2017

Project SAFE

Substance Abuse Family Evaluation

Preferred Practice Standards

Revised October 2017

Contents

Project SAFE

Key Contact Information

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Project SAFE Referral Line (24 hours)……1-800-272-0097
Main Number ……1-860-638-5309
Billing Department……1-860-704-6144
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Advanced Behavioral Health Website:
https://www.abhct.com/

Department of Children and Families Website:
http://www.ct.gov/dcf/

Department of Mental Health and Addiction Services Website:
http://www.ct.gov/DMHAS/

Welcome to Project SAFE

Welcome to the Advanced Behavioral Health (ABH®) Project SAFE Provider Network. As a member of the Project SAFE Provider Network, you have joined a group of highly respected Behavioral Health professionals. We recognize that you share our commitment to improve our clients' quality of life by providing a continuum of high quality, accessible behavioral health care services.

This Preferred Practice Standards (PPS) handbook has been developed to inform you of standard practice of Providers in the ABH® Project SAFE Network. The handbook includes an introduction to Project SAFE policies and procedures for referral, authorization, claims submission, and the complaints, grievances, and appeals process. Finally, the necessary forms are included at the conclusion of this document for your convenience. Services provided for ABH® Project SAFE clients must be consistent with the practices in this handbook. Should you have any questions, please contact ABH® Project SAFE at 1-800-272-0097.

History

The Department of Children and Families (DCF) initiated Project SAFE (Substance Abuse Family Evaluation) in 1995 as a way to connect its child protection system with the adult substance abuse treatment system. DCF contracted with ABH® to coordinate central intake and priority access to drug screening, evaluation, and ambulatory treatment for substance abusing primary caregivers of children receiving DCF services. DCF began collaborating with the Department of Mental Health and Addiction Services (DMHAS) in October 1999 to identify and address substance abuse issues more effectively and to coordinate state, federal, and private resources to meet the needs of these populations.

Program Overview

Project SAFE is a program designed to provide priority access to substance abuse evaluations and outpatient treatment services. Clients are eligible for Project SAFE services if they meet the following criteria:

- Parent or Primary Caregiver involved in DCF Child Protective Services.
- DCF has identified that substance use/abuse may be affecting the referred individual's ability to parent effectively and substance abuse treatment or further evaluation is needed.
- A Project SAFE Referral has been made by the DCF Social Worker, prior to any treatment and /or evaluation service.

Funding for Project SAFE services is provided by DCF and DMHAS and administered by ABH®. This funding system is designed as a **payer of last resort**. The term 'payer of last resort' indicates that the Project SAFE funds are used to reimburse Providers on a fee-for-service basis **when there is no other source of reimbursement available**.

Project SAFE Covered Services

There are a variety of services that are reimbursed under Project SAFE's payer of last resort system. In the following section, we will define all services covered by Project SAFE.

There are nine basic treatment services that are reimbursable within Project SAFE

- Evaluation
- Individual Therapy (SA I.1)
- Group Therapy (SA I.1)
- Family Therapy (SA I.1)
- Intensive Outpatient Therapy (IOP) (SA II.1)
- Partial Hospitalization Program (PHP) (SA II.5)
- Urine Drug Screens
- Hair Testing

The following section contains a description of these services.

Evaluation
Clients are referred for a Project SAFE evaluation because the DCF Social Worker has found reason to believe that the individual's ability to parent effectively may be impaired as a result of his/her substance use. The evaluation is conducted by an approved Project SAFE Provider and consists of a bio-psychosocial assessment focusing on the following areas:

- Demographic information
- Family composition and history
- Substance abuse history
- Mental health and trauma history
- Treatment history
- Medical history and current medical status
- DSM V Diagnostic formulation
- Drug screen results
- Summary and recommendations

Each evaluation should contain a written narrative in the aforementioned areas.

Once the evaluation is completed by the Provider, the results of the evaluation should be **verbally** communicated to the DCF Social Worker within **twenty-four (24) hours (one business day)** of its completion. A written clinical summary should be forwarded to the DCF Social Worker within **five (5) business days** of the evaluation.

When the evaluation recommendation concludes **"No Treatment Recommended,"** the Provider should **verbally** communicate the results to **the DCF Social Worker** and **RRG** within **twenty-four (24) hours (one business day)** to solicit additional information pertinent to the final

recommendation**. DCF** should respond to the Provider with additional details within **twenty-four (24) hours.**

Individual Therapy
Individual therapy consists of one-to-one therapy in duration of up to one hour, with a frequency of no more than once weekly and no less than once per month. Treatment focuses on assisting the individual in recovery, building recovery capital, reducing symptoms, improving function, maintaining abstinence and relapse prevention.

Group Therapy
Group therapy consists of therapy in duration of up to one and a half hours, with a frequency of once or twice weekly. Treatment focuses on assisting the individual in recovery, building recovery capital, reducing symptoms, providing psycho-education, improving functioning, relapse prevention and maintenance of abstinence. Groups should be limited to no more than twelve (12) clients per group session.

Family Therapy
Family therapy consists of therapy sessions with a client and one or more individual(s) identified by the client as family, with duration of up to one hour and frequency of no more than once weekly. Treatment focuses on building and maintaining supports for recovery, improving relationships, reducing symptoms, providing psycho-education and maintenance of abstinence and sustaining recovery.

Intensive Outpatient Therapy (IOP)
IOP is a non-residential service provided in a general hospital, a private freestanding psychiatric hospital, a state-operated facility or by a Provider that is a non-profit entity that involves ambulatory intensive psychiatric and/or substance abuse treatment services. IOP services provides each client with **three to four (3-4) hours per day, three to five (3-5) days per week** of clinically intensive programming, based on an individualized treatment plan. Treatment focuses on assisting the individual in recovery, building recovery capital, reducing symptoms, improving functioning, maintaining community connection and relapse prevention. As a client is preparing for discharge, titration of IOP visits may occur, decreasing the frequency to less than three (3) times per week. IOP must include one (1) therapy session per day, inclusive of (at least) one (1) individual therapy session per week. Random drug screens can be completed on the same day that a patient attends and are reimbursed separately.

Partial Hospitalization Program (PHP)
PHP is a non-residential service provided in a general hospital, a private freestanding psychiatric hospital, a state operated facility or by a Provider that is a non-profit entity that involves ambulatory intensive psychiatric and/or substance abuse treatment services. PHP services are designed to serve individuals with significant impairment resulting from substance abuse as well as co-occurring psychiatric disorders. These services target adults who have recently been discharged from inpatient facilities or whose admission to inpatient care may be prevented by treatment in a PHP program and must be pre-authorized by Project SAFE. PHP consists of

therapeutic programming of **a minimum of four (4) hours per day, at least four (4) days per week**, based on a comprehensive and coordinated individualized treatment plan involving the use of multiple concurrent treatment services and modalities. Treatment focuses on assisting the individual in recovery, building recovery capital, reducing symptoms, improving functioning, maintaining community connection, and relapse prevention. As a client is preparing for discharge, titration of PHP may occur, decreasing the frequency to less than four (4) times per week. PHP must include one (1) therapy session per day, inclusive of (at least) one (1) individual therapy session per week. Random drug screens can be completed on the same day that a patient attends and are reimbursed separately.

Urine Drug Screens
Urine drug screens are used to determine the recent use/abuse of substances. The DCF Social Worker may make a referral for one (1) drug screen or for a series of random drug screens. Outpatient treatment through Project SAFE includes urine drug screens.

- **Single Urine Drug Screen** - A referral for one (1) drug screen is usually made at the time of the referral for a Project SAFE evaluation.

- **Random Urine Drug Screens** - Random urine drug screens are defined as two (2) urine drug screens per week for a period of six (6) weeks. Random screens should not occur on the same day and time each week. In order for the screens to be random, the treatment Provider should contact the client and ask him/her to come in within the next twenty-four (24) hours for a drug screen. Random drug screens may be requested by DCF under the following circumstances:

    - In response to a court-ordered request
    - When a substance abuse evaluation has already been completed within the past six (6) months.
    - On a case by case basis

Hair Testing
Hair testing is utilized to determine a three-month history of substance use/abuse prior to the hair test. Hair testing requires special prior authorization from DCF. Careful collection of samples by authorized treatment Providers following collection guidelines is necessary to ensure effective use of hair testing. **Positive** hair test results can be further analyzed to determine if the client's use/abuse of substances occurred within 30/60/90 days prior to collection. This multi-sectional testing can be performed on a positive sample of hair (collected from the head only – body hair collection cannot be segmented) per request of the referring DCF Social Worker or Provider. A hair test may be requested for some of the following reasons:

- DCF or Provider staff has reason to believe that the client has attempted to alter the urine drug screens.
- The client has failed to keep scheduled appointments, complete random urine drug screens, and/or engage in recommended substance abuse treatment.

- DCF Central or Area Office has concerns about a particular high risk or high profile case.
- DCF staff identifies cases in which domestic violence is connected with substance abuse.
- The Court requires documentation of historical drug use during a 30/60/90 day period.
- DCF staff identifies abuse/neglect cases in which the primary caregivers are said to be in recovery from substance abuse.
- Family reunification planning is expected to occur in the immediate future.

Treatment Levels of Care

In this section, guidelines adapted from the ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised (ASAM PPC-2R), published by the American Society of Addiction Medicine ASAM in 2001, are used to define treatment levels of care. Each level of care has general characteristics and criteria. Project SAFE provides reimbursement to Providers for the following outpatient levels of care:

- Outpatient Services – Level I SA1.1
  - Individual Counseling, Family Counseling, Group Counseling, Urine Screens, and Hair test
- Intensive Outpatient Services – Level II, SA II.1
- Partial Hospitalization Program Services – Level II, SA II.5

In an effort to provide general guidelines, this Preferred Practices document includes a level of care table, **(See *Level of Care Guide Tables I-III*).** It is intended as a guide for clinical practice rather than a set of rules.

Service Limitations and Exclusions

The following limitations shall apply to substance abuse services performed under Project SAFE:

- Covered services and procedures are limited to those listed in the Project SAFE fee schedule

- At the time of initial referral from the DCF Social Worker, the following types of services can be authorized:
  - One (1) evaluation
  - One (1) urine drug screen
  - Twelve (12) random drug screens
  - One (1) hair test
  - Outpatient SA I.1 levels of care following a Project SAFE evaluation which recommends outpatient SA treatment or as a step down from a higher level of care.

Reimbursement for the following behavioral health services is **excluded** under Project SAFE:

- Psychiatric evaluation
- Medication Management
- Medication Assisted Treatment e.g., methadone maintenance, Suboxone
- Psychological Assessment
- Services that Project SAFE, DCF and DMHAS determine are not directly related to the diagnosis and treatment of a behavioral health disorder or those that do not reduce symptoms and/or psychological distress.
- Services, consultation or information provided over the telephone.
- Services that Project SAFE, DCF and DMHAS determine are primarily for vocational or educational guidance or that are related solely to a specific employment opportunity, work skill work setting and/or the development of an academic skill.
- Breathalyzer testing
- Inpatient or Residential levels of care

Project SAFE also does not reimburse for any required co-pays.

Level of Care Guide (Table I)

Level I: (SA I.1) Outpatient

Level of Care Guide		
Level of Care	**ASAM Dimension**	**Description of General Criteria**
Level I: (SA I.1) Outpatient	**Dimension 1**	Patient has no signs and symptoms of withdrawal.
	Dimension 2	If any biomedical conditions are present, they are sufficiently stable to permit participation in outpatient treatment.
	Dimension 3	Any symptoms of a co-occurring disorder are generally stable, may require some monitoring and do not interfere with the patient's ability to focus on addiction treatment issues. Mental status does not preclude ability to understand information, and participate in treatment.
	Dimension 4	Patient is willing to participate and cooperate with treatment, acknowledges that he or she has a substance–related problem and wants to change. If having difficulty with the above, the patient may need monitoring.
	Dimension 5	Patient is able to achieve abstinence and/or an awareness of a substance related problem
	Dimension 6	The patient's psychosocial environment is sufficient to support treatment feasibility.

Level of Care Guide (Table II)

Level II: (SA II.1 & MH II.1) Intensive Outpatient (IOP)

Level of Care Guide		
Level of Care Guide		
Level of Care	**ASAM Dimension**	**Description of general criteria**
Level II: (SA II.1) Intensive Outpatient (IOP)	**Dimension 1**	Patient has no signs and symptoms of withdrawal.
	Dimension 2	If any biomedical conditions are present, they are sufficiently stable to permit participation in outpatient treatment.
	Dimension 3	Patient engages in abuse of family members or significant others and requires intensive outpatient treatment to reduce the risk of further deterioration, *or* the patient has a diagnosis requiring intensive outpatient monitoring to minimize distractions from recovery. **Patients meeting Dimension 3 description require dual diagnosis treatment.**
	Dimension 4	Efforts at outpatient level (SA I.1 or MH I.1) have failed to promote recovery, **or** although the patient is willing to participate, his/her perspective inhibits ability to make behavior change with repeated structured intervention.
	Dimension 5	The patient has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms, **and** his or her level of functioning is deteriorating.
	Dimension 6	The patient lacks social contacts so as to jeopardized recovery **and/or** continued exposure to school, work, or living environment will render recovery unlikely.

Level of Care	ASAM Dimension	Description of general criteria
Level II: (SA II.5) Partial Hospital & SA Day/Evening	**Dimension 1**	Patient has no signs and symptoms of withdrawal.
	Dimension 2	If any biomedical conditions are present, they are sufficiently stable to permit participation in outpatient treatment; however they may provide distraction from recovery efforts.
	Dimension 3	The patient's mental status history is characterized by a mild to moderate psychiatric decompensation on discontinuation of the drug(s) of abuse. **Patients meeting Dimension 3 description require dual diagnosis treatment.**
	Dimension 4	Efforts at another treatment level have failed and structured programmatic milieu interventions are not likely to succeed at Level II.1, **or**, although the patient is willing to participate, his/her perspective and lack of impulse control inhibits ability to make behavior change with repeated structured intervention.
	Dimension 5	The patient has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms, **and** his or her level of functioning is deteriorating; ***or*** a lack of awareness of relapse triggers creates is a high likelihood of relapse.
	Dimension 6	The patient's family members or significant others, who live with the patient, are not supportive of recovery goals, **and** continued exposure to school, work, or living environment will render recovery unlikely.

Level of Care Guide (Table III) Level II: SAI I.5 & MH II.5 Partial Hospital & SA Day/Evening

Referral and Authorization Process

Project SAFE requires close coordination and cooperation between DCF, Providers, and ABH®. There are a variety of procedures each party is required to follow. The following section outlines what ABH®, DCF and/or the Provider are required to do in order that clients receive services in an efficient, professional, and timely manner.

Service Authorization and Referral Process for Covered Services

One of Project SAFE's goals is to ensure that adults involved in the child welfare system have priority access to substance abuse evaluations, drug screening, and outpatient services. By definition, **Priority Access** means once contacted with an evaluation referral, the Provider will offer an evaluation appointment within five (5) business days, whenever possible. If requests are urgent, the Provider should attempt to offer an appointment within twenty-four (24) hours. The following section sets forth the general requirements for referrals and service authorization for service types and levels of care.

- **Initial Referral:** An initial referral is the first time any DCF Worker has called ABH® Project SAFE regarding an identified client to make a referral.
    - An initial referral must be made to ABH® in order for an individual to be considered a Project SAFE client.
    - The DCF Social Worker must obtain a **release of information** for ABH® and the treatment Provider the client is being referred to prior to making the referral.
    - A referral will only be accepted from a DCF Social Worker or other DCF designated staff (Supervisor, Area Resource Group, Central Office).
    - To make a referral, the DCF Social Worker calls the ABH® Project SAFE Referral Line (1-800-272-0097).
    - The DCF worker will be asked a series of questions including which Provider they would like the client to see.
    - The Project SAFE Intake Coordinator(s) will enter the information into the database, creating a Project SAFE Client ID number and electronic record. The electronic record will include demographic information, substance use concern(s) as identified by the DCF Social Worker, and an initial authorization for the service/services being requested.
    - The Project SAFE intake coordinator will then securely transmit the referral (which also serves as the authorization) to the specified Project SAFE Provider.

- **Evaluation:** The DCF Social Worker requests an evaluation once the DCF substance abuse screen and/or a consult with RRG staff is completed and/or there is suspicion that the individuals' ability to parent effectively is impaired as a result of substance use. To include a urine drug screen as part of the evaluation, the DCF Social Worker should also request one (1) urine drug screen.

- Prior to making the ABH® Project SAFE referral, the DCF Social Worker will obtain a release of information from the client for Advanced Behavioral Health and the Provider.
- The DCF Social Worker calls the Project SAFE Referral Line at 1-800-272-0097.
- The DCF Social Worker will provide basic demographics, reason for referral, and any updated information.
- Once the Telephonic referral is completed, the Project SAFE Intake Coordinator will fax the ***Client Referral Form [Appendix A]*** to the Project SAFE Provider. This serves as an authorization for the evaluation.
- The DCF Social Worker should fax the signed release of information to the Provider. **Providers will be unable to schedule an appointment without a signed release of information.**
- The Provider should verify the client's health insurance using the EDS or other means. If the client has insurance, the Provider should submit a claim to **both ABH® Project SAFE and the client's health insurance carrier**. ABH® Project SAFE is the payer of last resort.
- The preferred location for conducting evaluations is at the Provider's place of business; in addition, the Provider is expected to conduct a chain of custody urine screen.
- Upon completing the evaluation, results should be verbally communicated to the DCF Social Worker within twenty-four (24) hours (one business day). When the evaluation results indicate "No Treatment Recommended," the Provider should contact the DCF Social Worker and RRG for any additional information pertinent to the final recommendation. DCF should respond to the Provider within twenty-four (24) hours with necessary information.
- A written clinical summary should follow this verbal communication within five (5) business days. The summary should contain the following minimum information:

    - Demographic information
    - Family composition and history
    - Substance abuse history
    - Mental health and trauma history
    - Medical history and current medical status
    - DSM V TR Diagnostic formulation
    - Drug screen results
    - Treatment recommendations

- Upon completion of the evaluation, Providers are responsible for entering the following information through the Project SAFE web-based system:

    - ***Client Report Form*** [***Appendix B***]
    - ***Needs Assessment Form (for females only)*** [***Appendix C***]
    - ***TANF Eligibility Form*** [***Appendix D***]
    - OTR completed if the Provider is recommending IOP or PHP levels of care.

- The Provider must inform the DCF Social Worker within twenty- four (24) hours when a client fails to show for a drug screen and/or evaluation before rescheduling. It should be decided jointly who will contact the client to reschedule. While reasonable efforts should be made to provide priority access, the Provider may apply their agency's policy regarding rescheduling if a client has a history of "no shows" with the assigned Project SAFE Provider. The appointment must be rescheduled and the client seen within forty-five (45) days of the date of the original referral date. If this does not occur, the DCF Social Worker has to make another referral by calling the Project SAFE Referral Line, at 1-800-272-0097.

- **Outpatient 1.1 levels of care:** There are three (3) basic outpatient services that are reimbursable within Project SAFE, individual psychotherapy, group counseling, and family counseling**.**
  - When the client completes a Project SAFE evaluation and is recommended for outpatient 1.1 levels of care, a "Treatment Only" referral, through Project SAFE, is automatically generated by ABH®, when the treatment begins within the initial 45 day authorization period. All treatment referrals include an authorization for random drug screens.
  - If the treatment does **not** begin within the initial forty-five (45) day authorization period, the DCF Social Worker must make a telephonic referral for "Treatment Only", by calling the ABH® Project SAFE Referral Line at 1-800 272-0097.
  - The ABH® Project SAFE Intake Coordinator will enter the "Treatment Only" referral information into the Project SAFE data system and fax the referral to the Provider.
  - The "Treatment Only" authorization will allow the Provider to receive reimbursement for the provision of individual, group and /or family/couple counseling treatment and random drug screens.
  - The Provider should notify the DCF Social Worker when a referral lapses beyond the 45-day limit to request that the DCF Social Worker call in a "Treatment Only" referral.
  - The Provider is to notify the DCF Social Worker if the client does not show for his/her treatment appointment.
  - The Provider should regularly report to DCF the course of the client's treatment.

- **IOP:** IOP services provide each client with three to four (3-4) hours per day, three to five (3-5) days per week of clinically intensive programming based on an individualized treatment plan.
  - IOP services may be recommended based on an evaluation that has been completed within six (6) months of the service request.
  - The client must have an active Project SAFE referral, i.e., treatment begins after the completion of a Project SAFE evaluation **and** within the forty-five (45) day period of authorization of the PS evaluation **or** the DCF SW has made a Project SAFE "Treatment Only" referral.

- The Provider must complete an OTR and send it to ABH® via facsimile at 860-638-5302. The OTR can be downloaded from the following web address: www.abhct.com (for process see ***Appendix E***).
- Services will be authorized based on a Utilization Review process.
- Clinical staff at ABH® will review all OTR information for clinical appropriateness and Provider compliance with submission criteria.
    - **Submission criteria**:
        - The OTR should be completed in its entirety.
        - The OTR should be submitted prior to admission to the IOP level of care.
        - The Provider should promptly respond to any inquiries for supporting clinical information.
- ABH® will help to educate treatment Providers about clinically appropriate treatment planning and decision-making processes regarding level of care, and review the OTR within three (3) business days. An OTR will be processed with one of the following four outcomes:
    - **Authorization** – an authorization will be processed, entered into the ABH® system, and a fax authorization notification will be generated and forwarded to the Provider;
    - **Request for Additional Information**- the clinician submitting the OTR will be contacted telephonically, with a request for additional information;
    - **Administrative Denial** – a denial letter will be issued based on procedural exceptions;
    - **Clinical Denial** – a clinical denial will be issued based upon a review of clinical information.
- ABH® will provide an appropriate appeal process for all adverse determinations.

- **PHP:** PHP consists of therapeutic programming with a minimum of four (4) hours per day, at least four (4) days per week, based on a comprehensive and coordinated individualized treatment plan involving the use of multiple concurrent treatment services and modalities. PHP services require prior authorization from ABH® Project SAFE.

    - PHP services may be recommended based on a bio-psychosocial evaluation that has been completed within six (6) months.
    - The client must have an active Project SAFE referral, i.e., treatment begins after the completion of a Project SAFE evaluation **and** within the forty-five (45) day period of authorization of the PS evaluation **or** the DCF SW has made a Project SAFE "Treatment Only" referral.
    - The Provider must first verbally provide pre-authorization information to the ABH Clinical Care Coordinator at 860-704-6297 with twenty-four (24) hours of the admission. Next, the Provider completes an OTR and faxes to ABH® at 860-638-5302. The OTR can be downloaded from the following web address: www.abhct.com (for procedures see ***Appendix E***).

- Services will be authorized based on a Utilization Review process.
- Clinical staff at ABH® will review all OTR information for clinical appropriateness and Provider compliance with submission criteria.
    - Submission criteria
        - The OTR should be completed in its entirety.
        - The OTR should be submitted prior to admission to the PHP level of care.
        - The Provider should promptly respond to any inquires for supporting clinical information.
- ABH® will review the OTR within three (3) business days. An OTR will be processed with one of the following four outcomes:
    - **Authorization** – An authorization will be processed, entered into the ABH® system and an authorization notification will be generated and forwarded to the Provider.
    - **Request for Additional Information**- The clinician submitting the OTR will be contacted telephonically, with a request for additional information.
    - **Administrative Denial** – A denial letter will be issued based on procedural exceptions.
    - **Clinical Denial** – A clinical denial will be issued based upon a review of clinical information.
- ABH® will provide an appropriate appeal process for all adverse determinations.

- **Random Drug Screens:** Random urine drug screens are defined as two (2) urine drug screens per week for a period of six (6) weeks and should not occur on the same day and time each week. Urine Screens can be requested for clients who are not in treatment if in response to a court-ordered request, following a PS evaluation in which no treatment was recommended, following the completion of SA treatment, or other reasons to be considered on a case by case basis. Please see the ***Project SAFE Urine Drug Testing Methodology [Appendix J]***

    - The DCF Social Worker makes a telephonic referral to ABH® Referral Line. This referral results in an authorization for services.
    - ABH® Project SAFE will authorize twelve (12) random urine screens. The authorization includes the instant drug screens and confirmation(s), if needed.
    - The screens can be initiated at any time during the next forty-five (45) days. Once the random screens have begun they may continue for a period of no longer than six (6) weeks.
    - The Provider is required to collect all urine samples using the chain of custody protocol.
    - To schedule a random screen, the Provider will contact the client asking the client to come in within the next twenty-four (24) hours for a drug screen.
    - The Provider will verbally communicate all drug screen results to the DCF Social Worker within forty-eight (48) hours. If a lab confirmation is needed,

written results should be faxed to the DCF Social Worker within twenty-four (24) hours of receipt of written correspondence from the lab.

- **Special Drug Testing:** The instant drug test used by Project SAFE tests for Cocaine, THC, Opiates, Synthetic Opiates, Benzodiazepines, PCP and Amphetamines. Testing for additional substances must be authorized by the DCF Substance Abuse Specialist (SAS), Behavioral Health Program Director (BHPD) or designee. The Project SAFE referral will indicate the additional substance(s) authorized by DCF and the number and frequency of testing. **Providers will only be reimbursed for special drug testing when there is a DCF authorization in place**.

- **Hair Testing:** Hair testing is utilized to determine the substance use/abuse history of a client up to three (3) months prior to the sample collection. This test will indicate whether a client has used any of the following substances during that period:

    - Cocaine
    - Opiates (including synthetic opiates)
    - PCP
    - Amphetamine/Methamphetamine
    - Marijuana/THC

In addition, when a positive result is determined by the standard hair test results, a multi-sectional test can be performed per request of the referring DCF Social Worker.

- The DCF Social Worker will discuss the necessity and request for approval with the Substance Abuse Specialist, BH PD, supervisor, or designee in the Substance Abuse Division and obtain a Release of Information from the client for the Provider, who will be conducting the hair test.
- The DCF Social Worker then calls the ABH® Intake Coordinator at 1-800-272-0097 for the hair test referral and provides the following information:
    - Name of person authorizing the test (SAS or designee has to approve before the referral is called into ABH® Project SAFE)
    - Name and demographic information or ABH® ID number of the client
    - Provider to whom the client is being referred to for the hair test

- ABH® Project SAFE enters an authorization and securely transmits the notification to that Provider.
- The DCF SW will fax a signed release of information to the Provider.
- The Provider will complete a Custody and Control Form (CCF) and complete a hair test.
- The Provider should collect a sufficient quantity of hair (refer to Psychemedics on line training www.haircollectionexam.com – password = hairsample. The hair testing facility will complete a 5-panel hair toxicology

screen (Cocaine, Methamphetamine, Opiates, PCP, Marijuana). Results will be reported within 2-6 business days.

If there are positive results reported from the Standard Hair Test Screen, the Provider can call the testing facility (Psychemedics at 1-800-522-7424) to request a complete sectional analysis. (Body hair cannot be segmented.) It is important to clarify that you are calling about an ABH® client and requesting the additional testing. Psychemedics will invoice ABH® directly for additional testing.

NOTE: Providers should contact Psychemedics Customer Service at -1-800-522-7424 for collection supplies for hair testing. Please allow two weeks for delivery.

Referral and Authorization Process (CHART)

Type of Service/Level of Care	Information Needed From DCF	Information Needed from the Provider	Information needed or provided by ABH®	Authorization Requirements
Evaluation (up to ninety (90) minutes)	• Telephonic referral to ABH® including GAIN SS, if completed. • Release of Information from the client faxed to the Project SAFE Provider.	Verbal report to DCF within one (1) business day with results and recommendations. Written results and recommendations forwarded to DCF within five (5) business days. ***Client Reporting Form* TANF a**nd Needs Assessment for Women to ABH® - enter info during claims submission.	***Project SAFE Client Referral Form*** *[Appendix A],* which serves as the authorization for the evaluation. Basic demographic information and substance abuse information from the DCF worker.	Telephonic call from DCF
Outpatient SA Treatment (Individual, Group, Family/Couples) Following a Project SAFE Evaluation, outpatient treatment that begins within the initial forty-five (45) day referral period is authorized and ongoing as long as there is not a gap of forty-five (45) days between services.	Telephonic referral for "Treatment Only" is needed if treatment does not begin within the initial forty-five (45) day referral period ***or*** there has been a forty-five (45) day lapse in services.	Verify client's insurance, check for existing referral.	Random drug screens are included. An evaluation has been conducted within the last six (6) months.	There has been a Project SAFE evaluation, or equivalent completed within the last six (6) months recommending treatment, or the person is stepping down from a higher level of care. An active Project SAFE referral must exist.
IOP	Same as Outpatient	An OTR needs to be submitted **before** services are rendered	Utilization Review of OTR	Provider faxes OTR to ABH® directly.

Type of Service/Level of Care	Information Needed From DCF	Information Needed from the Provider	Information Needed or provided by ABH®	Authorization Requirements
PHP	Same as Outpatient	Verbal pre-authorization and an OTR needs to be submitted **before** services are rendered	Utilization Review of OTR	Pre-authorization information given verbally to ABH at 860-704-6297. Provider faxes OTR to ABH® directly.
Urine Drug Screens – Instant (Includes lab Confirmations, as needed) Shall accompany a referral for a PS evaluation.	Telephonic referral from DCF			Telephonic referral by DCF worker needs to be called in prior to services
Random Urine Drug Screens ONLY (Instant Confirmations, as needed is included)	Telephonic referral from DCF	Once begun, random screens have to be done within six (6) weeks	Will authorize 12 units to be conducted within six (6) weeks.	Project SAFE Evaluation needs to have been completed w/in past six (6) months, or court order, or other reason considered on a case by case basis.
Special Drug Testing	SAS, BH PD, or designee authorization	See "Special Drug Testing"	Authorization for Reimbursement for special drug testing	Telephonic authorization
Hair Test	SAS authorization, Court Order and/or Program Supervisor authorization	See Hair testing procedure	Set up a referral upon telephonic referral from DCF.	Telephonic authorization

Reimbursement Protocol

There are a variety of procedures that each party involved in ABH® Project SAFE is required to follow. In the following section, we will outline what we ABH® will do, and what DCF and/or the Provider are required to do in order that client services are reimbursed.

Provider Credentialing

Project SAFE services will be provided by agencies, licensed by the Department of Public Health to provide outpatient substance abuse services that have an agreement with ABH® to participate in the Project SAFE Network of Providers. Professionals within an agency who hold one of the following qualifications will be eligible to conduct Project SAFE evaluations:

- Certified Alcohol and Drug Counselor (CADC)
- Certified Alcohol Counselor (CAC)
- Licensed Alcohol and Drug Counselor (LADC)
- Master's or doctoral level clinician with at least two years of experience in the treatment of substance abuse
- Connecticut licensed Registered Nurse with at least two years of experience in the treatment of substance abuse

Staff with backgrounds other than those listed above, will be considered on a case-by-case basis and require approval by the ABH® Project SAFE Program Manage, or designee. All non-certified or non-licensed evaluators must be supervised by a licensed masters or doctoral level clinician.

Providers will submit a roster of staff and their qualifications during the credentialing process. Staff rosters should be updated with ABH® at least annually.

Reimbursement

Project SAFE provides reimbursement based on the Project SAFE fee schedule for all **authorized** evaluations, outpatient treatment services, drug screens/hair tests and court costs. ABH® Project SAFE offers Providers a web-based electronic system to submit claims electronically. ABH® Project SAFE encourages Providers to make use of this system. ABH® offers training regularly on how to submit claims using the electronic system. Additionally, ABH® Project SAFE will make itself available to Providers for assistance or individual trainings on an ad hoc basis.

ABH® Project SAFE is the payer of last resort and as such, clients are expected to use their insurance plan when receiving Project SAFE services. Providers will be reimbursed the difference between what the insurance company pays and the approved Project SAFE reimbursement rate. Fee schedules are furnished to Provider groups as part of the contracting process.

Reimbursement Procedures:

- Evaluation
- Treatment
- IOP and PHP
- Drug Screens
    - Urine Screens
    - Special Drug Testing
    - Hair Testing
- Court Appearances

Reimbursement for Evaluation

Provider Responsibilities

The Evaluation Provider needs to be aware of any existing referrals. Appointments should be provided within the priority access guidelines. If the Provider is unable to do so, they should notify ABH® Project SAFE.

The Provider needs to contact the DCF Social Worker with verbal results of an evaluation within Twenty-four (24) hours (1 business day) and with written results within five (5) business days.

A referral will lapse if no service is provided within the forty-five (45) day authorization period. To determine if the Referral has lapsed, the Provider will look on the ***Client Referral Form [Appendix A]*** to review the service requested end date. The evaluation needs to be conducted before this date; if not, the Provider should request that the DCF Social Worker call ABH® Project SAFE to make a new Project SAFE referral.

The Provider needs to complete the following information and submit it along with each evaluation through the ABH® on-line claims system.

- ***Client Report Form [Appendix B]***
- For women only, the ***Needs Assessment Form [Appendix C]***
- ***TANF Eligibility Screening Form [Appendix D]***

The Provider must submit claims for reimbursement **no more than sixty (60) days following** the date the service was provided. Claims submitted beyond this time frame will be denied reimbursement for "untimely filing."

If there is a correction required on any submitted claim, the Provider has ninety (90) days from the **service date** to correct the claim.

ABH® Project SAFE Will

ABH® will fax the referral information to the Provider when a DCF Social Worker makes an evaluation referral. This referral information serves as the authorization. *[Appendix A]* ABH® will maintain an electronic record of every referral, which will allow reimbursement for an evaluation provided. Project SAFE will reimburse for only one evaluation per client per six month period per Provider organization.

Reimbursement for Treatment

Provider Responsibilities

The Treatment Provider needs to be aware of any existing referrals. If the treatment services begin within forty-five (45) days of the start date of the evaluation referral, the Provider can submit claims as described in the claims submission portion of this document.

If a referral lapses because it is beyond the forty-five (45) limit, the Provider should contact the DCF Social Worker and request that he or she call in a new referral for "Treatment Only".

The Provider should communicate the course of client treatment by contacting the DCF Social Worker regularly. Providers who create a treatment plan which recommends IOP or PHP must complete an ***OTR [Appendix E].***

The Provider must submit claims for reimbursement no more than sixty (60) days following the date the service was provided. Claims submitted beyond this time frame will be denied reimbursement for "untimely filing."

Providers should verify the client's insurance and indicate this information in the claims submission process. If a client does have insurance, but is unable or unwilling to use it, a special exception may be requested. See ***Special Exception procedure [Appendix G].***

"Treatment Only" referrals can be made under these circumstances:

- Following an acute care episode, e.g., stepping down from a residential level of care to an outpatient level of care with the same Provider;
- The need to transfer a client from one Project SAFE Provider to another; and/or
- Following a gap of 45+ days in Project SAFE services.

In every case, either an evaluation has been completed within the previous six (6) months ***prior*** to the DCF Social Worker making a "Treatment Only" referral or the Provider completes an assessment to determine the current level of care.

"Treatment Only" referrals include authorization for one (1) assessment and recommended outpatient levels of care (IOP and PHP require submission of an OTR). Authorization for outpatient treatment is ongoing as long as there is not a gap of forty-five (45) days.

****

ABH® Project SAFE Will

ABH® Project SAFE will:

- Fax the ***Client Referral Form*** *[**Appendix A**]* with "Treatment Only" indicated in the service(s) requested section *(**Appendix B**).* A separate referral for urine screens is not required under a "Treatment Only" referral.
- Maintain an electronic record of every referral, which will allow reimbursement for treatment. Project SAFE will reimburse a maximum of one group per day, two groups per week.
- Reimburse Instant Drug Screens and Lab confirmations, if needed, as described under the Project SAFE Urine Toxicology Methodology under the "Treatment Only" or Drug Screen authorization.

Reimbursement for IOP or PHP Levels of Care

Provider Responsibilities

IOP and PHP levels of care are authorized based upon a process of Utilization Review (UR). To engage in this process, the Provider must complete a verbal pre-authorization and submit an ***Outpatient Treatment Request Form (OTR) [Appendix E]***.

For a new request for IOP or PHP, The ***OTR form*** **(*Initial Registration*)** must be completely filled out with the necessary demographic and clinical information, **prior to admission** to the IOP or PHP levels of care.

For a continued stay request for IOP or PHP, An ***OTR form*** **(*Continued Stay Review*)** needs to be completed prior to the expiration or completion of services previously authorized. Any subsequent OTR forms should be completed with new clinical information and an updated treatment plan. The Provider is required to respond promptly to any inquiries for supporting clinical information.

The Provider must submit claims for reimbursement no more than sixty(60) days following the date the service was provided. Claims submitted beyond this time frame will be denied reimbursement for "untimely filing."

****

ABH® Project SAFE Will

Help educate treatment Providers about clinically appropriate treatment planning and decision-making processes regarding level of care decisions as requested.

Receive and process Outpatient Treatment Requests (OTR) for IOP and PHP levels of care through Utilization Review. In order to ensure that patients require IOP and PHP levels of care, these services are authorized based upon a process of Utilization Review (UR).

Provide a three (3) day turnaround time on authorization decisions with access to urgent authorizations when clinically necessary.

Provide an appropriate appeal process for all adverse determinations. (See ***Appeals Process*** **)**

Maintain a copy of the OTR for download at the following web address: http://www.abhct.com/ .

Reimbursement for Hair Testing

Provider

The Provider is required to collect a sufficient sample for a hair test in

Responsibilities

accordance with standards for hair testing as specified in the training. The Provider then submits the sample with a request for a standard screen to Psychemedics.

If the results are positive and there is a need for a more detailed analysis, the Provider can request a multi-sectional testing of the positive result by calling Psychemedics at their toll-free number and requesting that a multi-sectional be completed. As this multi-sectional analysis does not require the client to return to the office, an additional administrative cost will not be reimbursed to the Provider by ABH®. (Please note body hair cannot be segmented.)

The Provider should discuss the results with the DCF Social Worker through telephone contact as soon as possible.

The Provider must submit claims for reimbursement no more than sixty (60) days following the date the service was provided. Claims submitted beyond this time frame will be denied reimbursement for "untimely filing."

****

ABH® Project SAFE Will

ABH® will serve as the coordinator of Hair testing requests, and as the conduit for information between Psychemedics and other parties involved.

ABH® will help expedite procedures whenever possible, and will provide a forum for training for any Provider who is interested.

ABH® will ensure that Psychemedics is meeting the criteria for timely reporting of results through a monitoring program.

ABH® will reimburse Providers an administrative fee related to collection and submission of the hair sample to Psychemedics. Psychemedics will invoice ABH® for the actual cost of the hair test and multisectional analysis, if conducted.

Reimbursement for Urine Drug Screens

Provider Responsibilities

For a complete description of the Project SAFE Urine Toxicology Methodology, please see the ***Overview on Project SAFE Drug Testing [Appendix J]*** Providers are required to follow the chain of custody protocol for collecting and interpreting instant urine drug screens and for sending out samples for lab confirmation under the following circumstances:

- When the client disputes a positive substance(s) result;
- When a client reports taking a prescribed mrdication (to verify the substance; and/or
- When the DCF SAS or BHPD has authorized special drug testing.

Providers are required to report to the DCF worker the results of all positive drug screens within forty-eight (48) hours and all negative drug screens within seventy-two (72) hours. Written results of lab confirmations should be faxed to the DCF Social Worker upon receipt of the results.

When DCF requests a series of random drug tests, ABH® Project SAFE will authorize a maximum of twelve (12) random drug screens over a six-week period.

The Provider must submit claims for reimbursement no more than sixty (60) days following the date the service was provided. Claims submitted beyond this time frame will be denied reimbursement for "untimely filing."

****

ABH® Project SAFE Will

ABH® will indicate on the ***Project SAFE referral form [Appendix A]*** if DCF has requested a single drug screen or a series of random drug screens. Outpatient treatment through Project SAFE includes reimbursement of random drug testing to a maximum of one (1) per date of service, two (2) per week.

Requests for Court Cost Reimbursement

DCF Responsibilities

Project SAFE Providers, on occasion, are subpoenaed to testify in court regarding DCF cases. In order to support the benefit of such testimony, DCF has agreed to reimburse Providers for their time as related to court testimony through Project SAFE

****

Provider Responsibilities

When a Provider receives a subpoena to give testimony in court on a Project SAFE case, the Provider may request to be placed "on call" by contacting the Assistant Attorney General (AAG) at the telephone number listed on the subpoena. If the Provider is unable to reach the AAG, the Provider may contact the Attorney General's Office in Hartford at 860-566-3696 and request to be placed "on call" for the specific case.

If the Provider goes to court on a Project SAFE case, the Provider may bill ABH®, based on the time spent in the courtroom, whether or not the Provider actually testified in the case.

To be reimbursed, the Provider will type a brief letter to the ABH® Project SAFE Manager identifying the client by name and ABH® number, the date of the court appearance, and the name of the clinician with the appropriate rate and final figure. Whenever possible, the letter should be co-signed by the Executive Director of the agency.

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ABH® Project SAFE Will

ABH® will provide reimbursement to Providers for time spent in court in accordance with its fee schedule.
ABH® will remit that reimbursement upon receipt of appropriate written documentation.

Special Exceptions

As the payer of last resort, Project SAFE funds are used to reimburse Providers on a fee-for-service basis, **when there is no other source of reimbursement available**. DCF and DMHAS recognize that there are circumstances under which a client may not be able to access services under his/her current payer source or under the structure or function of payer of last resort, hence there may be exceptions granted. Exceptions may be granted for the circumstances indicated below:

- The Project SAFE Provider does not participate in the client's insurance plan and referring the client to another Project SAFE Provider is not an option.
- The client has no reliable transportation to the in-network Provider **and** the client has to be referred to an out of network Provider.
- Insurance company/entitlement does not provide the needed level of care.
- Client may go from having no insurance to having insurance, with the Provider being out-of-network.
- The Out-of-network Provider offers daycare/babysitting and/or transportation services that are essential to the client engaging in services.

Please note: Project SAFE does not reimburse to cover the costs of spend-downs and high deductibles. However, a Special Exception Form should be completed by the Provider and submitted to ABH to document the situation.

To obtain consideration for a special exception, the following steps need to be followed:

- A ***Special Exception Form [Appendix G]*** needs to be completed in its entirety by the Project SAFE Provider.
- The form should be complete on or before the date of service. ABH® will only back-date up to five (5) business days.
- The Provider should fax the ***Special Exception Form [Appendix G]*** to ABH® at 860-638-5302.

All information must be provided for the exception to be granted and services reimbursed.

Exceptions, other than those listed here, should be directed to the Project SAFE Program Manager or designee. Every effort will be made to address any and all unique circumstances in an efficient manner.

For more information, please see the ***FAQ on Special Exceptions in [Appendix H]***

Claims Process

There are a variety of procedures that each party involved in Project SAFE is required to follow. In the following section, we will outline steps to assist in claim submission.

Overview

ABH® utilizes a web based claims submission system. For services to be reimbursed, an authorization needs to exist in the ABH® Project SAFE data system (see Referral and Authorization section of these *Preferred Practice Standards*). Once a referral has been made by DCF, Providers must submit claims for reimbursement **no more than sixty (60) days** following the date the service was provided. Claims submitted beyond this time frame will be denied reimbursement for "untimely filing." Should there be a compelling reason why the claims submission may be delayed, a call should be made, in advance, to the ABH® Claims Coordinator (860-704-6144) explaining the reason (staff shortage, vacation schedules, etc.) and expected timeframe for submitting claims.

In using the web-based claims submission system, the Provider will need to have a password to access the system. To obtain or reset a username and password, contact the ABH® Claims Coordinator at 860-704-6144.

Web Base Claim System – See page 50 for a complete overview on ABH's Project SAFE web based claims system

Complaints, Grievances, and Appeals

Utilization Review Process

Before authorizing any services for Project SAFE clients, ABH® Utilization Review staff must ascertain whether the client's symptoms meet Service Necessity Criteria for the requested service. The Utilization Review staff may use the ABH® Medical Director or his/her designee to assist in making that determination.

In order to make a determination that the requested service(s) meets the Service Necessity Criteria, the service must meet all of the following criteria:

- The service is appropriate for the symptoms, diagnosis and treatment of a particular disease or condition that is defined under the DSM V-TR or its successor.
- The service is provided in accordance with generally accepted standards of substance abuse and/or behavioral health professional practice. This includes the type, level, and length of treatment services that are needed to provide safe, adequate and appropriate care and are intended to improve the individual's condition. Treatment geared toward simply maintaining the individual's current level of functioning is appropriate only when, without such treatment, the individual would be likely to suffer a relapse or deterioration of health status. Service Necessity Criteria does not include "custodial care."

All clinical denials must be based on a review made by a Connecticut licensed clinical reviewer. If during the normal course of the review, a Provider decides to withdraw the request for additional services, the case does not have to be subject to clinical review.

If the Utilization Review staff determines that Service Necessity Criteria has not been met, the Provider will be notified via certified mail of the decision.

Appeals

There are two types of appeals that may be lodged regarding denial of service by ABH® Project SAFE, clinical appeals and administrative appeals:

- **Clinical appeals:** A Provider, a client, and/or his/her authorized representative or designee may appeal a decision to clinically deny, reduce or terminate a behavioral health service. The appeals process is as follows:

    - Upon receipt of the denial, an appeal may be initiated by providing additional justification of the need for service. This appeal must be submitted to ABH® no later than seven calendar days after receipt of the denial decision.
    - The Provider, client, or his/her authorized representative will be sent notice of the decision on the appeal no later than one (1) business day after receipt of information required rendering a decision.
    - If dissatisfied with the first level appeal decision, a second level appeal must be submitted to ABH® no later than seven calendar days after the first level appeal denial is received.
    - The Provider or his/her authorized representative will be sent notice of the decision on the second appeal no later than two (2) business days after receipt by ABH® Project SAFE of information required to render a decision.
    - If dissatisfied with the second level appeal decision, a third level appeal must be submitted directly to DMHAS no later than seven (7) calendar days after the second level denial.
    - A third level appeal will not be considered if the first or second level appeal is still being reviewed within the established time frames.

- **Administrative Appeals:** A Provider may appeal an adverse decision by ABH® that is based on non-compliance with administrative procedures. The appeals process is as follows:

    - Within seven (7) calendar days of the denial from ABH®, the Provider or his/her authorized representative may initiate the administrative appeals process by providing additional information or by demonstrating "good cause."
    - The Provider will be sent notice of the decision within seven business days following receipt of the appeal by ABH®. The notification will include the principal reason (s) for the decision and instructions for requesting a further appeal, if applicable.
    - If dissatisfied with the first level decision, the Provider or his/her authorized representative may submit a second level appeal directly to DMHAS no later than seven days after the denial of the first appeal. The appeal must be accompanied by information necessary and sufficient to render a decision.

For first level appeals, send correspondence to:

Advanced Behavioral Health, Inc.
Project SAFE
213 Court Street
Middletown, CT 06457

For second level appeals, send correspondence to:

Ms. Kimberly Karanda, Ph.D., LCSW
Director, Statewide Services Division
Department of Mental Health & Addiction Services
410 Capitol Avenue
Hartford, CT 06134

Complaints and Grievances:

A Project SAFE client may utilize the Providers' established grievance procedure to seek resolution of complaints and grievances concerning the quality or level of services provided. Grievances are defined as a complaint against a service Provider in matters other than the denial, reduction or termination of services.

Appendices

Appendix A
Client Referral Form (page 1)

Advanced Behavioral Health, Inc.
Middlesex Corporate Center
213 Court Street
Middletown, Connecticut 06457

Date: 3/23/2016
Time: 2:36 PM
Page: 1 of 2

Client Referral

Social Worker

Name . . . . . . Social Worker
Address . . . <None>
City . . . . . . MIDDLETOWN **Zip:** 06457
Phone . . . . . (999) 999-9999 **FAX . . .** (999) 999-9999
Unit . . . . . . Investigations
Supervisor UNKNOWN

Provider

Name . . . . . Test Site
Phone . . . . . (111) 111-1111
Address . . . Test Address
City . . . . . . Test City
Contact . . . Test
Region 6

Insurance

Payor . . . . . Other
Health Plan None

Client Information

ABH ID #. . . . 00000
Name . . . . . . Test First Test Last
Address . . . . Test Street
City . . . . . . Middletown
State . . . . . . CT **Zip:** 06457
Link # 0
DOB 01/01/1991
Phone . . . . . (860) 000-0000
Referred to RCM / RSVP - Yes (RCM)

Gender . . . Female **Soc Sec #. . .** NEED SOC. SEC. #
Race: □Asian □Black/African American □White/Caucasian □Native American/Alaskan Native □Native Hawaiian/Pacific Islander √ Unknown □Mixed/Other
Home Language . . . . English

Outside Language . . English

Substance Abuse Treatment Code . . . Protective Services

Suspected Substance(s) Use:
Other (See Explanation)
Explanation:Test Substance(s)

Reason(s) for Suspecting:
Other (See Explanation)
Explanation:Test Reason

Service(s) Requested:	# Units	Begin Date	End Date
Evaluation	1	3/23/2016	5/7/2016

Reason for Referral: Test Reason

Advanced Behavioral Health, Inc.
Middlesex Corporate Center
213 Court Street
Middletown, Connecticut 06457

Date: 3/23/2016
Time: 2:36 PM

Client Referral

Client ID: 00000
Name: Test First Test Last

Substance Abuse Screening / Information Form

No	1. Client appeared to be under the influence of drugs and/or alcohol.
No	2. Client showed physical symptoms of trembling, sweating, stomach cramps, nervousness.
Not answered	3. Drug paraphernalia was present in the home, i.e., pipes, charred spoons, foils, blunts, etc.
Not answered	4. Evidence of alcohol was present in the home, i.e., excessive number of visible bottles/cans whether empty or not.
Yes	5a. There was a report of a positive drug screen at birth for Mother: List drugs detected: **Marijuana**
Yes	5b. There was a report of a positive drug screen at birth for Child: List drugs detected: **Marijuana**
Yes	6. There was an allegation of substance abuse in CPS Report.
Yes	7. Is there a child 4 years of age or older in the home?
	No The child(ren) reports substance abuse in the home. When?
Yes	8. The client has been in substance abuse treatment. When?
	January 2016
Unknown	9. The client has used the following in the last twelve months:
	_____Marijuana/Hashish _____Heroin/Opiates _____Cocaine/Crack _____Other Drugs
Yes	10. Client shared that s/he has experienced negative consequences from the misuse of alcohol:
	Yes DWI/DUI
	Yes Domestic Fights
	Unknown Job Loss
	No Arrests
	No Other:
Yes	11. Client shared s/he has experienced trouble with the law due to the use of alcohol or other drugs, i.e.:
	Yes DWI/DUI
	No Domestic Violence
	No Drug Possession
	No Other:
Not answered	12. There are adults who may be using drugs and/or misusing alcohol who have regular contact with the client's child(ren).
Unknown	13. The client acknowledged medical complications due to the use of substances.
	14. Other Comments
	Test Comments

Appendix B
Client Report Form

ABH® Contact: ***Referral Date/Time:*** ***Ref #:***

ADVANCED BEHAVIORAL HEALTH, INC.

Middlesex Corporate Center, 213 Court Street, Middletown, CT 06457
Phone: 860.638.5309

PROJECT SAFE
DCF Substance Abuse Services for Primary Care Givers

To:_____ and _____
DCF SOCIAL WORKER **ABH® INTAKE WORKER**

DATE:_____ CLIENT NAME:_____

ABH® CLIENT ID #_____
The above client received: (Check all that apply)
DRUG SCREEN:_____ EVALUATION:_____
TREATMENT RECOMMENDED: CHECK ONE
START DATE FOR BELOW TX:_____

_____ NO TREATMENT RECOMMENDED

_____ INDIVIDUAL THERAPY

_____ GROUP THERAPY

_____ FAMILY/COUPLE THERAPY

_____ INTENSIVE OUTPATIENT

_____ PHP

_____ EARLY INTERVENTION

_____ METHADONE (Not funded by DCF contract)

_____ INPATIENT DETOX (Not funded by DCF contract)

_____ AMBULATORY DETOX (Not funded by DCF contract)

_____ RESIDENTIAL SERVICES (Check below; not funded by DCF Contract)
With Children_____ Without Children_____
Clinician Name: _____ Date:_____
(Please Print/Required field)

SIGNATURE_____

Name of Provider _____

Appendix C
Needs Assessment Form

ADVANCED BEHAVIORAL HEALTH, INC.

Residential Services for Substance Abusing Women and Their Children

Client Name:_____

ABH® #:_____

Date of Evaluation:_____

Evaluator:_____Provider:_____

_____Yes _____No Is this client clinically most appropriate for residential treatment?

(If No, Stop Here, if Yes Continue.)

Please complete the following on all clients for whom residential is assessed as the most clinically appropriate level of care,(Regardless of whether a referral for that level of care is actually made).

_____Yes _____No Client accepted recommendation for residential treatment.

If No, why not? (childcare, work, etc.) _____

_____Yes _____No Bed was available.

Name of Residential Program_____

If not admitted to residential treatment, did client accept referral to alternative level of care?

_____Yes _____No

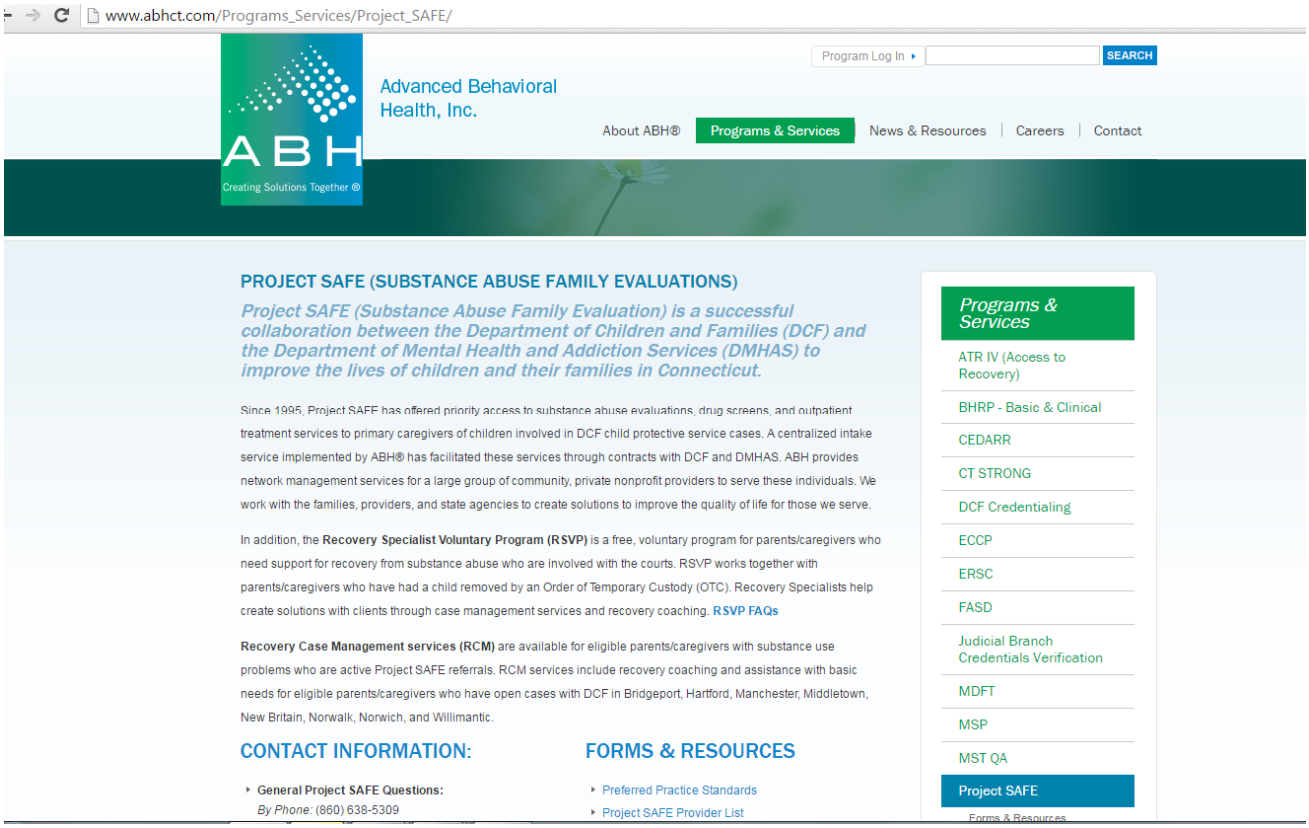
If Yes, specify level of care_____

DCF-Needs Assessment Form March 20**03**

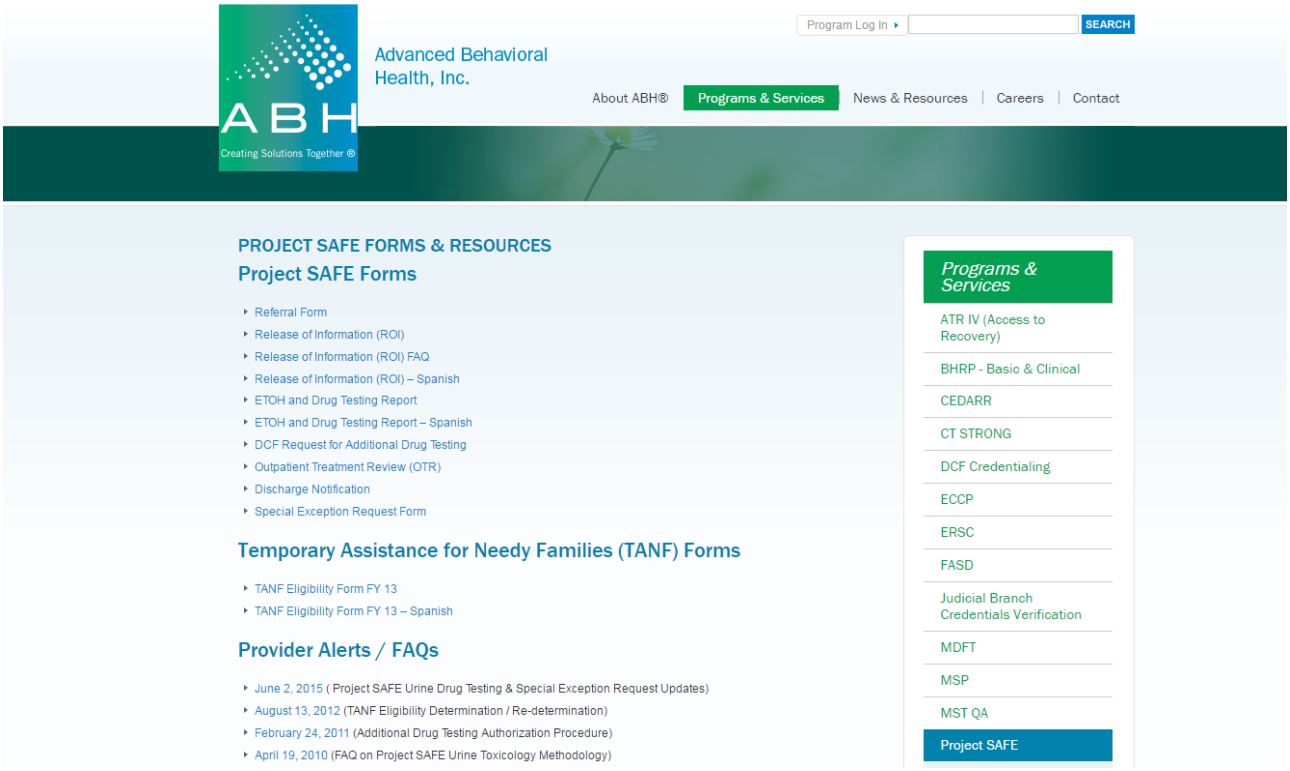
Appendix D:
Outpatient Treatment Review Downloading Procedure

- Once you access the ABH® website you will see this screen.
- Move the cursor to Programs & Services and select Project SAFE.
- Provider information, resources, forms and alerts are listed.

Outpatient Treatment Review Downloading Procedure (page 2)



Outpatient Treatment Review Downloading Procedure (page 3)



Appendix E:
Outpatient Treatment Review Form

SELECT ONE:
Initial Registration ☐
Continued Stay Review ☐

Project SAFE Outpatient Treatment Review Form (OTR)

Client Name (Last, First): _____
ABH Number: _____
Client's Date of Birth: _____ Admission Date: _____
Client's Address: _____
Provider Name: _____
Provider Service Address: _____

Service Type (MUST select one):
☐ MH Partial Hospital (MH II.5)
☐ MH Intensive Outpatient (MH II.1)
☐ SA Partial Hospital (SA II.5)
☐ SA Intensive Outpatient (SA II.1)

DIAGNOSES – (Required) *Substance Abuse diagnosis must be primary*
_____
_____
_____
_____
_____
_____

Treatment Plan: _____
_____
_____
_____
_____

Expected Frequency & Duration of IOP _____ x per week for _____ weeks

Expected Frequency & Duration of PHP _____ x per week for _____ weeks

Requested Number of Units (Required): _____

Projected Discharge Plan (Required):
Anticipated Discharge Date: _____
Referral Projected to: _____ (Service/Level of Care)
_____ (Provider Name)

Symptom Checklist (Select at least one – Required)

☐ Isolation	☐ Peer/Relationship Difficulty
☐ Eat/Sleep Disturbance	☐ Suicidal/Homicidal Ideation
☐ Manic Behavior	☐ Sexually Inappropriate Behavior
☐ Inadequate Self Care	☐ Active Substance Abuse
☐ Recent Relapse	☐ Paranoia
☐ Current symptoms of withdrawal	☐ Bizarre Behavior
☐ Delusions/Hallucinations	☐ Violent/Aggressive Behavior

Substance Use History (Required for all OTRs):

Substance	Date Last Used	Method of Use	Age at First Use	Quantity	Frequency

Current Medications: ☐ No Medications

Medication	Dosage	Frequency	Method	Ended On

Status Checklist

☐ Medication Compliant	☐ Frequent Therapeutic Intervention Needed
☐ Medication Non-compliant	☐ Frequently Misses Appointments
☐ Significant Risk for Relapse	☐ Compliant with Treatment
☐ Vocational/Job Issues	☐ Refusing Treatment Recommendations
☐ Housing Issues	☐ Stable/Preparing for Discharge
☐ Current/Chronic Medical Issues	☐ In Need of Higher Service Intensity
☐ Pending/Current Legal Issues	☐ Progress Made/Further Stabilization Needed
☐ Attending 12-Step Recovery Groups	☐ No Progress Made/Improvement Expected
☐ Using Community Supports	☐ Lacks Necessary Community Supports

Date/Results of Drug Toxicology (Required for all OTRs):
Date of Most Recent Drug Toxicology: _____ ☐ Never tested
Results: ☐ Positive ☐ Negative
If Positive, MUST select at least one:
☐ Opiates ☐ Benzodiazepines ☐ Cannabis ☐ Cocaine

☐ Attention/Impulse Disorder	☐ Intense/Frequent Drug Cravings
☐ Confusion/Disorientation	☐ Cognitive Impairment
☐ Early Recovery Issues	☐ Substance-related Medical Issues
☐ Obsessive/Compulsive Behaviors	☐ Acute psychosocial stressors
☐ Depression	☐ Thought Disorder
☐ Nightmares/Flashbacks	☐ Inappropriate Affect
☐ Anxiety/Panic Attacks	
☐ Recent suicide attempt(s)	

Form Completed By: _____ Telephone #: _____ Date: _____

Reviews may be faxed to: Advanced Behavioral Health, Inc. at (860) 638-5302
Please keep a record of this transaction for your records

Updated 3/23/16

Appendix F:
Request for Special Exception

ABH ~ Project SAFE
Special Exception Request

Date of Request: _____
Provider Name: _____
Person Requesting Exception: _____

Client Name: _____ **Client ABH#:** _____

Client DOB: _____ **Client SSN:** _____ - _____ - _____

Client's Insurance: _____

Reason for Exception:

- ☐ Project SAFE Provider does not participate in client's insurance plan – Out of Network
- ☐ Client's insurance changed to out of network
- ☐ Clinician is out of network with client's insurance
- ☐ In-network service does not have childcare
- ☐ Services not covered by client's insurance plan
- ☐ No transportation to in-network provider
- ☐ Client's State/Private/Medicare will not authorize services (PHP,IOP,OP-IND,GROUP)
  Reason: _____

(The following two categories are being collected for tracking purposes only at this time.)

- ☐ Private Insurance has high deductible: **Amount of Deductible- $**_____
- ☐ Spend down – **Reason/Amount of Spend down: $**_____

Type of Treatment Requested:

- ☐ Individual
  # of sessions: _____ Start date: _____ End date: _____
- ☐ Group
  # of sessions: _____ Start date: _____ End date: _____
- ☐ Family
  # of sessions: _____ Start date: _____ End date: _____

Special Exceptions for IOP & PHP Services

- ☐ IOP ****Please fax OTR with this form for clinical review**
- ☐ PHP ****Please fax OTR with this form for clinical review**

Clinician Signature: _____

Appendix G:
FAQ for Project SAFE Special Exceptions

1. What is a special exception?

The special exception is a means which Providers who are unable to access client's insurance can be reimbursed for services. Special exceptions are granted under the following circumstances:

- *Services rendered are not covered by the client's insurance*
- *The Provider is out of the client's insurance network*
- *The in-network Provider does not have needed childcare or transportation available to the client.*

No special exception needs to be completed for evaluation services. This only applies to outpatient services including IOP, PHP, group, individual, and family therapy.

2. When should I fill out a special exception?

A special exception form should be completed after insurance has been verified and the client meets one or more of the above criteria. Project SAFE is the ***payer of last resort****; as such the Provider is expected to bill the client's primary insurance first. No special exception is needed for the evaluation service.*

A special exception form should be completed ***prior*** *to the service start date or the first date of service. Special exceptions submitted more than five calendar days after the date of service will be denied for untimely submission.*

3. Who needs to complete the special exception?

The special exception form can be completed by any staff at the Provider agency familiar with the client; this includes administrative assistants, case managers, clinicians or billing staff. All the information needs to be included (client name, ABH® #, client DOB, type of treatment, number of sessions being requested, start and end dates of treatment, etc.)

4. What services can be requested with the special exception?

IOP, PHP, and outpatient (individual, group, family) services can be requested by special exception.

5. If a client comes in for an evaluation and has had a previous evaluation at another facility within the past six (6) months will ABH® reimburse for the Project SAFE evaluation if the client's insurance will not?

Project SAFE will cover the substance abuse evaluation if the client's insurance will not cover the service and there is an active Project SAFE referral for an evaluation. A claim should be submitted for the evaluation with a note indicating that the client's insurance will not cover services. This does not require a special exception and should follow the traditional claims process for evaluations. If the client was referred for "Treatment Only", the Provider can bill for one assessment, or intake, appointment prior to the start of treatment.

6. If a client is on spend-down or high deductible and does not have the money to cover services, will Project SAFE reimburse for services rendered?

Spend- down is based on the State Medical Assistance program (Medicaid) operated by DSS. There are certain qualifications that an individual must meet to be eligible for Medicaid. Spend- down is used when a person is not eligible based on excess income. In some cases a person can qualify if his/her income is over limit. This process is spend-down and lets the person reduce the excess income to bring him/her within eligibility for Medicaid.
The Provider should verify that the client is on Medicaid, but indicate specifically how the spend-down is a barrier to the client engaging in treatment. These requests will be considered on a case by case basis by the Project SAFE Program Manager.

7. **If a client on private commercial insurance reports that they cannot afford their co-pay will Project SAFE reimburse the Provider?**

Project SAFE does not cover co-pays.

8. **If the client is in IOP or PHP, but is also receiving other treatment i.e. domestic violence, anger management, and the insurance is paying for IOP or PHP and will not cover the other treatment, will Project SAFE reimburse for the other treatment service?**

Project SAFE will reimburse for treatment not covered by the insurance if the client has been provided a Project SAFE evaluation, authorization for services have been called in by the DCF worker or treatment begins with forty-five (45) days of the initial referral, and the services are related to the client's recovery from substance abuse, and the treatment is provided by a credentialed Project SAFE provider.

9. **If the clinician providing the clinical services is not credentialed with the client's insurance company, but the Provider agency is in the network will Project SAFE reimburse under a special exception?**

Project SAFE is a payer of last resort. The Provider should attempt to have the client seen by a Provider credentialed by the client's insurance network whenever possible.

Appendix H:
Web-Based Claims System

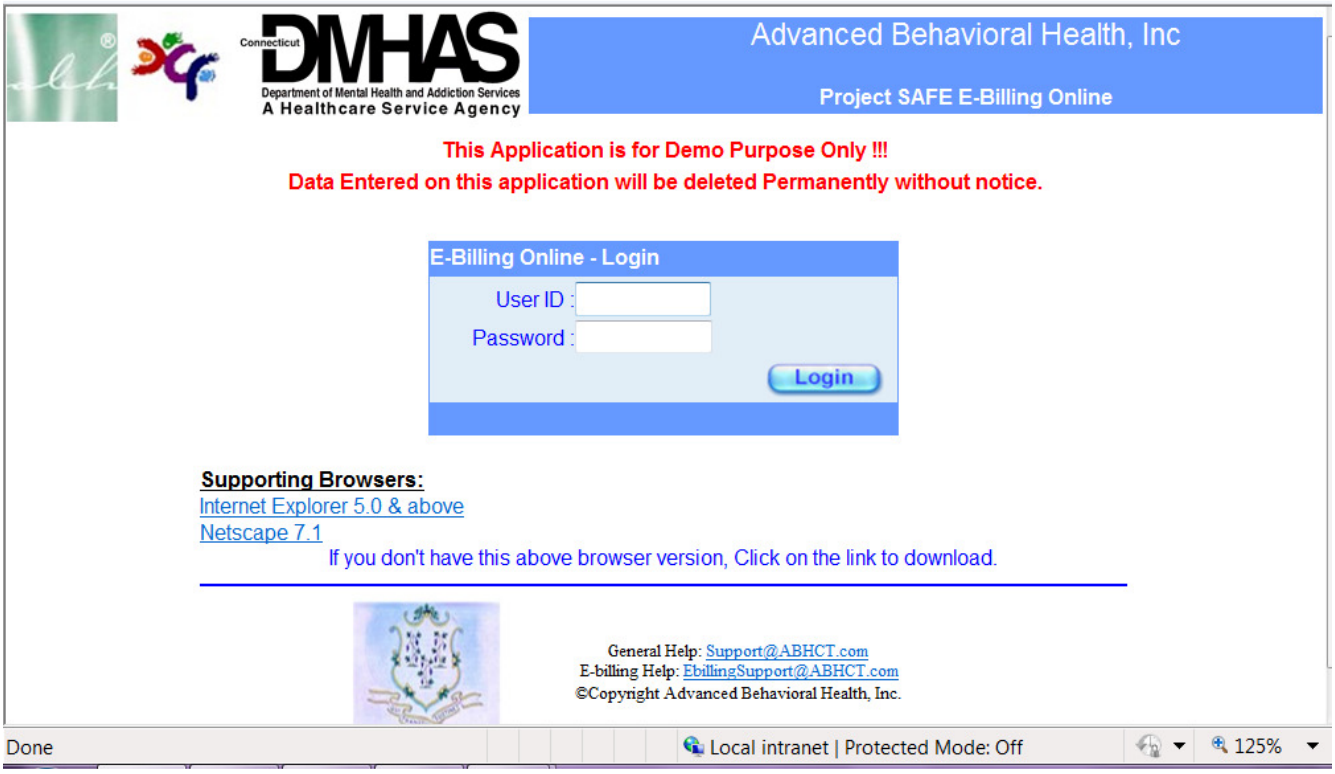
PROJECT SAFE
Claims Entry
Provider Manual

Advanced Behavioral Health
213 Court Street – 8th Floor, Middletown CT 06457
860-704-6144 (Billing Dept) 860-638-5309 (ABH Main Number)

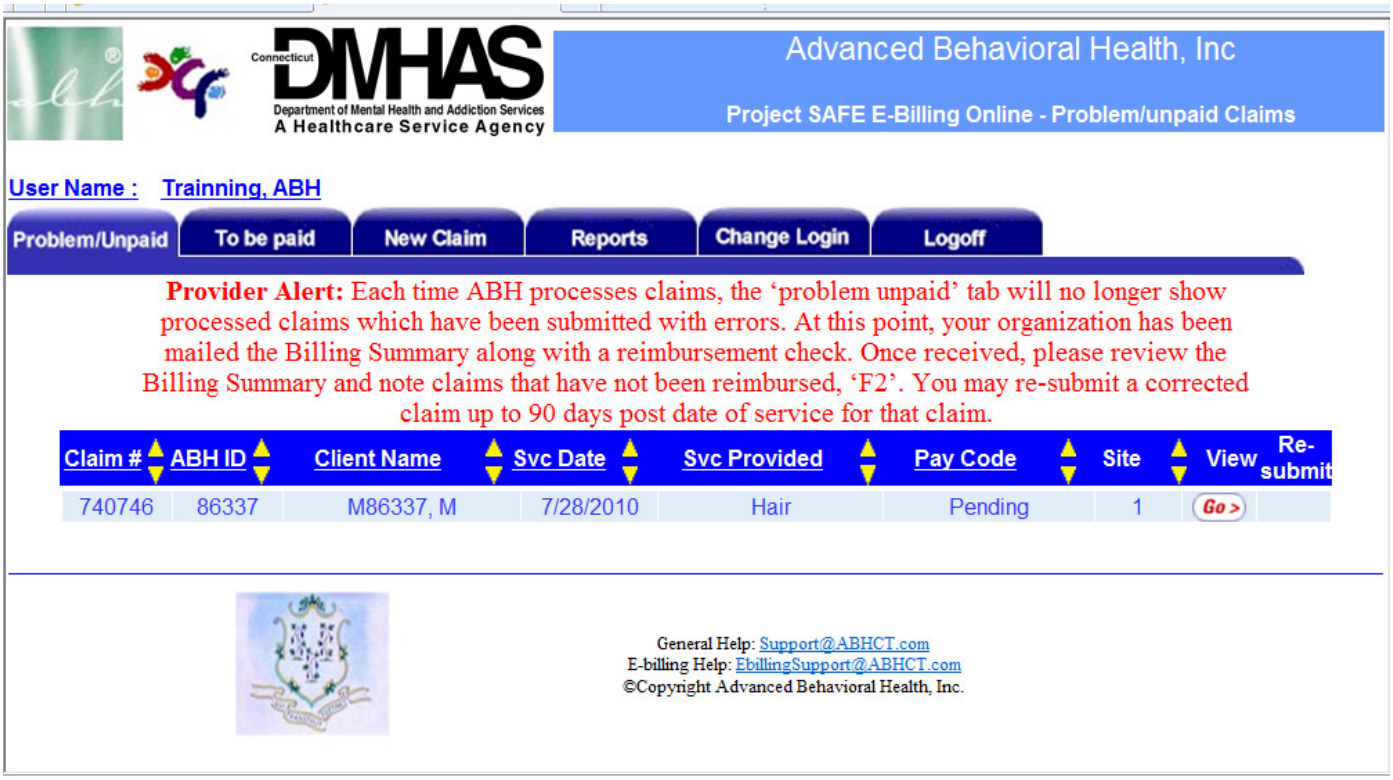
LOGIN

www.abhct.com

- Once you access the ABH® website you will see this screen.
- Move the cursor to Program Log In. A drop down list will appear.
- Move the cursor to Project SAFE E-Billing.



In order to log into the claims system you need to enter a username and password. If you do not have a username and password or you are locked out please contact Sharron Holland-Project SAFE Claims Coordinator at 860-704-6144.



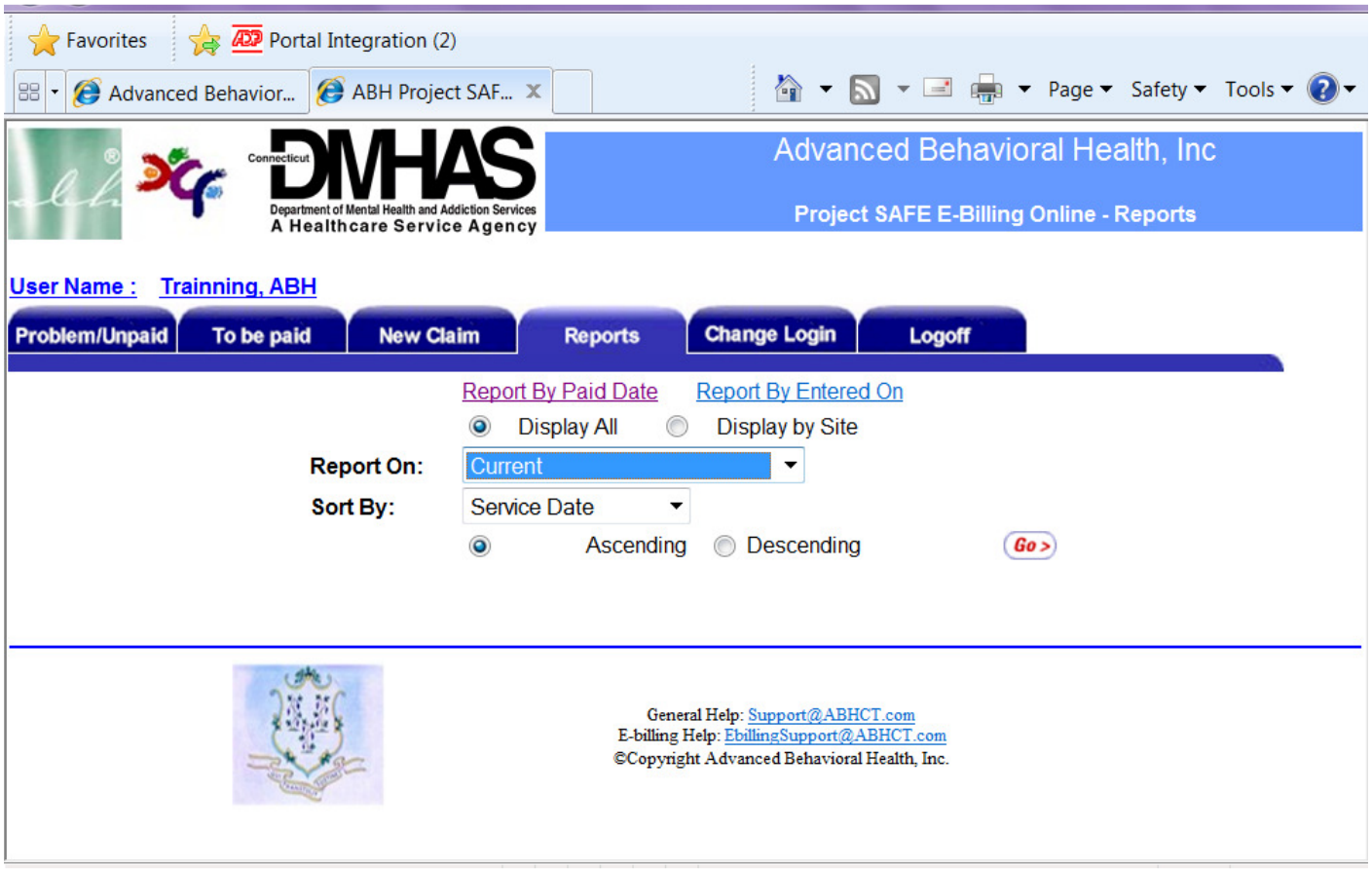
When Logging into Project SAFE E-billing, a user will have access to the claims processing system.
The claims system has Six (6) tabs. Problem/Unpaid, To be paid, New Claim, Reports, Change Login, Logoff.

- Problem/Unpaid – in this tab you are able to review all claims that are going to be paid, denied claims and pending claims. In this tab you can also resubmit denied claims.
- To Be Paid – in this tab you can see what will be paid on the next *Check Run*. Check Runs are done every other Tuesday of each month.
- New Claim – in this tab you can submit all new claims
- Reports – in this tab you can print out reports and current EOBs.
- LOGOFF – you will logoff the claims system.

NEW CLAIMS TAB

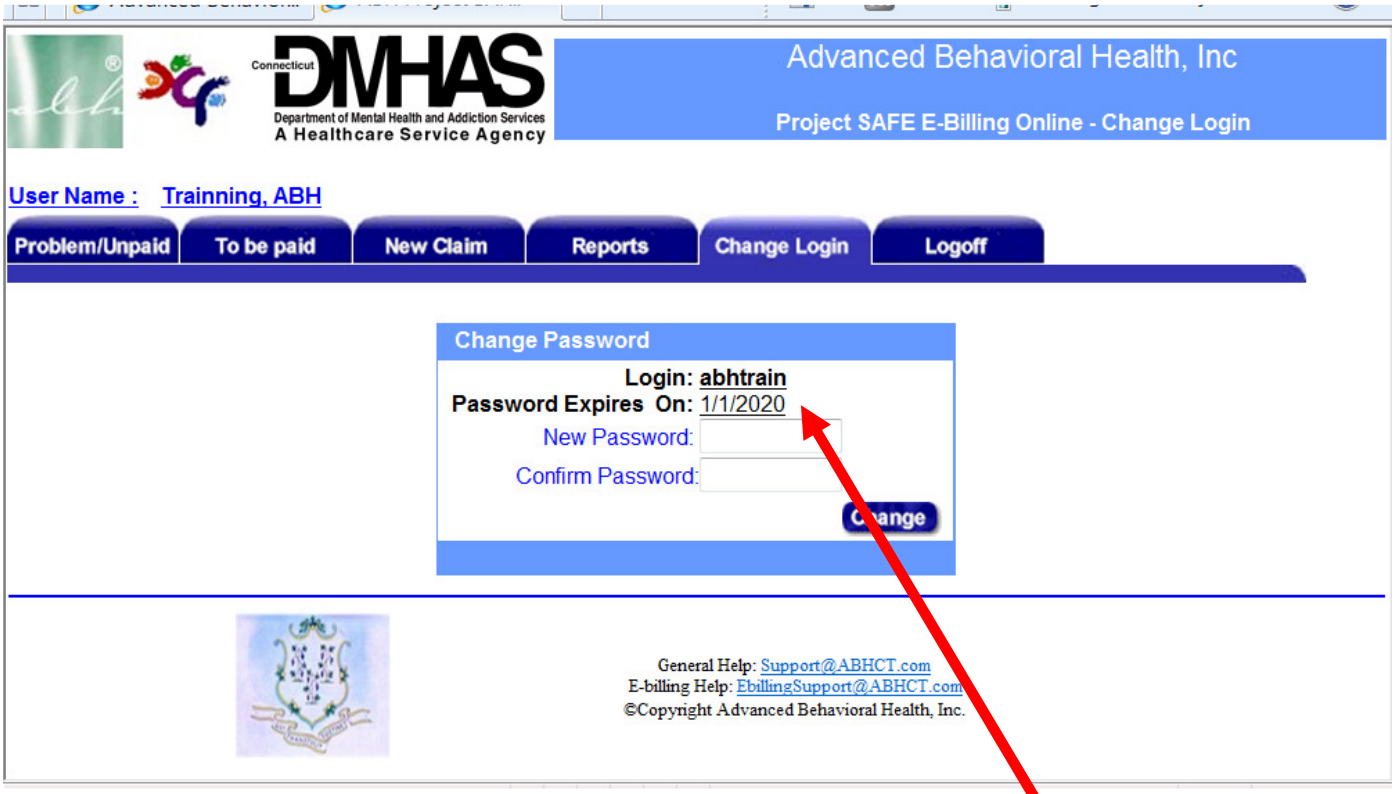
1. Insert Date of Service as shown above example: 08/01/2011. You must put in all 4 numbers of the current year.
2. Choose the service: EVALUATION, DRUG SCREEN [I(**Instant**) – CS(**Confirmation Substance**) – CO (**Confirmation Opeate**)- CE (**Confirmation Extended**)]**, HAIR TEST, OP-INDIVIDUAL, GROUP, IOP, PHP AND FAMILY
3. Input ABH ID number

** Drug Screen I (instant) when processing this service you need to put the ABH# in the Specimen ID#. Drug Screen CS (confirmation) needs to be submitted with the same date of service as the Drug Screen I and when processing the service you need to put the Specimen ID#. When Processing a Special Drug Screen CO you need to follow the same steps as when you put in the Drug Screen CS. REMEMBER: Each Confirmation you enter must have the same date of service of a Drug Screen I(Instant) was performed. **



REPORTS TAB

The reports tab shows all available reports. You can print out the last 3 Project SAFE Check Runs (closings) by dates when selecting "Report on".



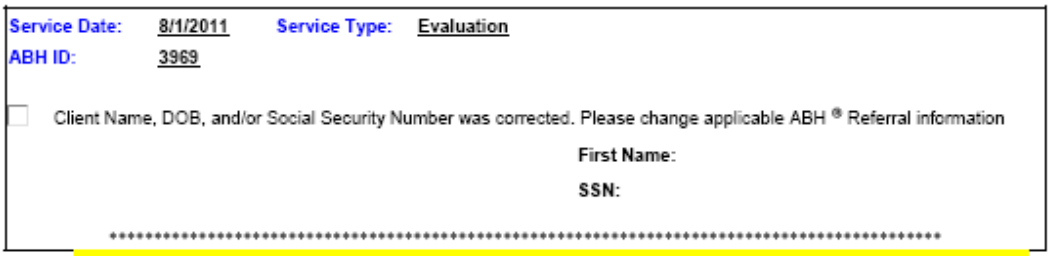
CHANGE LOGIN

In this tab you are able to change your password and it also shows a date when it will expire. Passwords must be changed every 45 days. This Print-Screen will show when the password will expire.

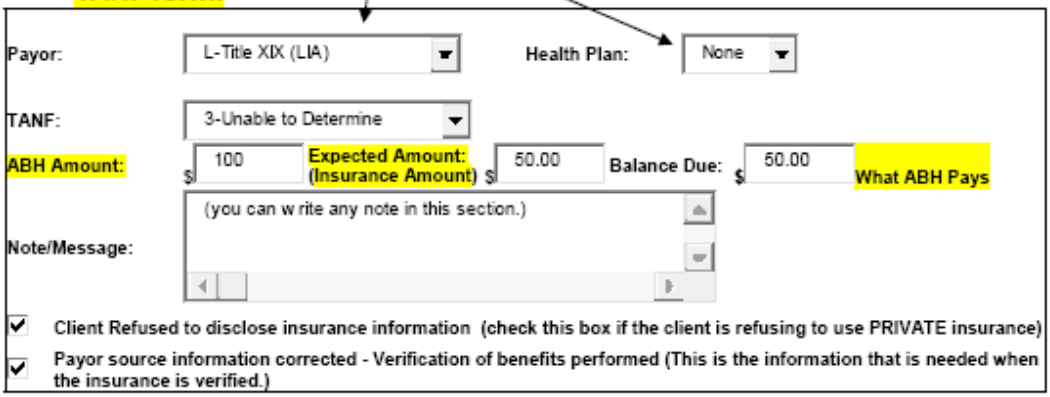
EVALUATION CLAIMS

1. Go to NEW CLAIMS tab
2. Insert SERVICE DATE (make sure you put in the full 4-digit current year)
3. Select EVALUATION
4. Input ABH ID NUMBER
5. Hit the SEARCH Button

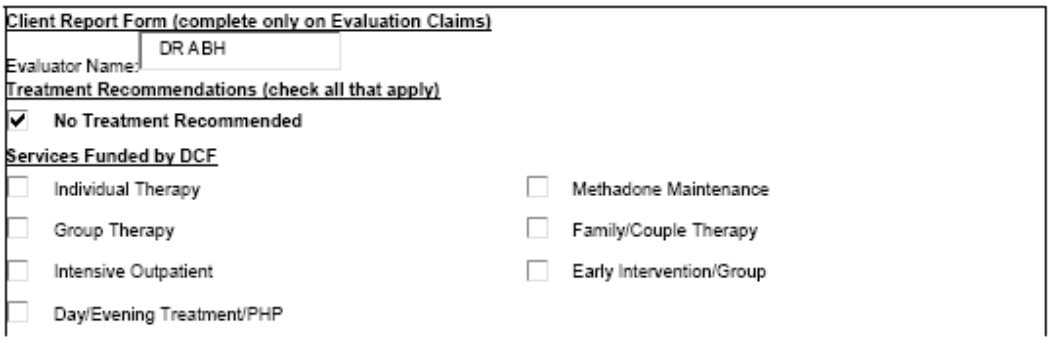
1. **Check to make sure Service Date, Service Type & ABH Number is correct**



2. **Input the insurance (Payor). The amounts should "Auto Fill" based on the insurance type you have entered. Also enter the information from the TANF form.**



3. **Please data Enter all information in the Client Report Form Provided by the clinician and note that the Needs Assesement is for Females only.**



Services NOT Funded by DCF

- [ ] Residential Services with Children
- [ ] Residential Services without Children
- [ ] Residential Services - Unspecified
- [ ] Inpatient Substance Abuse
- [ ] Psychiatric Services

Need Assessment (Complete only on Evaluation Claims for Women)

Is the client clinically most appropriate for residential treatment? No

Client accepted recommendation for residential treatment? No

Reason not Accepted

- [ ] Child Care
- [ ] Treatment Resistance
- [ ] Work Related
- [ ] Other

Other Reason Not Accepted:

Was bed available?

Identify Location

- [ ] Amethyst House/Crossroads (New Haven)
- [ ] Mother's Retreat/Connection (Groton)
- [ ] Coventry House/ADRC (Hartford)
- [ ] New Life Center/CPAS (Putnam)
- [ ] STAR/CVH (Middletown)
- [ ] Project Fresh Start (Hartford)
- [ ] Women and Children's Unit/Crossroads (New Haven)
- [ ] Women and Children's Center/Connection (Middltown)
- [ ] Families in Recovery/Liberation (Stamford)
- [ ] Women and Children's Program/Morris (Waturbury)
- [ ] Hogar CREA (Hartford)
- [ ] Guenster (Bridgport)

Other:

If not admitted to residential treatment, did client accept referral to alternate level of care?

Alternate Level of Care

- [ ] Inpatient Substance Abuse
- [ ] Individual Therapy
- [ ] Intensive Outpatient
- [ ] Psychiatric Services
- [ ] Group Therapy
- [ ] Day/Evening Treatment/PHP

Submit Then hit Submit

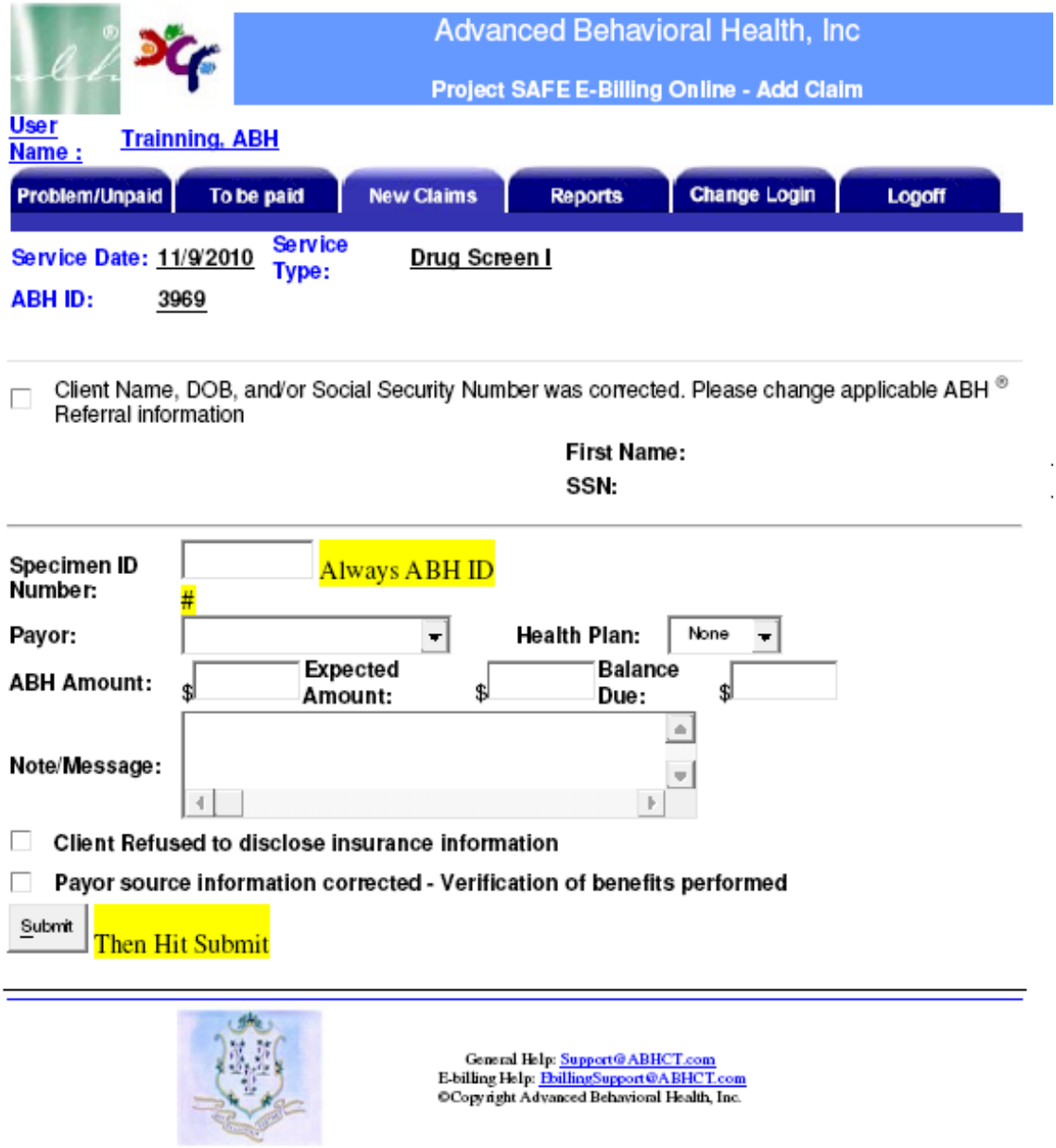
*****

Please allow no more than 24 – 48 hours if Claims Coordinator is unable to attend to the claims that are pending. If it's any longer than that and cannot wait please contact ABH ~ Project SAFE Claims at 860-704-6144.

DRUG SCREEN I

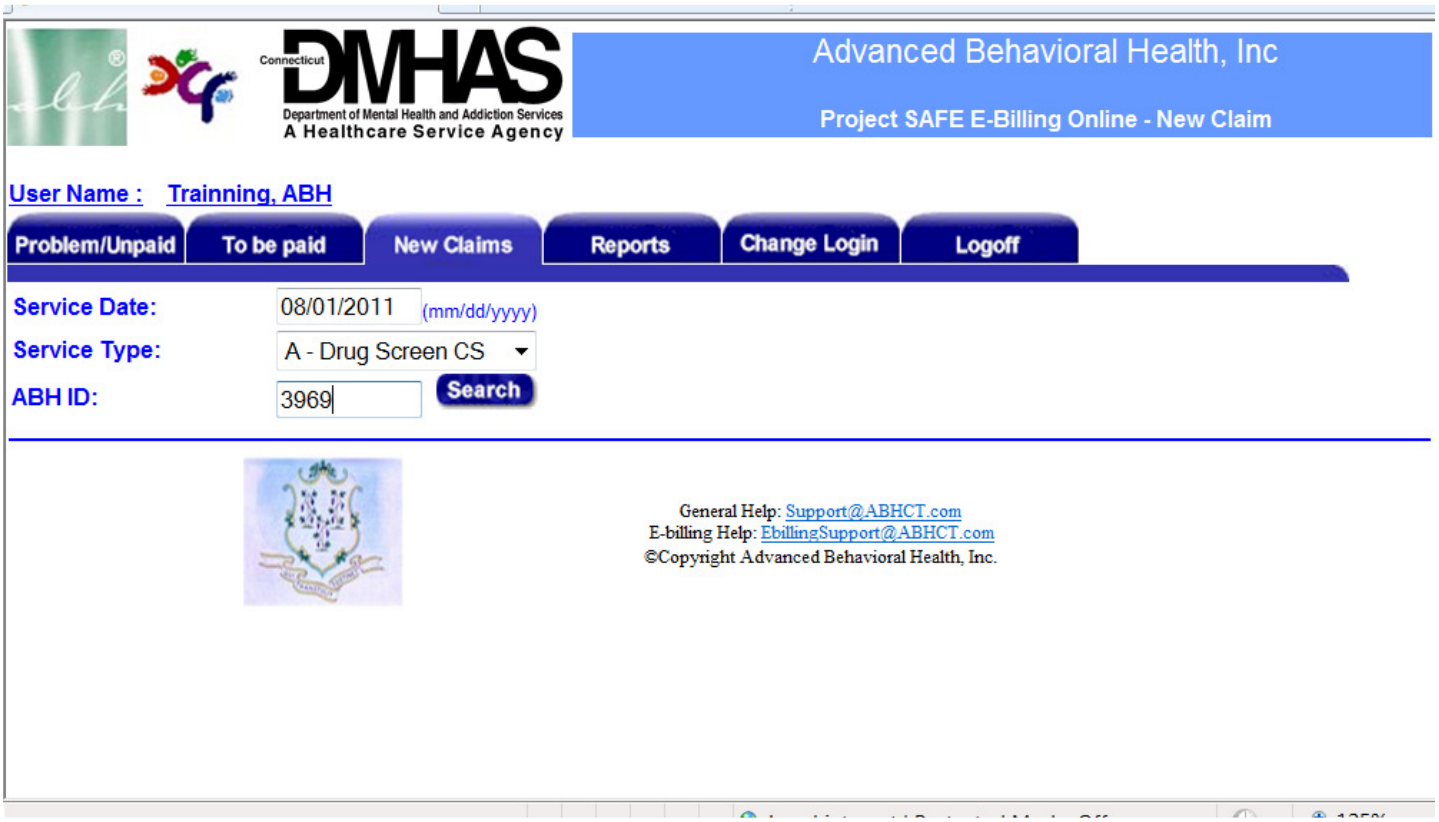
To input Drug Screen I- Instant it's similar to the Evaluation Process but with less steps.

1. Go to NEW CLAIMS tab.
2. Insert SERVICE DATE
3. Select DRUG SCREEN I
4. Input ABH ID NUMBER
5. Hit the SEARCH button



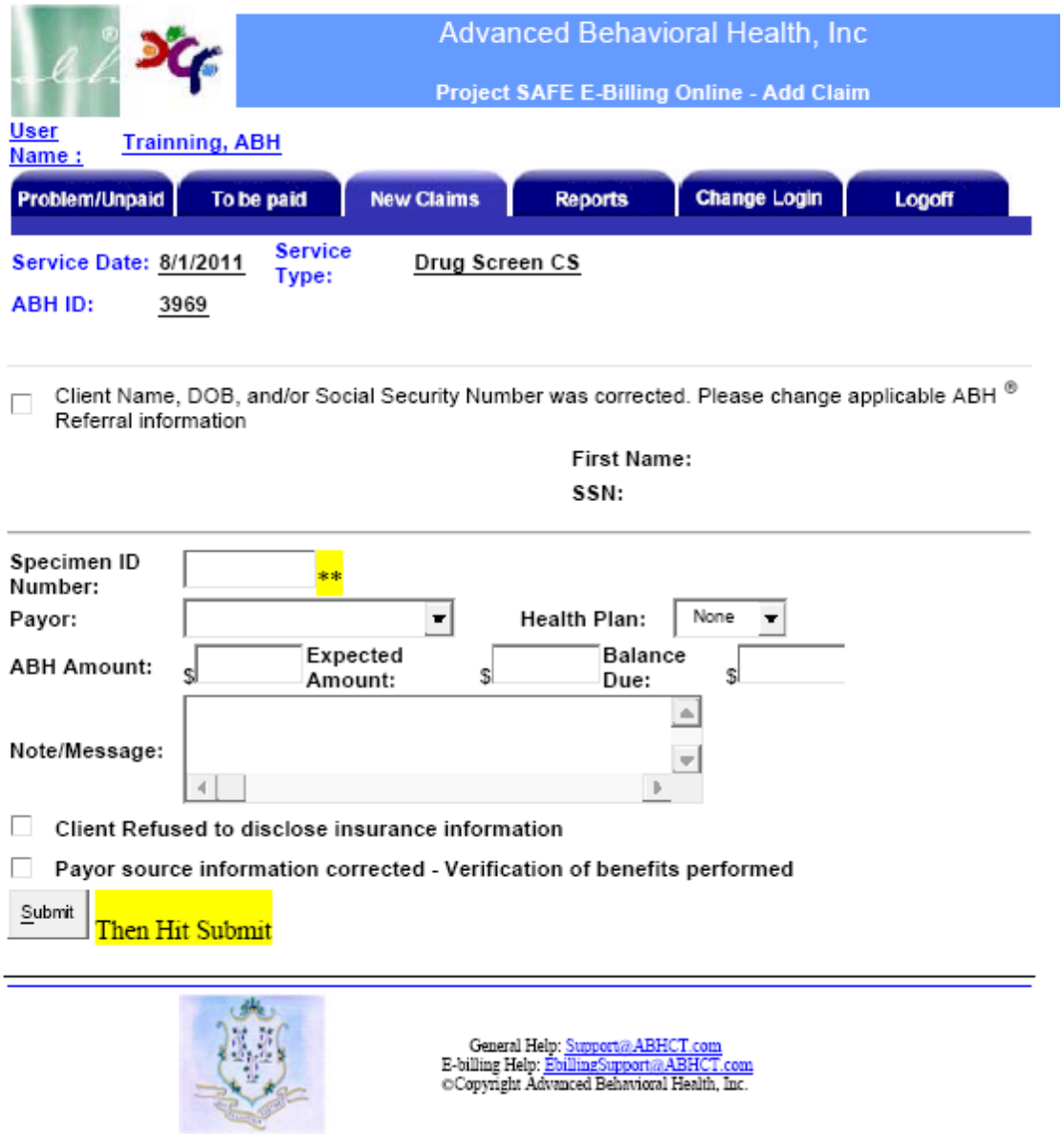
NOTE: for all Drug Screen I-Instant claims, the specimen ID number is always the ABH ID Number.

1. Check all demographics
2. Input the information as requested in each box
3. Then hit Submit.



DRUG SCREEN CS

1. **Go to NEW CLAIMS tab**
2. **Insert SERVICE DATE**
3. **Select Drug Screen CS**
4. **Input ABH ID NUMBER**
5. **Hit the SEARCH button**



**When inputting a Drug Screen CS please follow the format of putting in DRUG SCREEN I, however, there is a Specimen ID number for each Drug Screen CS and the clinician should provide you with that information for proper data entry. When finished with claim hit "submit". NOTE: In order to be reimbursed for the Drug Screen CS-Confirmation, there must also be a Drug Screen I-Instant submitted on the same date of service.

GROUP – OP INDL – FAMILY – IOP – PHP CLAIMS

1. Go To NEW CLAIMS Tab
2. Insert Date of SERVICE
3. Select ANY treatment Service
4. Hit the SEARCH button.

**Always follow the same data entry procedures when putting in any treatment claims because it's the same data entry process.

Questions? ~ Contact Project SAFE Claims Coordinator at 860-704-6144.

EDITING PROBLEM UNPAID

1. Hit RESUBMIT Go the butting that is on the Far Right NOTE there should be a go ICON there this is just for training purposes.

When a claim is denied and it's in PROBLEM/UNPAID you would hit the button (resubmit GO) to edit. The reason codes are always in **RED.** Check off specific boxes that need to be changed and always hit submit when finished.

Appendix I:
Project SAFE Drug Testing Methodology

Project SAFE

Overview of Drug Testing

Drug testing is available through Project SAFE to assist in the evaluation, treatment, and monitoring of parents/caregivers with current or significant history of problematic use of substances. The goal is to support parents/caregivers in their recovery and in providing for the safety and well-being of their families. The following is a brief overview of the referral process and drug testing methodologies available through Project SAFE.

Referral Process for Drug Testing through Project SAFE

DCF makes Project SAFE Referral for	Requirements	Includes	Additional Information
Single Urine Drug Screen (UDS) –7 panel	Request accompanies referral for Project SAFE evaluation	Lab confirmation(s) as needed	
Random Urine Drug Screens (UDS) – 7 panel	• PS Eval within past six months or court order • Other situations on a case by case basis	Lab confirmation(s) as needed 12 units over a six week period Max. 1 per day, Two per week	
Urine Drug Screen – Special Drug Testing	Authorization from DCF Substance Abuse Specialist (SAS) or Behavioral Health Program Director (BHPD) or designee	Substance(s) to be tested that are not part of the standard 7 panel must be specified on the request. Provider will send urine sample to lab for confirmation. Lab confirmation will take additional 1 – 2 business days.	

DCF makes Project SAFE Referral for	Requirements	Includes	Additional Information
Treatment Only	Random Drug Screens are included in the referral for outpatient SA treatment	Max. 1 per day, two per week	When the individual is referred for a PS evaluation, recommended for **and begins** outpatient treatment within the 45 day authorization period, Project SAFE automatically generates a "Treatment Only" referral that is ongoing as long is there is not a gap of 45 days in treatment services. If treatment begins after the end date of the authorization, or there is a gap in services of > 45 days, DCF needs to make a new, "Treatment Only" referral to Project SAFE
Hair Testing	Authorization from DCF SAS, BHPD, or designee	If initial result is positive, a segmented analysis can be requested. The segmented analysis is always done at the lowest level of detection.	

Project SAFE Urine Drug Testing Methodology

- **Standard Drug Testing:**
  Project SAFE currently uses the Noble 1 Step Cup 7 panel which screens instantly for:

  - Amphetamines, which includes stimulant medications (ADHD medications), Methamphetamine, may not identify Ecstasy.
  - Cocaine
  - Marijuana (THC)
  - Opiates (Heroin, Morphine, Codeine)
  - Synthetic Opiates
  - Benzodiazepines
  - Phencyclidine (PCP), also known as Angel Dust

  The Noble Split 1 Step Cup's results are ready in approximately 5 minutes. Instant results are **presumptive** and should be sent out for **GC/MS lab confirmation when challenged by the client**. The lab confirmation will be faxed back to the Project SAFE provider usually within two (2) business days. The GC/MS lab confirmations are considered the **final** results.

  Training on using the Noble 1 Step Cup is available at www.noblemedical.com. Providers can order drug testing supplies (Noble's 1 Step Cup, materials for sending samples to the lab for confirmation) directly from Noble.

  Project SAFE Providers will use the ***Project SAFE Alcohol and Drug Testing Form*** available at http://www.abhct.com/Customer-Content/WWW/CMS/files/Project_Safe/Project_SAFE_Alcohol__Drug_Screening_Report-English.pdf
  to document the results of the instant drug test. The form includes a place for the client and staff member to sign off on the results. Project SAFE recommends photocopying the results directly from the Noble 1 Step Cup if the client refuses to sign the form or if the results are disputed by the client and being sent for lab confirmation.

- **Special Drug Testing**

  All testing for additional substances not in the standard 7 panel is done at the lab. Results will be faxed to the Project SAFE provider usually within two business days. Instant testing for these substances is not currently available through Project SAFE. **DCF must authorize the additional drug testing in order for the PS Provider to be reimbursed for the lab test.** The provider would then conduct an instant urine drug screen using Noble Split Specimen Cup® and send the specimen to the lab with a request for the specific substance(s) noted regardless of the results of the instant drug screen.

  Additional testing of other substances can only be reimbursed by Project SAFE when authorized by the DCF Substance Abuse Specialist (SAS), Behavioral Health Program Director (BH PD), or designee. Some drugs that additional testing, through Project SAFE, might be requested if there is an allegation of problematic use or abuse include:

  - Barbiturates (Butalbital which is Fioricet, Phenobarbital, Butobarbital, etc.)
  - Ecstasy
  - Others

- **Consider the following:**
    - Request additional drug testing for prescription medications if the individual does not have a prescription for that medication and there is a self-report or allegation of use.
    - If an individual has a prescription for the medication, additional drug testing may not be useful as a positive drug screen cannot be interpreted as abuse.
    - If a person admits to the problematic drug use, you would not ask for the additional drug testing.
    - Most substances have a window of detection between 48 – 72 hours.
    - There must be an allegation/report/observation of use or abuse of a substance to request additional drug testing. Additional drug testing should not be conducted as a 'rule-out' of all potential drug usage.
    - Once an individual reports that they are no longer taking the prescription medication, then conducting additional drug testing for that medication could be useful in verifying this information, if necessary.

- **Project SAFE Procedure for requesting special drug testing:**

    - SW obtains authorization from DCF SAS, BHPD, or designee and contacts ABH's Project SAFE referral line at 1-800-272-0097 to request special drug testing. DCF SW will specify the additional substance(s) for which testing is being requested..
    - ABH faxes the referral and authorization for special drug testing to the provider.
    - Provider sends the urine specimen to the lab for testing, noting the specific substance requested in the "Remarks" section on page two of the chain of custody form. Results will be faxed back to the Provider usually within two (2) business days. Provider informs DCF of the results of the results of the special drug testing by faxing the lab confirmation to the DCF SW.
    - Provider submits claim for special drug testing confirmation through ABH's web based claims system.
    - Drug testing for atypical substances, e.g. bath salts, anabolic steroids, etc.

Project SAFE Hair Testing Methodology

Hair testing analysis has a three month window of detection. Hair testing through Project SAFE requires authorization by the DCF SAS, BH PD, or designee. Results will be reported within 2-6 business days. Project SAFE currently works with Psychemedics for hair testing, using a 5 Panel Plus to screen for:

- Amphetamines - including Amphetamine, methamphetamine, ecstasy, MDA, and MDEA (eve)
- Cocaine
- Marijuana (THC)
- Opiates (including heroin, Morphine and Codeine, Oxycodone (OxyContin), Hydrocodone (Vicodin), and Hydromorphone (Dilaudid)
- Phencyclidine (PCP), also known as Angel Dust

For training on the collection process, refer to Psychemedics' online training at www.haircollectionexam.com (password = hairsample). Providers should contact Psychemedics Customer Service at -1-800-522-7424 for collection supplies for hair testing. Please allow two weeks for delivery.

If there are positive results reported from the Standard Hair Test Screen, the Provider can call the testing facility (Psychemedics at 1-800-522-7424) to request a complete sectional analysis. It is important to clarify that you are calling about an ABH® client and requesting the additional testing. Psychemedics will then invoice ABH® directly for additional testing.

Important Considerations with Drug Testing

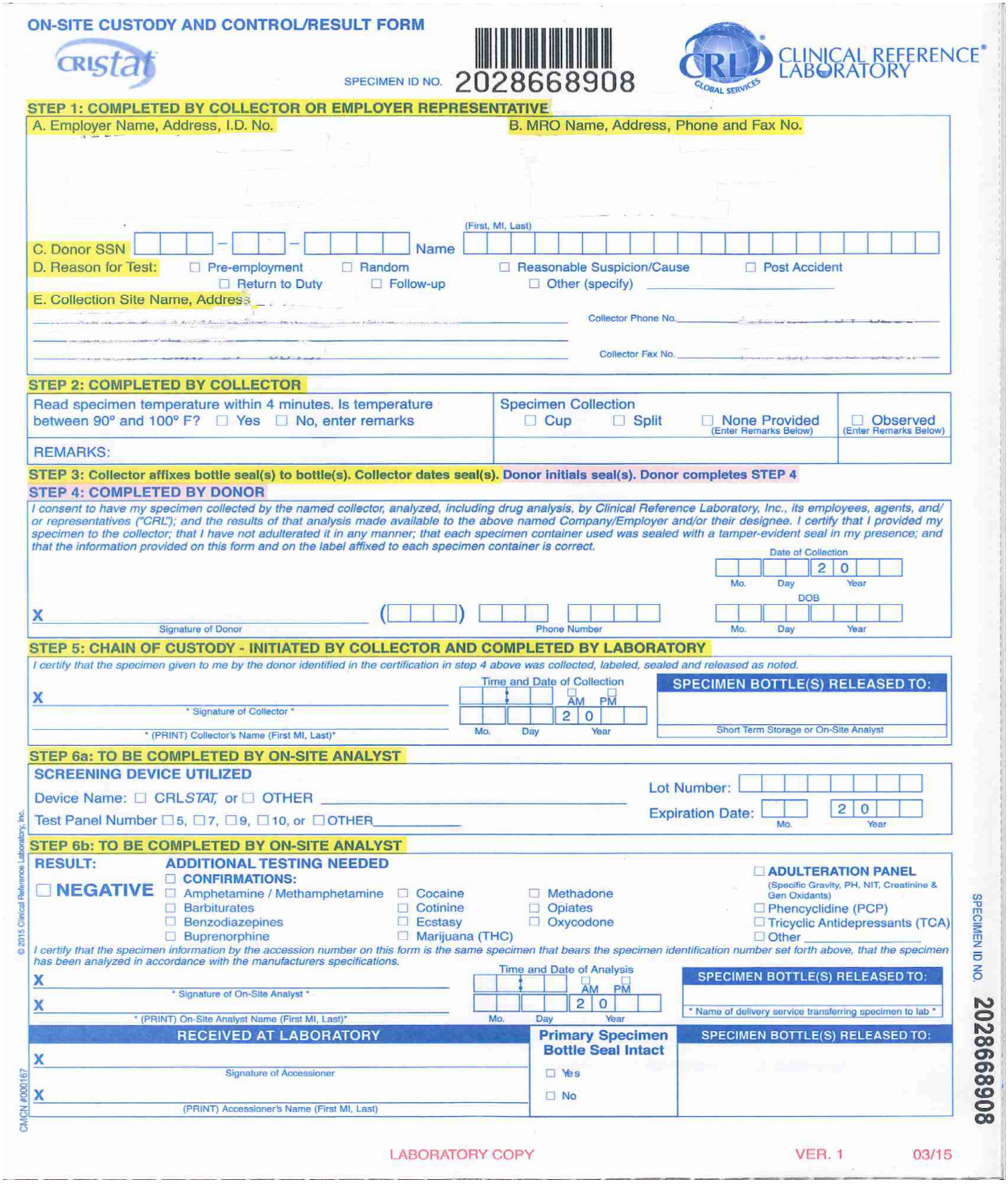
A positive level does not:

- Indicate level of intoxication
- Show administration route
- Distinguish between drugs of abuse and certain medications (Requires confirmation)

- Drug Detection Windows vary by substances and frequency of use.

- A negative result may not necessarily indicate the person is drug-free; Negative results can be obtained when the drug is present below the cut-off level of the test or was used outside the window of detection.

Noble On-Site Custody and Control/Result Form and Recommended Steps to Complete Form



ON-SITE CUSTODY AND CONTROL/RESULT FORM

CRISTAT

SPECIMEN ID NO. 2028668908

CRL GLOBAL SERVICES CLINICAL REFERENCE® LABORATORY

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone and Fax No.

C. Donor SSN ___ – ___ – ____ Name (First, MI, Last)

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

E. Collection Site Name, Address

Collector Phone No.

Collector Fax No.

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☐ Yes ☐ No, enter remarks	Specimen Collection ☐ Cup ☐ Split ☐ None Provided (Enter Remarks Below)	☐ Observed (Enter Remarks Below)
REMARKS:		

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 4

STEP 4: COMPLETED BY DONOR

I consent to have my specimen collected by the named collector, analyzed, including drug analysis, by Clinical Reference Laboratory, Inc., its employees, agents, and/or representatives ("CRL"); and the results of that analysis made available to the above named Company/Employer and/or their designee. I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; that each specimen container used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen container is correct.

Date of Collection Mo. Day 20 Year

X _____ Signature of Donor ( ) Phone Number

DOB Mo. Day Year

STEP 5: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification in step 4 above was collected, labeled, sealed and released as noted.

X _____ * Signature of Collector *

_____ * (PRINT) Collector's Name (First MI, Last)*

Time and Date of Collection ☐ AM ☐ PM Mo. Day 20 Year

SPECIMEN BOTTLE(S) RELEASED TO:

Short Term Storage or On-Site Analyst

STEP 6a: TO BE COMPLETED BY ON-SITE ANALYST

SCREENING DEVICE UTILIZED

Device Name: ☐ CRL*STAT*, or ☐ OTHER _____

Test Panel Number ☐ 5, ☐ 7, ☐ 9, ☐ 10, or ☐ OTHER_____

Lot Number:

Expiration Date: Mo. 20 Year

STEP 6b: TO BE COMPLETED BY ON-SITE ANALYST

RESULT: ☐ NEGATIVE

ADDITIONAL TESTING NEEDED

☐ CONFIRMATIONS:

☐ Amphetamine / Methamphetamine ☐ Cocaine ☐ Methadone

☐ Barbiturates ☐ Cotinine ☐ Opiates

☐ Benzodiazepines ☐ Ecstasy ☐ Oxycodone

☐ Buprenorphine ☐ Marijuana (THC)

☐ ADULTERATION PANEL (Specific Gravity, PH, NIT, Creatinine & Gen Oxidants)

☐ Phencyclidine (PCP)

☐ Tricyclic Antidepressants (TCA)

☐ Other _____

I certify that the specimen information by the accession number on this form is the same specimen that bears the specimen identification number set forth above, that the specimen has been analyzed in accordance with the manufacturers specifications.

X _____ * Signature of On-Site Analyst *

X _____ * (PRINT) On-Site Analyst Name (First MI, Last)*

Time and Date of Analysis ☐ AM ☐ PM Mo. Day 20 Year

SPECIMEN BOTTLE(S) RELEASED TO:

* Name of delivery service transferring specimen to lab *

RECEIVED AT LABORATORY

X _____ Signature of Accessioner

X _____ (PRINT) Accessioner's Name (First MI, Last)

Primary Specimen Bottle Seal Intact ☐ Yes ☐ No

SPECIMEN BOTTLE(S) RELEASED TO:

SPECIMEN ID NO. 2028668908

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CMCN #000167

LABORATORY COPY VER. 1 03/15

Step 1: The collector checks the pre-printed portions of the form. That should include: Company Name/Address/Phone and may also include Collection Site Name, Address, Phone, Fax

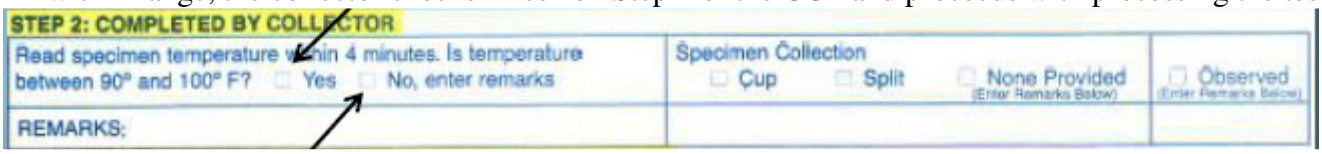
Step 1 continued: Collector enters the Collection Site information, if not pre-printed

The collector asks donor to present an acceptable form of identification. Collector enters ID# and Donor Name.

Next, the collector checks the appropriate Reason for Test in Step 1. (Shown here as Pre-employment)

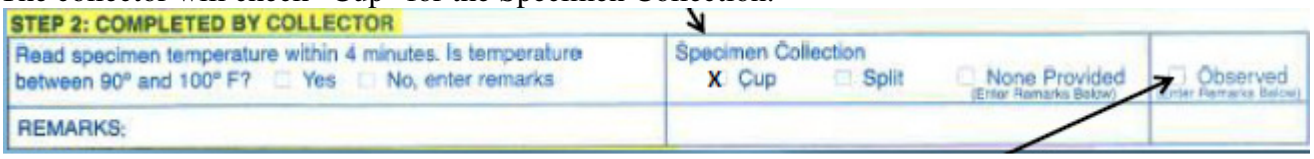
Perform Drug Screen

1) Collector removes the lid from the cup (The key and the lid are held by the collector.)
2) Donor provides specimen and gives to the collector. Collector secures lid tightly.
3) Collector verifies that the temperature is between 90-100 degrees Fahrenheit. If the temperature is within range, the collector checks "Yes" on Step 2 of the CCF and proceeds with processing the test.



If it is not within range, the collector needs to check "No" on Step 2 and enter remarks on CCF.

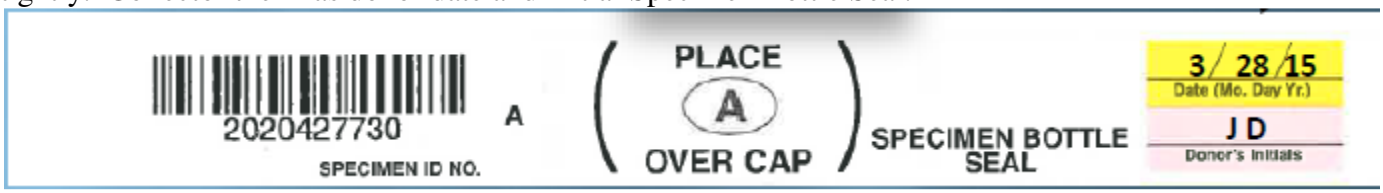
The collector will check "Cup" for the Specimen Collection.



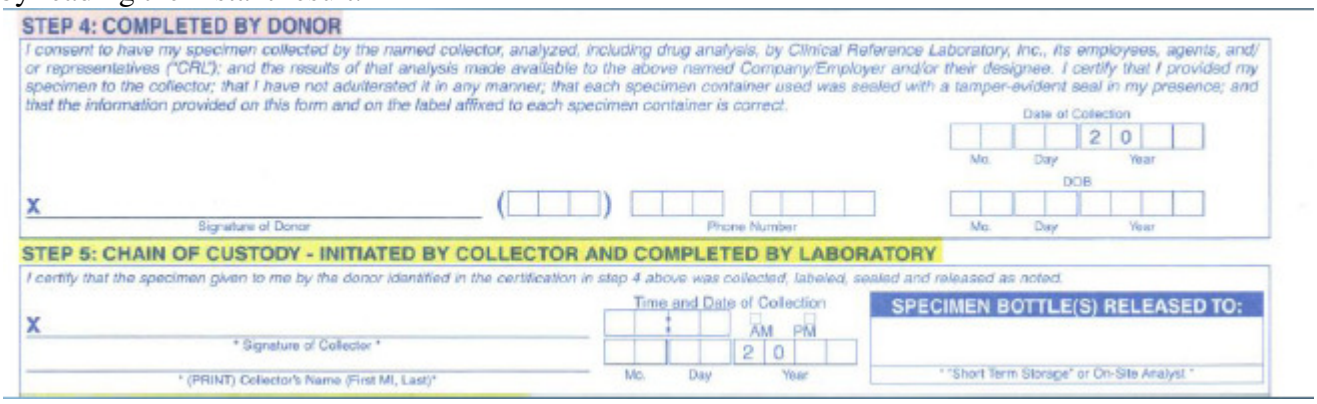
The collector will check the "Observed" box IF the collection was an Observed Collection.

4) The collector places the cup on a flat surface, inserts key and pushes in.
5) Collector peels off label to view results. Wait for the colored lines to appear and the adulteration strips to change. Results should be read at 5 minutes. Drug test results are stable for up to 60 minutes.
    a. Negative: A Negative test is indicated by the presence of a test line by each designated drug. Even a very light colored line indicates a negative result.
    b. Positive: A Positive test is indicated by the presence of only a "C" control line and the ABSENCE of *any* test line beside the designated drug.
    c. Invalid: An Invalid test is indicated only when the "C" control lines and the test lines are completely missing in *one or more* of the test windows. In the event of an invalid screen a second screen should be run. A photocopy of the results can be made by placing the entire cup with the result face down on the copier.
    d. Adulteration: Collector compares adulteration strip colors with color adulteration card to check for a normal or abnormal sample. Please consult the package insert provided in each case for further explanation.
6) Collector replaces key in cap.

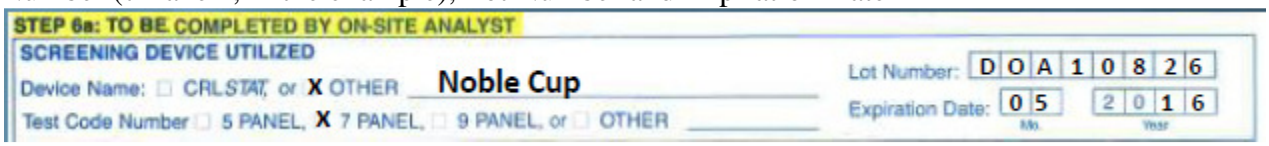
Collector removes Specimen Bottle Seal from CCF and places over cap and around side of bottle, sealing tightly. Collector then has donor date and initial Specimen Bottle Seal.



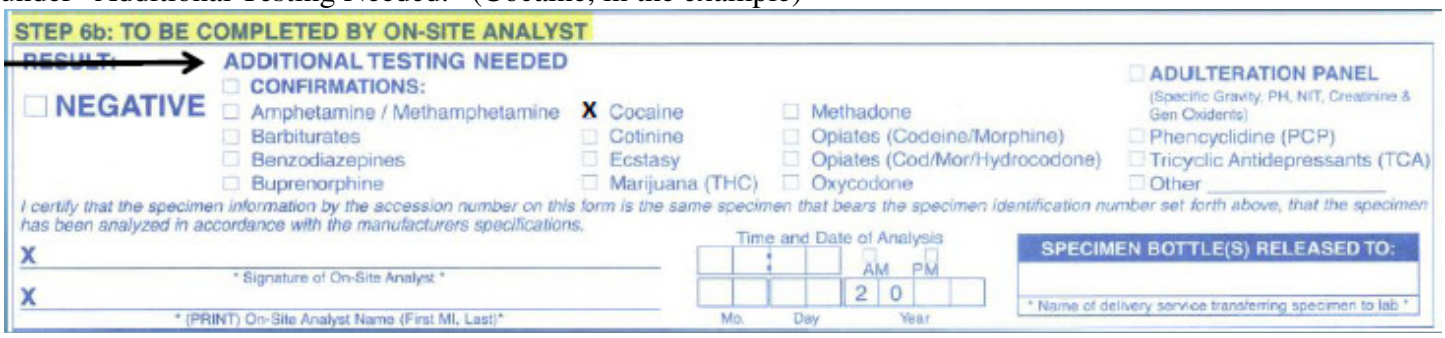
Step 4&5: The collector has the donor sign and date the form, and provide the phone number where the donor can be reached. The collector signs the form, and provides the time and date of collection. For "SPECIMEN BOTTLES RELEASED TO:" the collector will write Onsite Analyst, as they are also being the On-Site Analyst by reading the instant result.



Step 6a: The collector will enter the information about the rapid screening device: Device Name, Test Code Number (7 Panel", in the example), Lot Number and Expiration Date



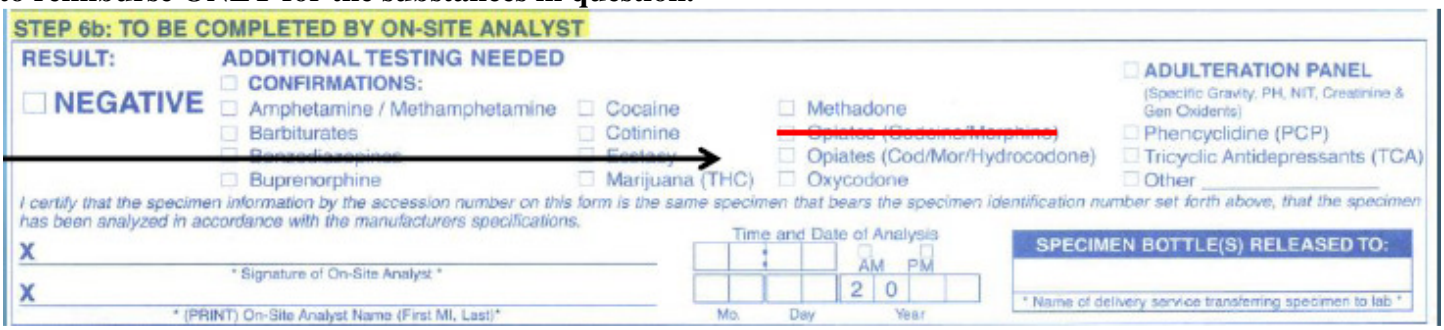
Step 6b: If the result is Negative, the collector will use the Project SAFE Alcohol and Drug Screening Report. The collector can then dispose of the negative sample according to company procedure. If the result is Non-Negative, the collector will determine which drug is Non-Negative and then will check the appropriate box under "Additional Testing Needed." (Cocaine, in the example)



The collector will then prepare the specimen for shipment to the laboratory. For "SPECIMEN BOTTLES RELEASED TO:" the collector will write FEDEX.

Please note: When confirming “Opiates”, please check the “Opiates (Cod/Mor/Hydrocodone)” box. The lab will confirm Codeine/Morphine/Heroin/Hydrocodone/Hydromorphone. Check the Oxycodone box if you need confirmation for Oxycodone/Oxymorphone.

***** ONLY SELECT SUBSTANCES IN NEED OF CONFIRMATION. Project SAFE reserves the right to reimburse ONLY for the substances in question.*****


STEP 6b: TO BE COMPLETED BY ON-SITE ANALYST

RESULT: ☐ NEGATIVE

ADDITIONAL TESTING NEEDED

CONFIRMATIONS:

☐ Amphetamine / Methamphetamine ☐ Cocaine ☐ Methadone

☐ Barbiturates ☐ Cotinine ☐ Opiates (Cod/Mor/Hydrocodone)

☐ Buprenorphine ☐ Marijuana (THC) ☐ Oxycodone

ADULTERATION PANEL (Specific Gravity, PH, NIT, Creatinine & Gen Oxidents)

☐ Phencyclidine (PCP)

☐ Tricyclic Antidepressants (TCA)

☐ Other _____

I certify that the specimen information by the accession number on this form is the same specimen that bears the specimen identification number set forth above, that the specimen has been analyzed in accordance with the manufacturers specifications.

X _____ * Signature of On-Site Analyst *

X _____ * (PRINT) On-Site Analyst Name (First MI, Last)*

Time and Date of Analysis: ☐ AM ☐ PM

Mo. Day Year 2 0

SPECIMEN BOTTLE(S) RELEASED TO:

* Name of delivery service transferring specimen to lab *

Should the sample need to go for further testing the collector places the Laboratory Copy of the form in the small pocket on the side of the bag opposite the Biohazard Label. The collector then places the sample in the zip lock portion of the bag and seals the zip lock tightly. If possible, collector can fold top of envelope over to tape. The collector then places the sample inside the FedEx shipping bag. Remove the clear strip to expose the adhesive and press firmly to make sure the FedEx Clinical Pak is completely sealed.

The collector fills out Section 1 of the airbill (From). The collector the checks to make sure Section 3 (To) has been preprinted, and the account number is preprinted in Section 7. The airbill is attached to the FedEx bag, and the bag is sealed. Collector contacts FedEx for pick-up.

PSYCHEMEDICS FORENSIC DRUG TESTING CUSTODY AND CONTROL FORM - (CCF) - ©

PSYCHEMEDICS CORPORATION

Client Code (if other than printed) | FOR LAB USE ONLY

PLEASE PRESS FIRMLY, YOU ARE MAKING MULTIPLE COPIES

STEP 1 Completed by Collector or Employer: A) Unless XXX'ed out, fill in Donor ID & Name. B) Put an "X" in box of choice for STEP 1 – C, D and E.

A. SAMPLE COLLECTED FOR:

B. DONOR IDENTIFICATION (18 character maximum) DONOR/EMPLOYEE ID #

DONOR LAST NAME | DONOR FIRST NAME

C. DONOR ID VERIFIED BY: ☐ Photo ID ☐ Representative (Signature of Representative: _____)

D. REASON FOR TEST: ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Re-Test ☐ Follow-Up

☐ Other (Specify) _____ **If No Reason for Test is chosen - The client's chosen default is:**

E. DRUG TESTS TO BE PERFORMED: If No Drug Test is chosen, then client's chosen default is:

THIS SIDE FACING OUT — FOLD IN HALF HERE

STEP 2 Completed by Collector: A) Obtain sample from donor, place in foil and insert foil in SAMPLE ACQUISITION CARD (SAC). B) Peel off BARCODE LABEL below and apply it to the SAC. C) Sign and date then wrap RED INTEGRITY SEAL over bottom edge of the SAC to seal. D) Check box below for SOURCE OF SAMPLE.

SOURCE OF SAMPLE: ☐ Head ☐ Underarm ☐ Leg ☐ Arm ☐ Chest ☐ Other (Specify) _____

REMARKS - ANY OBSERVATIONS ABOUT OR DONOR COMMENTS REGARDING HAIR:

STEP 3 Completed by Donor: A) Donor initials the SAMPLE ACQUISITION CARD (SAC) with the hair sample sealed inside. B) Read, sign and complete ALL information below.

Donor Certification and Authorization for Release of Test Results: I provided the sample in the Sample Acquisition Card (SAC), the sample was cut close to the skin, and I witnessed the collector seal the sample in the SAC. I consent to the testing of the sample by Psychemedics Corporation and to the release of the results to the authorized recipient.

If I am submitting my sample at the request of a Vendor Employer Compliance Testing Organization ("VECTOR") participant, I authorize Psychemedics Corporation to make available information about my test results to any and all VECTOR participants.

DONOR SIGNATURE X _____ | DONOR PRINTED NAME | DONOR PHONE NUMBER

STEP 4 Completed by Collector: A) Read, sign and complete ALL information below. B) Remove perforated edges from CCF, separate PAGE 1-LAB COPY and fold in half - printed side facing out. C) Insert PAGE 1-LAB COPY & SAC into the PLASTIC POUCH and seal it. D) Give PAGE 5-DONOR COPY to Donor.

I, the collector, certify that the enclosed sample was obtained with the consent of the donor, that proper identification of the donor was made, that the appropriate authorization was obtained from the donor for disclosure of the results to the authorized recipient, and that the sample was prepared for release to the delivery service transferring the sample to the lab.

COLLECTOR SIGNATURE X _____

PRINT COLLECTOR NAME

DATE MM/DD/YYYY TIME HH:MM ☐ AM ☐ PM

COLLECTION FACILITY NAME

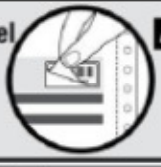
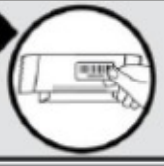
STREET ADDRESS

CITY | STATE / PROVINCE | COUNTRY (If other than USA) | ZIP / POSTAL CODE

USA: Please use (area code) + number Outside USA: Please use country code, area code + number

PHONE NUMBER ( )

FAX NUMBER ( )

Collector: Peel off Barcode Label and Apply to Sample Acquisition Card (SAC) → Peel  Apply on SAC 

BARCODE LABEL

STEP 5 Completed by Psychemedics' Lab Staff only

☐ NEGATIVE ☐ POSITIVE FOR: REMARKS:

PRINT CERTIFYING SCIENTIST NAME | SIGNATURE OF CERTIFYING SCIENTIST X | DATE (MM/DD/YY) MM/DD/YYYY

RECEIVED AT LAB: I, the accessioner, certify that the sample identified on the form was examined upon receipt, handled using chain of custody procedures and accessioned in accordance with applicable procedures.

INTEGRITY SEAL INTACT? ☐ YES ☐ NO

PRINT ACCESSIONER NAME | SIGNATURE OF ACCESSIONER X

DATE SAMPLE RELEASED TO TEMPORARY STORAGE (MM/DD/YYYY):

PAGE 1 - LAB COPY

5832 Uplander Way, Culver City, CA 90230 P: 800-522-7424 P: 310-216-7776 F: 800-643-2354

UAV5