interChange Provider Important Message

Attention: CT BHP Behavioral Health Providers Enrolled in Independent Practice and Group Practice, Psychologists, Licensed Marital and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Alcohol and Drug Counselors (LADCs)

Behavioral Health Clinician Groups and Individual Clinicians in Independent Practice FAQ updated 09/11/2023:

*All red text is new for 9/11/2023

Attestation

Following the Connecticut Medical Assistance Program (CMAP) Provider Bulletin 2023-14, all behavioral health providers must complete an attestation form. The submission requirement began on April 11, 2023. The attestation provided by Gainwell Technologies confirms the acknowledgment of the provider enrollment agreement and other CMAP requirements.

1. Are there any training materials?
    A. Yes. This training materials are for reviewing and understanding of the Connecticut Medical Assistance Program (CMAP) policy regulations set forth by the Department of Social Services (DSS) that the providers will have to attest to it. Please refer to provider bulletin 2023-14 "New Attestation Requirement for Behavioral Health Clinician Groups and Solo Clinicians in Independent Practice" for additional information.

Recording

Presentation Slides

2. To whom is this training applicable?
    A. All licensed behavioral health clinicians: LCSW, LADC, LMFT, LPC, and Ph.D. and Psy.D. (Provider Type 33 – Behavioral Health Clinicians)
    B. Licensed practitioners (e.g., APRNs) are not required at this time.
    C. Autism Specialty providers, BCBAs, are not required at this time.

3. When will the attestation be made available?
    A. Providers with new enrollments after April 11, 2023, and re-enrollments between April and June of 2023, the attestation document will be available as part of their required to Follow on Documents

(FODs). Submission instructions will be noted within the documents from Gainwell.

B. Providers currently enrolled, Gainwell will notify providers directly in mid-June to access and sign the attestation form electronically. At that time providers will then have to log into their provider portal, click on the link to review the attached recorded training and then complete the electronic attestation.

C. On July 6, 2023, letters started to be sent out in a phased approach to roll out the new required attestation process to all behavioral health providers. Letters will be sent primarily using the eDelivery process.

   If you have not signed up for eDelivery (an eDelivery account is required to receive the letters electronically for this new requirement), please refer to PB 2019-15 "Implementation of Electronic Delivery of Letters - Replacement to the Mailing of Connecticut Medical Assistance Program Letters" to sign up for your eDelivery account. If you have not set up eDelivery then the letters will be mailed to the address on file for the clinician or group.

4. When can the providers complete the training and sign the attestation?
   A. On July 6, 2023, letters started to be sent out in a phased approach to roll out the new required attestation process to all behavioral health providers.

   B. Providers have 75 days from when they receive the notification letter to complete the attestation form. Failure by the due date on the letter will cause the claims to deny with EOB code 1047 "BH Billing Provider Attestation not valid on DOS and EOB code 1059 "BH Rendering Attestation not valid on DOS".

   C. If you have submitted a paper copy attestation and you are not actively enrolling or re-enrolling, please log into your secure Web portal account and submit the attestation online. Paper attestations will not be accepted outside of the Enrollment process.

   D. Providers with new or re-enrollments must sign and submit the attestation as part of their required Follow On Documents (FODs).

      Providers that are actively enrolling or re-enrolling fail to sign the paper attestation form will cause claims to deny in the future with the following EOB codes: 1043 "BH Billing Provider Attestation Needs to be

Signed" or EOB code 1046 "BH Rendering Attestation Needs to be Signed".

5. What instruction does the Provider Enrollment FOD contain?

   A. Provider to watch the Behavioral Health Clinic Training video and review training slides at Welcome | Carelon Behavioral Health of Connecticut (ctbhp.com) – this is the provider resource page. The BH training is under 'other resources.' **NOTE:** Provider will attest to watching the video and reviewing the slides on the Attestation for Behavioral Health Clinician Groups and Solo Clinicians in Independent Practice form.

   B. Attestation for Behavioral Health Clinician Groups and Solo Clinicians in Independent Practice (standard form provided by Gainwell Technologies as part of the provider follow on document).

6. I am a provider affiliated with a clinic or hospital. Who will sign as the 'owner' on the BH attestation?

   A. The owner does not need to sign off on the BH attestation if a provider is affiliated with a clinic or hospital—only the licensed clinician.

7. Are associate licensed clinicians required to sign the attestation?

   A. No. Associate licensed clinicians cannot enroll in CMAP and therefore do not need to sign the attestation. The licensed, enrolled, supervising provider signs the attestation and assumes responsibility for the services provided under their scope of practice. All licensed clinicians must sign the attestation, whether practicing independently or as part of a group practice.

8. I am getting a name mismatch/name not found error. How do I resolve this?

   A. We have identified situations where the signature is not matching the signed enrollment application because the enrollment application was signed with last name first and first name last, and the attestation form is being signed with first name first and last name last, or vice versa.

      We are working on a resolution that will look at the attestation signature both ways in trying to match with the enrollment application.

While we are working on the resolution, in order to successfully submit your attestation form you MUST sign the form the exact way you signed your enrollment application. If you signed your CT Medicaid enrollment form with your last name first and your first name last, then you must sign the attestation form the same way. Please review your enrollment PDF application prior to signing the attestation form to review how the application was signed by the clinician and how the owner's name was entered on the application.

Until the fix has been implemented, claims will not deny due to incomplete or denied attestations.

Claims and Billing Questions:

1. Can we bill for more than one (1) 90791 code?
    A. What if a member disengages and returns months later, and a new evaluation is required? The 90791 evaluation CPT code can only be billed once per member, per provider, per calendar year. However, certain circumstances may require an additional evaluation should the member leave treatment and return within a year. If the member returns due to a different behavioral health complexity and a new evaluation is required, clinical information must be well documented and explain the rationale for an additional evaluation.

2. Can a family and individual therapy session be billed on the same day? Can IOP and individual therapy be billed on the same?
    A. Yes, family and individual therapy can be billed on the same day as they are different services.
    B. Individual therapy and IOP can be billed on the same day as they are distinct and separate services.

3. I am billing for an individual and family therapy on the same claim, and they are denying for NCCI editing, how can I correct this?
    A. BH clinicians need to follow the CMS National Correct Coding Initiative (NCCI) editing. Please refer to provider bulletin 2015-86 "CMS National Correct Coding Initiative (NCCI)" for assistance, for some code pairs, modifiers maybe be used to bypass the edit.

4. What CPT code can be used for couples therapy?
    A. The 90847 code is applicable and inclusive of couples and family therapy.

5. Can two different providers bill for services on the same day for the same member?
    A. Yes. If services were provided to the same member by different providers, that is allowed to be billed.

6. Where can I find the billable procedure codes?
    A. Billable procedure codes are available at www.ctdssmap.com, under provider, then selecting Provider Fee Schedule Download. Scroll to 'I accept' at the bottom of the page; Behavioral Health Clinicians fee schedule is available as Behavioral Health Clinician CSV.

Authorization Questions:

1. Are outpatient evaluation authorizations required?
    A. Prior to September 1, 2022, prior authorization was required for the outpatient evaluation. Two units were made available to cover codes 90791 and 90792. Effective for dates of service on September 1, 2022, and forward, outpatient evaluation authorizations are no longer required. Claims may be billed directly to Gainwell.

2. Have authorization requirements changed for outpatient services?
    A. Authorization requirements remain the same. Please see the following bulletins for more information: Provider bulletin 2022-77 “Removal of Prior Authorization for Select Behavioral Health Services” and provider bulletin 2021-26 “REVISED Reinstating Prior Authorization Requirements that were Suspended During the Public Health Emergency”.

Policy, Procedure, and Regulation Questions:

1. When should treatment plans be updated?
    A. Treatment plans should be updated every six months to accommodate the member's needs and documented progress. Updates include detailed information about treatment, frequency, goals, and objectives.

2. How is medically necessary or medical necessity defined?
    A. As in section 17b-259b of the CT general statues, it "mean[s] those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or

other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition".

3. Is there available information on telehealth?
    A. The most up-to-date information on telehealth can be found in Provider Bulletin 2013-18, "New Guidance for Services Rendered via Telehealth under the Connecticut Medical Assistance Program (CMAP). Effective for dates of service, May 12, 2023, and forward, DSS will continue to reimburse for specified medical and behavioral health services when rendered as telehealth, as detailed in the CMAP telehealth table in the bulletin. Services noted within this bulletin detail the policy guidelines indicating coverage for audiovisual telehealth, audio only, or both for medically necessary services.

4. Can a provider be located out of state and provide services to Medicaid members via telehealth?
    A. An enrolled CMAP provider located out of state or in a border state must maintain an approved service location to perform eligible telehealth services even when the practitioner is not physically in person at one of the enrolled CT or border service locations at the time of service, so long as the provider remains in CT or the border state, or in the limited case of an approved out of state service that is not available in CT and comply with all state and federal regulations.

5. Can an electronic medical record (EMR) be utilized to reflect the start and stop times of services?

    A. Yes. If the EMR record documents session times, it is appropriate to use the times reflected.

6. How do we document time-based codes appropriately?
    A. In reporting individual psychotherapy, choose the code closest to the actual length of service. 90832 is equal to 30 minutes; the session must be at least 16 minutes long, or 37 minutes maximum, to use 90832. 90834 is equal to 45 minutes. The minimum length of time necessary is 38, maximum is 52 minutes to use this code. 90837 is equal to 60 minutes. The minimum to use this code is 53 minutes.
    B. Other types of psychotherapy that are time-based require at least 45 minutes.
        1. 90846, 90847, 90849, and 90853.

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Provider Assistance Information:

For support with:

1. Client & provider eligibility
2. Claim submission and processing
3. Provider enrollment
4. Fee schedules

Please contact the Provider Assistance Center at 1-800-842-8440 or visit www.ctdssmap.com.

Support for:

1. Clinical operations
2. Quality management
3. Covered services
4. Provider Trainings

Please contact Carelon Behavioral Health at 1-877-552-8247 or visit ctbhp@carelon.com.

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