



# Connecticut interChange MMIS

Provider Manual

## Chapter 7 - Licensed Behavioral Health Clinicians in Independent Practice

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## **Requirements for Payment of Services Provided by Licensed Behavioral Health Clinicians in Independent Practice**

### **Sec. 17b-262-912. Scope**

Sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of services performed by licensed behavioral health clinicians in independent practice for HUSKY C and HUSKY D clients under age twenty-one and HUSKY A clients of any age who are determined eligible to receive services under Connecticut's Medicaid program pursuant to sections 17b-261, 17b-261n and 17b-277 of the Connecticut General Statutes.

### **Sec. 17b-262-913. Definitions**

As used in sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes;
- (2) "Behavioral health clinician services" means preventive, diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed behavioral health clinician within the licensed behavioral health clinician's scope of practice under state law;
- (3) "Client" means a person who is eligible for goods or services under Medicaid and is a HUSKY C or HUSKY D member under age twenty-one or a HUSKY A member of any age;
- (4) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;
- (5) "Current treatment plan" means a treatment plan that has been reviewed and updated by the provider not more than six months before each treatment session;
- (6) "Department" means the Department of Social Services or its agent;
- (7) "Early and Periodic Screening, Diagnostic and Treatment Services" or "EPSDT Services" means the services described in 42 USC 1396d(r)(5);
- (8) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services that are not covered under the Medicaid State Plan but are covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is (A) medically necessary, (B) the need for the service is identified in an EPSDT screen, (C) the service is provided by a participating provider and (D) the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;

- (9) “Federally qualified health center” has the same meaning as provided in 42 USC 1396d(l);
- (10) “Home” means a client’s place of residence, including, but not limited to, a boarding house, community living arrangement, nursing facility or residential care home. “Home” does not include facilities such as hospitals, chronic disease hospitals, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;
- (11) “HUSKY A” means the Medicaid coverage groups for children, caretaker relatives and pregnant women authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to sections 17b-261 and 17b-277 of the Connecticut General Statutes;
- (12) “HUSKY C” means the Medicaid coverage groups for the aged, blind and disabled authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to section 17b-261 of the Connecticut General Statutes;
- (13) “HUSKY D” means the Medicaid coverage groups for low-income adults authorized by 42 USC 1396a(a)(10)(A)(i)(VIII) and operated pursuant to section 17b-261n of the Connecticut General Statutes, formerly referred to as the State-Administered General Assistance program;
- (14) “Licensed alcohol and drug counselor” means an individual licensed pursuant to section 20-74s of the Connecticut General Statutes;
- (15) “Licensed behavioral health clinician” means a licensed alcohol and drug counselor, licensed marital and family therapist, licensed clinical social worker or licensed professional counselor;
- (16) “Licensed clinical social worker” means a person licensed pursuant to section 20-195n of the Connecticut General Statutes;
- (17) “Licensed marital and family therapist” means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;
- (18) “Licensed professional counselor” means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;
- (19) “Licensed practitioner” means a physician, APRN or physician assistant;
- (20) “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;

- (21) “Medical necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (22) “Physician” means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes;
- (23) “Physician assistant” means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;
- (24) “Prior authorization” means the department’s approval for the provision of a service before a provider actually provides such service, except where section 17b-262-920 of the Regulations of Connecticut State Agencies specifically authorizes the department to grant prior authorization before paying for a service but after the provider has provided such service;
- (25) “Provider” means a licensed behavioral health clinician enrolled in Medicaid pursuant to a valid provider agreement with the department;
- (26) “Provider agreement” means the signed, written agreement between the department and the provider for enrollment in Medicaid;
- (27) “Registration” means the process of notifying the department of the initiation of a behavioral health clinician service, including evaluation findings and plan of care information;
- (28) “State Plan” means the current Medicaid coverage and eligibility plan established, submitted and maintained by the department and approved by the Centers for Medicare and Medicaid Services in accordance with 42 CFR 430, Subpart B;
- (29) “Treatment plan” means a written individualized plan developed and updated in accordance with section 17b-262-919 of the Regulations of Connecticut State Agencies that contains the type, amount, frequency and duration of services to be provided, and measurable goals and objectives developed in collaboration with the client after evaluation, in order to improve the client’s condition to the point that treatment by the licensed behavioral health clinician no longer becomes necessary, aside from occasional follow-up or maintenance visits; and
- (30) “Utilization management” means the prospective, retrospective or concurrent assessment of the medical necessity of services given, or proposed to be given, to a client.

#### **Sec. 17b-262-914. Provider Participation**

In order to enroll in Medicaid and receive payment from the department, a provider shall:

- (1) Comply with all applicable licensing, accreditation and certification requirements;

- (2) comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;
- (3) comply with sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies; and
- (4) have a valid provider agreement on file with the department.

**Sec. 17b-262-915. Eligibility**

The department shall pay for medically necessary behavioral health clinician services provided to clients eligible for such services, subject to the conditions and limitations that apply to these services.

**Sec. 17b-262-916. Services Covered**

The department shall pay only for behavioral health clinician services that are:

- (1) Within the licensed behavioral health clinician's scope of practice as defined by chapters 376b, 383a, 383b or 383c of the Connecticut General Statutes, as applicable to the behavioral health clinician; and
- (2) medically necessary to treat the client's condition.

**Sec. 17b-262-917. Service Limitations**

The department shall pay for covered services only in accordance with the treatment plan and with the following additional limits:

- (1) Only one diagnostic interview in any twelve-month period per licensed behavioral health clinician per client;
- (2) only one unit of individual counseling or individual psychotherapy per client, per day;
- (3) only one unit of family counseling or family psychotherapy per client, per day;
- (4) only one unit of group counseling or group psychotherapy per client, per day;
- (5) group psychotherapy sessions shall include a maximum of twelve participants per group session, to the extent clinically appropriate, regardless of each participant's payment source, and the provider shall document the number of participants in each session in the client's chart;
- (6) family, group and multiple-family group psychotherapy sessions shall be at least forty-five minutes in length, and the provider shall document the length of time of each session in the client's chart;

- (7) family and multiple-family group psychotherapy shall be reimbursable for one identified family member client per session, without regard to the number of family members in attendance or the presence of behavioral health conditions among other family members in attendance; and
- (8) multiple-family group psychotherapy shall include a maximum of twenty-four participants per group regardless of each participant's payment source, shall include members of at least two unrelated families and the provider shall document the number of participants in each session in the client's chart.

**Sec. 17b-262-918. Services Not Covered**

The department shall not pay for the following behavioral health clinician services:

- (1) Information or services furnished by the licensed behavioral health clinician to the client electronically or over the telephone, except for case management services provided to clients age eighteen and under;
- (2) case management services provided to clients age nineteen and older;
- (3) evaluations, diagnostic interviews and therapy services performed in hospital inpatient or outpatient settings;
- (4) concurrent services involving the same treatment modalities for the same client by different health professionals;
- (5) cancelled office visits or appointments not kept;
- (6) services, treatment or items for which the provider does not usually charge;
- (7) behavioral health clinician services in excess of those medically necessary to treat the client's condition;
- (8) services not directly related to the client's diagnosis, symptoms or medical history;
- (9) services provided by anyone other than the provider; and
- (10) services that are primarily for vocational or educational guidance.

**Sec. 17b-262-919. Need for Service and Treatment Plan**

The department shall pay for medically necessary behavioral health clinician services. The provider shall establish a treatment plan for each client based on the initial diagnostic evaluation before commencing treatment and shall regularly update the treatment plan in accordance with the client's progress as necessary and at least every six months. Notwithstanding section 17b-

962-917 of the Regulations of Connecticut State Agencies, the department shall pay for an initial diagnostic evaluation in order to enable the licensed behavioral health clinician to develop the treatment plan. The treatment plan shall specify the treatment modalities and frequency of care necessary to meet the client's needs, identify measurable outcomes to be achieved and identify any medical providers with whom the licensed behavioral health clinician is coordinating care.

**Sec. 17b-262-920. Prior Authorization and Registration**

- (a) Where a service requires prior authorization or registration under this section, the department shall not pay for such service unless the provider complies with this section and all of the department's requirements for prior authorization or registration, as applicable.
- (b) The department shall designate services that require prior authorization or registration in the department's fee schedule or on the department's website or by other means accessible to providers, with advance notice given to providers before changing the prior authorization or registration requirements. Registration may serve in lieu of prior authorization only if the department designates a service as requiring registration but not prior authorization. Prior authorization is also required for:
  - (1) Any service that is not in the department's fee schedule; and
  - (2) EPSDT Special Services.
- (c) The following requirements shall apply to all services that require prior authorization or registration under subsections (a) and (b) of this section:
  - (1) The initial prior authorization or registration period shall be based on the client's needs;
  - (2) if prior authorization is needed beyond the initial or current prior authorization period, the provider shall submit a request to the department to extend the prior authorization before the end of the current prior authorization period;
  - (3) except as provided in subdivision (9) of this subsection or for the purpose of initial assessment, the provider shall receive prior authorization before rendering services or submit complete registration information to the department within the timeframes established by the department and posted on the department's website;
  - (4) in order to receive payment from the department, a provider shall comply with all prior authorization and registration requirements. The department, in its sole discretion, determines what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met;

- (5) a provider shall present medical or social information adequate to evaluate medical necessity when requesting prior authorization. The provider shall maintain documentation adequate to support requests for prior authorization and registration including, but not limited to, medical or social information adequate to evaluate medical necessity;
- (6) requests for prior authorization for continued services shall include: progress made to date with respect to established treatment goals; future gains expected from additional treatment; and medical or social information adequate to evaluate medical necessity;
- (7) the provider shall maintain documentation adequate to support requests for continued prior 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 to evaluate medical necessity;
- (8) the department may require a review of the discharge plan and actions taken to support successful implementation of the discharge plan as a condition of prior authorization;
- (9) a provider may request retrospective prior authorization from the department before payment has been made but after a service has been provided for clients who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service;
- (10) for clients who are granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall initiate this review to enable authorization and payment for services;
- (11) for all prior authorization requests for EPSDT Special Services, a provider shall attach a physical or electronic copy of a prescription signed by a licensed practitioner acting within the licensed practitioner's scope of practice under state law or an order signed by a licensed behavioral health clinician acting within the licensed behavioral health clinician's scope of practice under state law. The provider shall keep the original prescription or order on file and subject to the department's review; and
- (12) the department may deny prior authorization or registration if the provider does not comply with utilization management policies and procedures.

#### **Sec. 17b-262-921 Billing Procedures**

- (a) Providers shall submit claims on the department's designated form or by electronic transmission as established by the department and shall include all information required by the department to process the claim for payment.



- (b) The amount billed to the department shall represent the licensed behavioral health clinician's usual and customary charge for the services provided.
- (c) When a licensed behavioral health clinician is requested to attend a staff conference for a client, the name of the referring practitioner, clinic or agency shall be entered in the appropriate section of the claim form.

**Sec. 17b-262-922. Payment**

- (a) Licensed behavioral health clinicians who are fully or partially compensated by a Medicaid participating general hospital, public or private institution, freestanding clinic or federally qualified health center shall not receive payment from the department for services rendered at such entities unless the licensed behavioral health clinician maintains an office for private practice at a separate location from the entity referenced above where the licensed behavioral health clinician is employed. The licensed behavioral health clinician shall bill the department only for a service provided to a client whose overall treatment is provided through the provider's private practice, although each individual service may be provided either at the practice, the client's home or in the community.
- (b) Payment for services directly performed by a licensed behavioral health clinician in private practice shall be made at the lowest of:
  - (1) The provider's usual and customary charge;
  - (2) the lowest Medicare rate; or
  - (3) the amount in the department's applicable fee schedule.

**Sec. 17b-262-923. Payment Rate**

The commissioner shall establish, update and publish the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

**Sec. 17b-262-924. Payment Limitations**

- (a) The fees for a diagnostic interview examination, as stipulated in the department's applicable fee schedule, represent one unit of service. The provider shall bill for only one unit of service for a diagnostic interview examination regardless of the number of days it takes to complete.
- (b) If a session includes a combination of individual and family psychotherapy, the provider shall bill for the modality that comprises the greater part of the session. The provider shall not bill for both individual and family psychotherapy for the same date of service

unless each modality individually meets the minimum time requirement for the modality specified in the department's fee schedule or in section 17b-262-917 of the Regulations of Connecticut State Agencies.

**Sec. 17b-262-925. Documentation**

- (a) Providers shall maintain (1) a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan signed by the licensed behavioral health clinician and (2) documentation of services provided, including, types of service or modalities, date of service, location of the service and the start and stop time of the service.
- (b) For treatment services, the provider shall document the treatment intervention and progress with respect to the client's goals as identified in the treatment plan.
- (c) Providers shall maintain all required documentation in its original form for a minimum of five years or longer if required by applicable statutes and regulations, subject to review by the department. In the event of a dispute concerning a service provided, the provider shall maintain documentation until the end of the dispute, five years or the time required by applicable statutes and regulations, whichever is greater.
- (d) The department may disallow and recover any amounts paid to the provider for which required documentation is not maintained and provided to the department upon request.
- (e) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.
- (f) Providers shall make all entries in ink or electronically and shall incorporate all documentation into a client's permanent medical record in a complete, prompt and accurate manner.
- (g) Providers shall make all documentation available to the department upon request in accordance with 42 CFR 431.107.