disorder services.

(B) The main provisions of the regulation: (1) update definitions; (2) update requirements for supervision of practitioners working in the clinic, including LMSWs; (3) update requirements for chemical maintenance services, (4) add language regarding autism spectrum disorder services; (5) add language regarding individual and group tobacco cessation counseling services; and (6) update and clarify language throughout the regulation.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: This regulation updates the requirements for behavioral health clinics, including changes necessary to comply with federal Medicaid requirements for chemical maintenance services, updates to incorporate a new licensure category and new covered services, and general updates and clarifications to the regulation.

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