State of Connecticut
Department of Mental Health and Addiction Services

GENERAL ASSISTANCE BEHAVIORAL HEALTH PROGRAM

PROVIDER MANUAL

MAY 2005

Table of Contents

Section 1. **General Information** .... **Page 1**
- Welcome and Introduction
- Background and History
- Overview
- Goals of the Program
- Staff functions and Fact Sheet

Section 2. **Eligibility** .... **Page 7**
- Determining eligibility for behavioral health services
- CHNCT and Medical Coverage
- Out of State/Network Providers
- Medicaid Recoupment

Section 3. **Covered Services** .... **Page 10**
- Behavioral health, by levels of care
- Utilization Management Model
- Recovery Support Services
- Special Service Initiatives
- Laboratory Services
- Service Limitations and Exclusions

Section 4. **Obtaining Authorizations to Treat**........................ **Page 22**
- Electronic Registration System
- Process for telephonic reviews
- Clinical information necessary to do reviews
- Discharges
- Critical Incidents

Section 5. **Claims Submission** .... **Page 28**
- General Requirements
- Filing Requirements (paper, on-line, electronic batches)
- Service Limitations
- Claims Inquiries and Appeals

Section 6. **Support of Contracted Providers** .... **Page 34**
- Credentialing and Contracting
- ASO Responsibilities
- Provider Responsibilities

Section 7. **Appeals, Complaints and Grievances** .... **Page 36**

Section 8. **Glossary of Terms** .... **Page 39**

Section 9. **Appendix and Forms** .... **Page 42**

SECTION 1 – GENERAL INFORMATION

Welcome!

Introduction to the General Assistance Behavioral Health Program

The Connecticut Department of Mental Health and Addiction Services (DMHAS), together with Advanced Behavioral Health, Inc. (ABH), are pleased to welcome you to the General Assistance Behavioral Health Program (GABHP).

Your organization, as a provider in the DMHAS GABHP, is a valuable part of the statewide continuum of behavioral health services. You have joined a network devoted to insuring access to a comprehensive, quality driven, and progressive delivery system. Your agency partners with the State to integrate a recovery orientation in the treatment of mental health and substance abuse disorders.

This manual has been developed to answer your questions about the GA Behavioral Health Program. It will describe the policies and procedures - from covered services to referrals, from authorizations to appeals, from credentialing and contracting to claims submission.

Your adherence to the guidelines presented here will assist your organization with obtaining authorizations, submitting claims and receiving payment in a rapid, efficient manner. Should there ever be any question or comment regarding the contents of this manual, or at any other time, please call us on our toll free number.

1- 800 – 606 – 3677

Option 1, Clinicians and Authorizations
Option 2, Customer Service
Option 3, Provider Relations
Option 4, Claims

We look forward to a dynamic and rewarding relationship, as we focus on delivering services of the highest quality to the General Assistance recipients relying on us for care.

> Important Notice – DMHAS reserves the right to interpret terms and provisions of this manual and to amend the manual, from time to time, as may be required to improve operation of the Program. To the extent that there are inconsistencies between this manual and the Provider Agreement or Policies governing the Program, the Provider Agreement and Policies shall apply.

BACKGROUND AND HISTORY
GENERAL ASSISTANCE BEHAVIORAL HEALTH PROGRAM

Prior to July 1, 1997, the Department of Social Services (DSS) had responsibility for oversight of the delivery of behavioral and medical health services, which was delegated to the towns and cities of Connecticut.

On July 1, 1997, the Department of Mental Health and Addiction Services assumed responsibility for managing the delivery of behavioral health services. DMHAS contracted with Advanced Behavioral Health, Inc., for that fiscal year, as a pilot, with a focus on developing a new approach to managing services for GA recipients. In 1998, as a result of a competitive procurement process, the contract for program management was awarded to ValueOptions, who subcontracted the utilization management functions to Advanced Behavioral Health. As a result of a second competitive procurement process initiated in the fall of 2004, on July 1, 2005, ABH will act as the Administrative Services Organization (ASO) for all aspects of the General Assistance Behavioral Health contract.

Centralizing the utilization management function has historically offered the opportunity to develop consistency within the process. It has also allowed for ongoing data collection, which serves in turn to inform the Department regarding utilization patterns, trends, and needs within the behavioral health delivery system in the state. The Department of Social Services continues to maintain responsibility for determining eligibility for the General Assistance program.

DSS has contracted with Community Health Network of Connecticut (CHNCT) as of August 1, 2004, to act as the ASO responsible for managing the medical services portion of the General Assistance Program. GA recipients receive primary medical care and case-managed health services under the state's partnership with CHNCT, primarily in Federally Qualified Health Centers (FQHC) located throughout the state.

DMHAS seeks to build on the strengths and successes of the existing statewide delivery system, by collaborating with all stakeholders. With the introduction of the Recovery Model by the Commissioner in 2002, DMHAS acknowledges the value of, and seeks to integrate recovery oriented values, language, and action into the system of care.

PROGRAM OVERVIEW

Advanced Behavioral Health (ABH) has been contracted by the Department of Mental Health and Addiction Services (DMHAS) effective July 1, 2005, to act as the Administrative Services Organization (ASO) for the General Assistance Behavioral Health Program (GABHP). DMHAS and ABH share a vision: that the GA Behavioral Health Program will meet the goals of enhancing access to care, ensuring the continuity of care, and delivering a quality of care with fiscal responsibility for the General Assistance population in the State of Connecticut. Integrating **recovery** as a value and an orientation will ensure a dynamic, responsive, and progressive client-centered service delivery system.

Care management activities, and requests for recovery supports from the Basic Needs Program, are transacted in ABH offices located in the city of Middletown. **Claims, contracting** and **credentialing** also occur in offices located in Middletown, through the Customer Service and Provider Relations Departments. **Case** management activities, inclusive of the services of entitlements specialists, occur both in the field and in offices located throughout the state. Care and case management are coordinated for GA recipients who meet the designation of 'high utilizer', in order to ensure appropriate coordination and continuity of care for those individuals who are frequent users of behavioral health care services. The GA **Community Liaison** also has an office in Middletown. **Information Systems**, offering technical support to the staff of ABH and to ERS users, is located in Middletown. **Quality Management** functions operate in Middletown, with a constant interface with Providers and with DMHAS. The medical needs of General Assistance recipients are served through the Connecticut Health Network of Connecticut.

General Assistance recipients may concurrently be involved in other programs for which ABH has oversight. Such programs include Access to Recovery, Project SAFE, and Women's Behavioral Health Services. Every effort is made to ensure quality coordination between programs when that is appropriate.

Effective 7/1/05, requests for prior authorization of inpatient levels of care can be made twenty-four (24) hours a day, seven (7) days a week, by calling **1-800 – 606 – 3677, option 1.** Prior authorization requests for ambulatory levels of care can be submitted via fax 24 hours a day at **860-704-6145**. In addition, requests for continued stays, discharge information, questions regarding referrals, or other inquiries, can also be made by dialing the toll free number listed above. Should Providers or recipients have questions, they may also contact ABH by using the number listed above.

GOALS OF THE DMHAS GENERAL ASSISTANCE BEHAVIORAL HEALTH PROGRAM

Goals offer purpose and guidelines as stakeholders collaborate to shape the delivery of behavioral health care in the State of Connecticut, in a recovery oriented, progressive and fiscally responsible manner.

The goals of the DMHAS GA Behavioral Health Program are to:

- Facilitate the delivery and integration of high quality behavioral health services to eligible individuals;

- Coordinate and link behavioral health services with a broader array of publicly funded human service programs, as well as informal community support systems available to GA recipients;

- Provide timely access to all clinically necessary and appropriate behavioral health services;

- Increase the self-sufficiency of individuals seeking General Assistance through the coordination of behavioral health with vocational services and/or entitlements assistance;

- Manage program expenditures in a cost-effective manner, through the appropriate authorization of services and administrative expenses;

- Integrate recovery core values, recovery principles, and recovery language into all aspects of treatment delivery. To achieve a quality of care, a recovery oriented system of care will be age and gender appropriate, culturally competent, and attend to trauma and other issues that impact the work of recovery; and,

- Create a model for healthcare and welfare reform that can be replicated for other programs serving indigent and uninsured individuals within the State of Connecticut.

DMHAS believes that a truly collaborative relationship with providers creates the necessary framework for the success of this program. DMHAS enjoys great confidence in the skills and professionalism of the providers located in the State of Connecticut.

STAFF FUNCTIONS

Care Management staff will perform utilization review for initial requests for behavioral health services, as well as requests for continued stay, and will seek discharge information. This staff includes Clinical Care Managers and Utilization Review Supports.

Recovery Support (Case Management) staff will work with high-risk target population clients to assist individuals in engaging in and moving through the recovery continuum. This staff includes Regional Coordinators, Recovery Specialists, and Entitlements Specialists.

Basic Needs Program staff will process requests for recovery support services for those GA recipients who are compliant with treatment. This staff includes Determination Coordinators and Eligibility Coordinators.

Customer Service staff will provide general information and answer questions from General Assistance recipients and GABHP Providers related to benefits, authorizations and claims payment.

Provider Relations staff will work closely with providers in credentialing, contracting, and various other administrative and management issues. This staff includes the Provider Relations Director, and Field Representatives. Provider Field Representatives will be available to visit provider sites for on-site training and support related to GABHP contracted functions.

Claims Operations staff will process, adjudicate, generate Explanations of Payments (EOP), and pay claims. This staff includes the Claims Director, Claims Processors, and Claims Auditors.

All staff members work together to provide response service in real time to recipients, providers, and DMHAS.

DMHAS
GA BEHAVIORAL HEALTH PROGRAM
CONTACT FACT SHEET

Advanced Behavioral Health, Inc. is located at
213 Court Street
Middletown, Connecticut 06457

The main telephone number is 1 – 800 – 606 – 3677.
Option 1, Clinical Department
Option 2, Customer Service
Option 3, Provider Relations
Option 4, Claims Department

The main fax number is 1 – 800 – 704 – 6145.

Authorization Requests can be submitted by fax at:
1 – 860 – 704 – 6145

Authorization Requests may be submitted
by authorized ERS users at:
www.abhct.com

Claims submitted on **paper** are to be sent to
DMHAS GA Behavioral Health Program
c/o Advanced Behavioral Health
P.O. Box 1325
Middletown, Connecticut 06457

Claims submitted by **fax** are to be sent via:
1 – 800 – 704 – 6145

Claims submitted **on-line** should go through
www.abhct.com

SECTION 2
ELIGIBILITY VERIFICATION

The Department of Social Services (DSS) is the agency responsible for determining eligibility for General Assistance benefits. Potential recipients need to present in person at their local DSS office for enrollment in GA. Once enrolled, recipients are given CONNECT cards with identification and contact information.

Providers must verify clients' eligibility for General Assistance by using the Automated Eligibility Verification System (AEVS) each time there is a request for behavioral health services. Given that General Assistance is a benefit, and not an entitlement, clients' eligibility is more dynamic than static. Providers will want to ensure that gaps in eligibility are identified at the time of admission to behavioral health services. It is also highly recommended that providers periodically re-confirm eligibility for clients throughout the course of treatment. Payment of services is based on eligibility at the time the service was rendered. It is important to remember that the authorization of any specific service is NOT a guarantee of payment.

AEVS NUMBERS: 1-800-842-8440 (statewide)
1-860-832-9259 (Hartford area)

The AEVS line eligibility inquiry will also indicate whether the recipient has a third-party payer who may be liable for some or all of the costs of behavioral health services. If, as a provider, you believe that the individual will meet criteria for eligibility for General Assistance, but has not yet been enrolled as a GA recipient, you should still contact the ASO to obtain an authorization. If the individual is subsequently found to be eligible for GA, the Provider can ONLY be paid on a retroactive basis when there is a prior authorization on record for the requested dates of service.

While the ASO has historical information regarding eligibility status on record, the AEVS line should be used for the most current information available.

MEDICAL SERVICES for SAGA RECIPIENTS

In August 2004, the Department of Social Services ((DSS) made a decision to contract for the management of medical services for SAGA recipients through a primary care provider network. **Community Health Network of Connecticut (CHNCT)** is the Administrative Services Organization responsible for the medical management, network management, pharmaceutical management and claims processing functions for primary, specialty and ancillary services. Only hospital inpatient and outpatient services will continue to be administered by the Department of Social Services. CHNCT has experience in our state working with the HUSKY Program since 1995. The majority of healthcare services will be received at Federally Qualified Health Centers (FQHC), located throughout the state. Eligible recipients receive a CHNCT ID card at the time of their enrollment.

When a **SAGA recipient** has questions about his/her medical benefit, s/he should call the **CHNCT Member Services Department at (866) 361 – SAGA (7242),** Monday through Friday, 8 a.m. to 6 p.m.

When a **Provider** has a question about coverage for medical benefits, claims status, pharmaceutical management, or care management, the call should be made to **CHNCT Provider Relations at (800) 440 – 5071,** Monday through Friday, 8 a.m. to 6 p.m.

Claims for behavioral health **Pharmacy** costs or services will be handled through CHNCT, as part of the medical services benefit. **Laboratory** services provided as part of ongoing medical care are also handled by CHNCT, while laboratory services provided as part of ongoing behavioral health care will be submitted to and processed by ABH.

OUT OF NETWORK PROVIDERS

Behavioral healthcare services are provided to SAGA recipients through a provider network that has been credentialed and contracted by DMHAS. There are no in-state, out of network options available to SAGA recipients. On the rare occasion that a SAGA recipient traveling out of state needs emergency behavioral healthcare in an **acute** inpatient treatment setting, the Provider caring for the SAGA recipient must contact the ASO within 48 hours of becoming aware that the client is served by Connecticut SAGA. At that time, the out of state Provider will need to contact the ASO to engage in the review process for preadmission and continued stay. If the out of state Provider admits five or more GA recipients within any calendar year, the Provider will also be asked to provide information necessary to become credentialed and contracted with the GA Behavioral Health Program.

MEDICAID RECOUPMENT

At times, clients who are active on General Assistance make application for and are granted Medicaid (Title XIX). When the Department of Social Services (DSS) makes that determination, it will also make a determination regarding retroactive eligibility. There are times that the client will be retroactively eligible for Medicaid during a time s/he was engaged in services for which a SAGA authorization was obtained, and for which claims were paid. When that occurs, the ASO will recoup the dollars paid by the GA Behavioral Health Program. The ASO will also, at that time, generate and send documentation to the Provider, which can be used to submit to Medicaid for reimbursement of the services provided.

SECTION 3
COVERED SERVICES

This section describes services available to General Assistance recipients who meet service necessity criteria through the General Assistance Behavioral Health Program. For all levels of care, it is expected that *discharge planning should begin at the time of admission.*

A. MENTAL HEALTH SERVICES

1. ***Acute Psychiatric Hospitalization Services (MH IV.2)*** – An inpatient service provided in a private, free-standing psychiatric hospital, general hospital, or state-operated facility, that involves medically directed treatment of a psychiatric or dual diagnosis condition, where recipient admission is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is used when 24-hour medical and nursing supervision is required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment. The service may be provided to recipients committed under a Physician's Emergency Certificate (PEC) pursuant to Section 17a-502 of the Connecticut General Statutes, in which case services will be provided on a locked unit.

2. ***Acute Inpatient Services (Pilot II)*** – An inpatient service provided in a private, freestanding psychiatric hospital or general hospital, that involves medically directed treatment of *either* psychiatric or alcohol or other substance use condition, where the recipient admission requires the services available in a hospital (24-hour medical and nursing care, psychiatric assessment, intervention, and management of either psychiatric or substance related symptoms). This service may be provided to recipients committed under a Physician's Emergency Certificate (PEC) pursuant to Section 17a-502 of the Connecticut General Statutes. Facilities with this level of care designation have negotiated inclusion in the Pilot with the Department of Mental Health and Addiction Services.

3. ***Intensive Crisis Stabilization (MH II.9)*** – A service provided by a general hospital, private freestanding psychiatric hospital, state-operated facility, or by a provider that is a nonprofit mental

health agency. The service includes concentrated and aggressive interventions designed to treat a rapidly deteriorating behavioral health condition, reduce the risk of harm to self or others, stabilize psychiatric symptoms or behavioral and situational problems (including abuse of substances), and, whenever possible, avert the need for acute hospitalization. Intensive crisis stabilization may include such services as crisis or respite bed care, intensive therapeutic intervention by mental health and substance abuse professionals and support staff, disposition and referral services, and evaluation, crisis stabilization, and management by a mobile crisis team.

4. ***Observation Bed (MH II.7)*** – An inpatient service provided in a general hospital, private freestanding psychiatric hospital or state-operated facility that involves medically necessary supervised stabilization, clinical monitoring, and, when necessary, laboratory testing, to facilitate the formulation of an appropriate diagnosis and a suitable disposition for recipients in urgent need of care. This service may be used for up to 23 hours, before a discharge or a referral to another level of care is required.

5. ***Partial Hospital Program, Mental Health (MH II.5)*** – An ambulatory service deemed medically necessary provided in a general hospital, private free-standing psychiatric hospital, freestanding mental health treatment facility, or a state-operated facility that involves ambulatory intensive psychiatric, or psychiatric and substance abuse services. This service provides recipients no less than four (4) hours per day, three (3) to five (5) days a week, of clinically intensive programming based on an individualized treatment plan. Programming will include one individual or group therapy session per treatment day. Services are designed to serve recipients who are stepping down from acute care, or, to avert acute care hospitalization for a recipient, while enhancing a recipient's overall level of independent functioning. Treatment may occur in a day or an evening program.

6. ***Intensive Outpatient, Mental Health (MH II.1)*** – An ambulatory service deemed medically necessary provided in a general hospital, a private freestanding psychiatric hospital, a psychiatric outpatient clinic for adults, or a state-operated facility. This level of care provides recipients three (3) to four (4) hours a day, three (3) to five (5) days per week of clinically

intensive programming based on an individualized treatment plan. Services will include one individual or group therapy session per treatment day. Intensive Outpatient treatment is based on a comprehensive and coordinated individualized and recovery-oriented treatment plan, involving the use of multiple, concurrent services and treatment modalities. Treatment focuses on reducing symptoms, improving overall functioning, supporting independent living in the community, preventing relapse, and decreasing the need for a more acute level of care.

7. ***Outpatient, Mental Health (MH I.1)*** – An ambulatory service provided in a general hospital, psychiatric outpatient clinic for adults, private freestanding psychiatric hospital, or state-operated facility. This level of care involves the evaluation, diagnosis, and/or treatment of individuals, couples, or families. It may be inclusive of Neuropsychological testing; the request for this service must be submitted with the appropriate form. (see appendix)

B. SUBSTANCE ABUSE SERVICES

1. ***Medically Managed Inpatient Detoxification (SA IV.2) –*** An inpatient service provided in a private, freestanding psychiatric hospital, general hospital or state-operated facility, that involves medically directed treatment of an alcohol or other substance use condition, where the recipient admission for detoxification is complicated by medical or psychiatric or other serious or dangerous condition that requires the services of a hospital-based setting to stabilize and treat. This service provides medically directed evaluation and withdrawal management. Psychiatric assessment, intervention, and management are available. This service may be provided to recipients committed under a Physician's Emergency Certificate (PEC) pursuant to Section 17a-502 of the Connecticut General Statutes.

2. ***Acute Inpatient Services (Pilot II)*** – An inpatient service provided in a private, freestanding psychiatric hospital or general hospital, that involves medically directed treatment of *either* psychiatric or alcohol or other substance use condition, where the recipient admission requires the services available in a hospital (24-hour medical and nursing care, psychiatric assessment, intervention, and management of either psychiatric

or substance related symptoms). This service may be provided to recipients committed under a Physician's Emergency Certificate (PEC) pursuant to Section 17a-502 of the Connecticut General Statutes. Facilities with this level of care designation have negotiated inclusion in the Pilot with the Department of Mental Health and Addiction Services.

3. ***Medically Monitored Intensive Residential Detox (III.7-D)*** – An inpatient service provided in a state-operated or in a facility licensed by the Department of Public Health (DPH) to offer 'residential detoxification and evaluation', involving medically directed treatment of an alcohol or other substance use condition. This service is used when 24-hour medical and nursing supervision is required, and thus provides 24-hour, medically directed substance abuse or dependence evaluation and withdrawal management, inclusive of laboratory testing.

4. ***Observation Bed (SA II.7)*** - An inpatient service provided in a general hospital, private freestanding psychiatric/substance abuse hospital, state-operated facility, or a facility that involves medically necessary supervised stabilization, clinical monitoring, and, whenever necessary, laboratory testing, to facilitate the formulation of an appropriate diagnosis and suitable disposition for recipients in urgent need of care. Observation services may be used for up to 23 hours, before a discharge or a referral to another level of care is required.

5. ***Intensive Residential Treatment (SA III.7)*** – A residential service provided in a state-operated facility, a private freestanding psychiatric hospital, or in a facility licensed by DPH to offer 'intensive treatment' to recipients who have a substance abuse primary diagnosis. These services are provided in a 24-hour setting designed to treat individuals with alcohol or other substance abuse conditions that require an intensive rehabilitation program. Services in this setting are by design *intensive*, and are provided within a 15 – 30 day period, in preparation for step-down to less restrictive levels of care. Services provided during residence include: an initial bio-psychosocial assessment, a medical evaluation, a psychiatric evaluation if indicated, daily individual or group therapy, and no less than twenty (20) hours a week of psychosocial education, orientation and referral to self-help groups, and development of a personal recovery plan.

6. ***Intermediate Residential Treatment (SA III.3)*** – A residential service provided in a facility licensed by DPH to offer 'intermediate or long-term treatment', or, 'care and rehabilitation' (formerly identified as SA III.5, SA III.3, or SA III.1). Professional addiction services are provided to recipients to address significant problems with behavior and functioning in major life areas, which exist as the result of substance dependence, with a goal of reintegration into the community. These services are provided in a structured environment that has a recovery orientation, most commonly identified as intermediate/long-term residential treatment, long-term care, or transitional/halfway house services. No less than twenty (20) hours of programmed addiction treatment services per week shall be provided if the facility has the license as 'intermediate or long-term treatment'. Up to twenty (20) hours per week of programmed addiction services shall be provided if the facility has the license as 'care and rehabilitation' or 'halfway house'. Professional addiction services provided during residence will include: an initial bio-psychosocial assessment, a medical or psychiatric evaluation where indicated, group or individual therapy, psycho-educational programming, orientation and referral to self-help groups, and development of a personal recovery plan.

7. ***Partial Hospital Program, Substance Abuse (SA II.5)*** – An ambulatory service provided in a general hospital, private free-standing psychiatric hospital, freestanding mental health treatment facility, state-operated facility, or a facility licensed by DPH to offer 'day or evening treatment'. This service provides recipients no less than four (4) hours per day, three (3) to five (5) days per week of clinically intensive programming based on an individualized treatment plan. Programming will include one individual or group therapy session per treatment day. Services are designed to serve recipients who are stepping down from a residential detox or other acute care setting, or, to avert acute care hospitalization for a recipient, while enhancing a recipients overall level of independent functioning. Treatment may occur in a day or an evening program. Services will include: diagnostic, therapeutic, and rehabilitative services, with access to psychiatric, medical, and laboratory services (in addition to substance abuse services). Treatment will include individual and group counseling, family therapy, educational groups, and occupational and recreational therapy.

8. ***Intensive Outpatient, Substance Abuse (SA II.1)*** – An ambulatory service provided in a general hospital, private freestanding psychiatric hospital, state-operated facility, or a facility licensed by DPH to offer 'intensive outpatient treatment'. This level of care provides recipients three (3) to four (4) hours a day, three (3) to five (5) days per week of clinically intensive programming based on an individualized treatment plan. Services will include one individual or group therapy session per treatment day. Treatment focuses on developing an individualized relapse prevention plan, and on enhancing the recipient's ability to initiate and manage behavior that promotes recovery.

9. ***Outpatient Treatment, Substance Abuse (SA I.1)*** – An ambulatory service provided in a general hospital, psychiatric outpatient clinic for adults, private freestanding psychiatric hospital, or state-operated facility, or in a facility licensed by DPH to offer 'outpatient treatment'. This service includes, but is not limited to, professionally directed evaluation (assessment), treatment and recovery services. These services are provided in regularly scheduled sessions, usually weekly, but no less frequently than thirty (30) days.

10. ***Methadone Maintenance (SA I.3)*** – An ambulatory service provided in a state-operated facility or a facility licensed by DPH to offer 'chemical maintenance treatment' to opiate addicted recipients. This service involves daily administration of methadone prescribed at individualized doses, regularly scheduled psychosocial treatment sessions, health education, and assessment of needs, including those related to accessing recovery supports.

11. ***Ambulatory Detoxification (SA I.D)*** – An ambulatory, medically necessary service provided in a private freestanding psychiatric hospital, or state-operated facility, or in a facility licensed by DPH to offer 'ambulatory chemical detoxification'. This service uses prescribed medication for the systematic reduction of physical dependence upon a substance for a recipient who has been evaluated as able to tolerate an outpatient detoxification. This service involves the assessment of needs, including those related to recovery supports, and expects that there will be engagement of the recipient in order to continue participation in the treatment process. Recipients

may concurrently participate in a program for up to four (4) hours each day.

12. ***Opioid Dependence Detoxification (SA I.2)*** – An ambulatory, medically necessary service provided in a state-operated facility or in a facility licensed by DPH to offer 'ambulatory chemical detoxification treatment' to opiate addicted recipients. This service involves daily administration of methadone, buprenorphine or other medications with gradual reductions in dosage to mitigate symptoms. This service involves the assessment of needs and enhancing motivation for continued participation in the treatment process. The service is designed to help the recipient achieve an opiate free state within 30 days (short term) or between 31 and 180 days (long term).

13. ***Ambulatory Detoxification with On-Site Monitoring (SA II.D)*** – An ambulatory, medically necessary service provided in a general hospital, private freestanding psychiatric hospital, state-operated facility, or a facility licensed by DPH to offer 'ambulatory chemical detoxification treatment'. This service involves rapid access to ambulatory detox, ongoing assessment of clinical, personal, and familial needs, daily administration of methadone or buprenorphine with gradual reductions in dosage to mitigate symptoms, during concurrent involvement in an IOP level of care. The service is designed to be able to transition recipients from detox concurrent with IOP to IOP within a six-day timeframe, for up to fourteen (14) days. Recipients may continue on in a long term taper in an outpatient level of care for up to six (6) months.

C. RECOVERY SUPPORT SERVICES

This section describes recovery support services available to SAGA recipients that are intended to assist the client in engaging in continuing care and recovery.

1. The ***Basic Needs Program*** **(BNP)** is designed to provide assistance with fundamental necessities for those SAGA recipients who do not receive SAGA cash benefits. ABH will manage the application by providers on behalf of recipients who are compliant with attendance to behavioral health treatment. The BNP provides **temporary** funding support for personal care items, clothing, bus passes, shelter beds, housing, and utilities.

2. The ***General Assistance Intensive Case Management Program*** **(GAICM),** was incorporated from a regional to a centralized function in January 2002 to allow for full integration of utilization and case management services. Recovery Specialists work with recipients identified as at risk, including those individuals who have had four (4) or more admissions to acute care in a six (6) month period) in order to engage and support the recipient's efforts to move through the continuum of care and recovery. Recovery Specialists are supervised in the field by Regional Coordinators. Potential recipients of these services are identified by the ASO's Quality Systems Specialists and Clinical Care Managers through daily review of authorization information. At times, when appropriate, other recipients may be assigned to a Recovery Specialist. The ***Eastern Region Service Center*** **(ERSC)** is a provider network in Region 3 that serves case management functions for indigent residents in the Region 3 area, and for General Assistance recipients.

3. **The *Recovery Houses*** were developed to address the needs of recipients who are ready to discharge from an acute care setting but for whom temporary housing is needed while receiving ambulatory services or awaiting admission at the next, less restrictive level of care. Acute care providers are expected to be the primary referral source for recipients, and priority is given to those engaged in one of the GABHP Special Service Initiatives, and to high utilizers or women. Recipients may stay in this transitional living environment for up to ninety (90) days, and are expected to concurrently engage in an ambulatory level of care.

In addition to those Recovery Support Services listed on the previous page, recipients may look to Info-Line at 211, the Connecticut Community for

Addiction Recovery (CCAR), Advocacy Unlimited, and to the self-help community, without cost, as adjuncts to the work of recovery.

E. SPECIAL SERVICE INITIATIVES

The ***Opioid Agonist Treatment Protocol*** **(OATP)** was initiated in April 2001 to offer the opioid dependent client with frequent inpatient admissions alternatives that would assist in engaging the client in continuing care. This protocol is the result of a unique collaboration between DMHAS, residential detox providers, ambulatory opioid treatment providers and the ASO. Recipients who have four (4) or more admissions to an acute care setting within a six-month period and a primary diagnosis of opioid dependence will, upon presentation for a fifth residential detox admission, be diverted to a participating OATP provider. The recipient will receive education while in detox about continuing care alternatives, including use of Methadone. If the recipient expresses interest in induction to Methadone Maintenance, s/he is inducted, rather than detoxed, and given priority access to ongoing Methadone Maintenance services. The recipient will also be assigned to a Recovery Specialist and will be given priority access to a Recovery House bed, if needed.

The ***Mental Health IV.2 Case Management Initiative*** was launched in January 2002 to identify and assist those recipients utilizing repeated or lengthy acute inpatient mental health services. Recipients with three (3) or more admissions to an inpatient setting within a ninety-day period, or having one (1) episode of care lasting thirty (30) or more days, were chosen for participation in this service initiative. Recipients participating in this initiative are assigned to a Recovery Specialist experienced in assisting individuals with mental health disorders, and also are assessed to determine whether they might benefit from assistance in applying for additional entitlements. The Recovery Specialist works with the recipient to access services that will assist in engaging the client in continuing care and supportive services.

F. LABORATORY SERVICES (Behavioral Health Services)

Laboratory services include services provided by a facility that is certified pursuant to the Clinical Laboratory Improvements Amendment of 1988. Services include specimen testing and analysis that will contribute to the diagnosis and treatment of eligible recipients. Laboratory services provided during the course of behavioral health treatment for a recipient engaged in a covered service cannot be billed separately unless the services are provided by a lab not directly associated with the provider.

SERVICE LIMITATIONS AND EXCLUSIONS

A. SERVICE LIMITATIONS

Covered services and procedures are limited to those listed in the DMHAS General Assistance Behavioral Health Program fee schedule.

1. Reimbursement of Outpatient service is limited to one session per provider, per day, for each GA recipient, for each of the following therapies, unless additional service is authorized in advance by DMHAS or its designated agent, ABH:
    a. Individual therapy
    b. Group therapy
    c. Family therapy

2. Medication management services shall not be reimbursed separately from individual or group therapy where the principal emphasis is medication monitoring or management if performed by the same practitioner, on the same day, for the same GA recipient, unless authorized in advance by DMHAS or its designated agent, ABH.

3. Group therapy sessions are limited to a maximum of eight participants, excluding supervising clinicians, per group session.

4. Reimbursement of the following procedures is limited to one such procedure for each GA recipient during one twelve-month period, if authorized in advance by DMHAS or its designated agent, ABH:
    a. Neuropsychological testing
    b. Psychological testing

5. Providers of methadone maintenance and partial hospitalization or day/evening treatment are required to furnish services at their licensed facility location, except as authorized by DMHAS or its designated agent, ABH.

6. Reimbursement for *authorized* Initial Intake Evaluations (CPT Code 90801) is available when:
    a. The client is eligible for General Assistance at the time of the evaluation or is found to be retroactively eligible for the date on which the evaluation occurred, AND
    b. The client does not begin treatment in a level of care other than standard outpatient services with the same Provider organization within ten (10) calendar days of the date of the evaluation, AND

c. The provider registers the procedure within fifteen (15) calendar days after the evaluation was conducted, AND
d. The Provider organization has not received reimbursement for an initial intake evaluation (procedure code 90801) for the client within the previous six (6) months, AND
e. The Provider organization has not sought or received reimbursement for emergency room services on the same day as the initial intake evaluation.

To obtain an authorization for the initial intake evaluation, the Provider should submit a GABHP Outpatient Treatment Request (OTR) form to ABH no later than fifteen (15) calendar days following the evaluation, AND only if the client does not begin treatment with the Provider within that fifteen (15) day time frame.

B. EXCLUSIONS

The following behavioral health services are excluded under the DMHAS GABHP:

1. Any services to a GA recipient with a primary DSM-IV diagnosis which is outside the range of diagnostic codes from 291.1 to 292.99, or 295 to 307.88 or 307.90 to 315.99.
2. Services that DMHAS, or its designated agent, ABH determines to be "experimental" in nature.
3. Services that DMHAS, or its designated agent, ABH determines do not meet "service necessity" criteria as defined in the most current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) or the DMHAS Clinical Protocols for Mental Health Levels of Care.
4. Concurrent services or procedures that DMHAS, or its designated agent, ABH determine to be similar or identical or redundant to services provided to the same GA recipient.
5. Services, consultation or information provided over the telephone.
6. Services that DMHAS, or its designated agent, ABH determines are primarily for vocational or educational guidance, or services that are related solely to a specific employment opportunity, job skill, work setting, or development of an academic skill.
7. Therapies, treatments or procedures related to transsexual or gender-change medical or surgical procedures.
8. Services, treatment or items furnished to a GA recipient for which the Provider does not usually charge non-GA recipients.

C. NON-REIMBURSABLE SERVICES

1. The day of discharge or transfer from inpatient services unless the GA recipient is discharged or transferred on the same day as the individual is admitted.
2. A leave of absence or pass from an inpatient or residential facility that occurs without staff permission or against staff advice.
3. A leave of absence or pass from an inpatient or residential facility with staff permission, if the absence is longer than twenty-four (24) hours, unless authorized in advance by DMHAS or its designated agent.
4. Emergency room services provided on the same day as behavioral health related inpatient admission to the same facility.
5. A session to obtain a prescription, the need for which has already been ascertained.
6. Electroconvulsive therapy, unless performed by a psychiatrist and pre-authorized by DMHAS or its designated agent, ABH.
7. Hypnosis, unless performed by a psychiatrist or a psychologist.
8. Psychological or intelligence testing, unless performed by a psychologist and preauthorized by DMHAS or its designated agent, ABH.
9. Neuropsychological testing, unless performed by a psychologist and pre-authorized by DMHAS or its designated agent, ABH.
10. Services performed by a staff member who is not a licensed physician, psychologist, registered nurse, or other licensed behavioral health professional, unless the following conditions are met:
    a. The treator is employed by, or under contract with, a licensed health facility whose medical or clinical director has determined that the staff member is qualified to render treatment services to GA recipients,
    b. The treator is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services, or a Connecticut Certified Clinical Supervisor, and,
    c. The supervising clinician has signed the GA recipient's recovery plan.
11. Routine or non-emergency services performed by staff of a licensed facility at a location other than that which is specified on the facility's license, unless the service is:
    a. within the scope of the facility's license,
    b. part of the GA recipient's recovery plan,
    c. recorded as a treatment or progress not in the GA recipient's medical/service record, and
    d. authorized in advance, where required, by DMHAS or its designated agent, ABH.

SECTION 4
AUTHORIZATION OF SERVICES

This section describes how and when to obtain an authorization for all types of behavioral health services. ***Services not authorized will not be reimbursed.*** *Emergency Room and Laboratory services do not require prior authorization.*

Service authorizations must be obtained for any recipient eligible or potentially eligible for SAGA benefits, regardless of the recipient's eligibility status at the time of admission. If the Provider believes that the client will meet criteria for eligibility for General Assistance, but the client has not yet been enrolled as a GA recipient, you should still contact ABH to obtain an authorization. *Services provided without an authorization in accordance with the procedures contained in this manual will not be reimbursed*. It is the primary responsibility of the provider to confirm eligibility at the time of admission and periodically (at least monthly) during the course of treatment.

Authorizations issued by the ASO confirm that the clinical information provided meets the service necessity requirements for the requested service; an authorization does not confirm eligibility for SAGA benefits and is not a guarantee of payment.

A prior authorization is required at the time of admission to ALL levels of care with the exception of standard outpatient services (MH I.1, SA I.1). All initial registrations for outpatient services (MH I.1, SA I.1) must be submitted within ten (10) business days of the first visit. All requests for continued care authorizations must be submitted no later than the date the previous authorization expires. Late requests for initial or continued stay authorization will result in an administrative denial of services occurring prior to contact with ABH.

Authorizations are issued for a specific time period. The authorization time period is fixed; service units not used within the time frame authorized become void. Authorizations are issued for a specific service location and are not transferable.

A. THE ELECTRONIC REGISTRATION SYSTEM (ERS)

The Electronic Registration System (ERS) was developed in order to create efficiency in the administrative process for contracted Providers of behavioral health care services. ERS uses the latest internet technology to provide a safe and secure method to authorized users to view current and historical authorization information, obtain initial and continued stay authorizations for

discreet levels of care, provide discharge information for any level of care, and monitor authorization information in order to ensure timely re-authorization of care. In addition, the ERS login and password will allow the authorized user the ability to view the status of claims submissions.

Access to ERS is granted following a brief training session that focuses on system functions and safe, appropriate use of confidential information. ERS users will be given an individualized login and password following training that allows access to site-specific, episode-specific, and client-specific authorization information. Depending on the level of security granted, users will be able to view and enter authorization information for a single site or all service locations for their organization. The same login/password will also allow users with the appropriate security access the ability to enter claims or view claims status information.

Entering an authorization via ERS requires data entry of a limited amount of clinical information and allows the user to print the authorization letter upon successful completion of the authorization request. The authorization can then be viewed on line within 30 seconds.

If a user has difficulty completing the registration or continued stay authorization request using ERS, users are encouraged to contact the ABH for assistance. If you are interested in obtaining access to ERS and are a contracted GABHP Provider, please contact ABH at 1 – 800 – 606 – 3677, Option 2.

B. REVIEW PROCESS

Admission/Pre-certification Requests to the following levels of care require a **telephonic** review to obtain authorization:

1. Acute Care (requests for admission to these levels of care can and should be made twenty-four hours a day, seven days a week)
    a. Acute Psychiatric Hospitalization (MH IV.2)
    b. Medically Managed Inpatient Detoxification (SA IV.2)
    c. Medically Monitored Intensive Residential Detoxification (III.7D)
    d. Acute Inpatient Services (Pilot II)
    e. Residential Services (SA III.7, SA III.3)
    f. Crisis Stabilization (MH II.9)
    g. 23-Hour Observation Beds (MH II.7, SA II.7)
    h. Partial Hospital, Day/Evening Treatment (MH II.5, SA II.5)
    i. Ambulatory Detoxification with On-Site Monitoring (SA II.D)

2. The services available for registration on-line through ERS or via fax submission of an Outpatient Treatment Review (OTR) include:
    a. Intensive Outpatient (MH II.1, SA II.1)
    b. Methadone Maintenance (SA I.3)
    c. Opioid Dependence Detoxification/Outpatient (SA I.2)
    d. Ambulatory Detoxification (SA I.D)
    e. Outpatient (MH I.1, SA I.1)

All pre-certification requests can be submitted 24 hours/day, 7 days/week, regardless of the method of review. Requests for continued stay authorization for acute levels of care should be submitted Monday through Friday between the hours of 8:00 am and 6:00 pm. Requests for continued stay authorizations submitted via ERS or OTR can be submitted 24 hours/day, 7 days/week.

When an initial intake evaluation (90801) is performed, Providers have fifteen (15) calendar days to enter the authorization request via ERS or submit the OTR. If a recipient is admitted to a higher level of care at the same provider organization within ten (10) calendar days of the evaluation, the authorization for the initial intake evaluation will be vacated, as the evaluation is considered to be part of the inclusive rate for the higher level of care. The Provider will then receive notification that the authorization for the initial intake evaluation has been cancelled.

Notification of discharge is required for every authorized service. Discharge information can be entered via ERS, by telephone, or through faxed notification.

C. INFORMATION NECESSARY TO OBTAIN AUTHORIZATION

Current clinical information is required at the time of the request for authorization for any behavioral health service. The information necessary to obtain an authorization for a new episode of care should identify the presenting problem and current status of the recipient, as well as the solution-focused, recovery-oriented plan for intervention and care. The length of stay and treatment plan for the recipient should be individualized. Because the focus on continued care is critical in engaging and assisting the client to move through the recovery continuum, discharge planning should begin at the time of admission to the current episode of care.

Requests for continued stay authorization should include progress made towards identified individualized goals as well as providing information about

the current status of the client and presence of symptoms that would preclude management in a less restrictive level of care.
The following are key information elements necessary during the review process:

1. **Demographic**
    a. The name of the recipient for whom services are requested, as well as the EMS identification number, and social security number
    b. Address of record, including telephone number wherever possible
    c. Date of birth
    d. Race, Gender, Language Preference
    e. Name of the Provider, and name of the caller requesting services

2. **Clinical**
    The information identified below contributes to the clinical "picture", and serves to inform any decision made to authorize care. Information should be updated at the time of continued stay and discharge review.
    a. Presenting Problem
    b. Symptoms related to the Presenting Problem
    c. Mental Status
    d. Medical history
    e. Psychiatric history, including medications
    f. Substance Abuse history
    g. Family/Social history
    h. Legal history
    i. Previous treatment history
    j. Treatment plan for this episode
    k. Axis I – V Diagnoses
    l. Projected Discharge Plan
    m. Clinical criteria met for this episode
    n. Projected length of stay

D. DISCHARGE REVIEWS

It is essential that key elements of discharge information be conveyed to the ASO within a brief period following discharge. Discharge information can be entered via ERS, fax submission or by telephone. The information needed at time of discharge is:

3. Date of Discharge: this would also include the date the client steps down from one level of care to the next at the same agency
4. Follow-up Level of Care
5. Aftercare Provider
6. Date of first appointment
7. Medications prescribed at time of discharge
8. Discharge Type
    a. Regular: successful completion at current level of care, plan in place for movement into the next, less restrictive level of care
    b. Refused Care: the recipient refuses to accept referrals for ongoing treatment
    c. Administrative: the discharge is a result of violation of facility or program rules
    d. Non-compliance: the discharge is a result of lack of compliance to treatment recommendations or program expectations
    e. Against Medical Advice (AMA): the client has left treatment against the medical or clinical advice of program staff
    f. Absent Without Leave (AWOL): the client has left inpatient treatment without the knowledge or consent of program staff
    g. Transfer: the discharge is the result of admission to a general hospital for medical reasons, or the client has required a transfer to a higher level of behavioral health care
    h. No Show: the client has been discharged due to failure to return to scheduled ambulatory care appointments
    i. Other: this category should be used when the discharge does not fit other discharge type descriptions (e.g., client incarcerated)

E. CRITICAL INCIDENTS

A critical incident is any event involving a GA recipient that results in serious injury, or risk of injury, a serious adverse treatment event, admission or transfer to a general hospital, death of a recipient, or some event, which has a serious impact on service delivery. As indicated by agreement with DMHAS and by policy, Providers must report to the ASO as quickly as possible any critical incident that involves a GA recipient for whom authorization of services has been obtained.

A Critical Incident includes, but is not limited to:

1. Death of a recipient, including any death that occurs within thirty (30) days of discharge from treatment (if known).
2. Elopement of a recipient from a hospital or unexplained absence from regular programming where there is substantial concern that the recipient is a danger to self or others.
3. Serious injury to a recipient, or serious physical illness of a recipient, that results in the admission to a general hospital; including any serious injury that occurs within thirty (30) days of discharge from treatment (if known).
4. Any serious suicide attempt, including suicide attempts that occur up to thirty (30) days of discharge from treatment (if known).
5. Suspected or documented client abuse, or allegations of client abuse, or violation of recipient confidentiality that has, or may have, serious consequences.
6. Serious adverse reaction to medication.
7. Threats by a recipient who has been assessed as representing a credible risk to staff or to other recipients, or to others.
8. Any event involving a recipient where it appears reasonable to expect media coverage will occur.
9. Escape from a hospital of any recipient under the jurisdiction of the Psychiatric Security Review Board, or of any recipient confined pursuant to Section 54-56d of the Connecticut General Statutes, or any recipient who escapes during a correctional transfer who is still under sentence at the time of the escape.

SECTION 5
CLAIMS SUBMISSION

A. GENERAL REQUIREMENTS

The minimum general requirements for reimbursement of services include the following:

1. Participating Provider in Good Standing: A provider shall be a "participating provider in good standing" in the DMHAS GA Behavioral Health Program on the date(s) on which services were rendered. Providers operating programs in compliance with applicable state and federal laws, regulations and DMHAS credentialing are considered to be a "participating provider in good standing".
2. DMHAS shall establish all rates for payment under this program.
3. The Provider shall be reimbursed at the rate established by DMHAS for each covered service, or at the billed rate, whichever is lower.
4. The Provider shall not be reimbursed for excluded services or for unauthorized services.
5. Providers may not bill nor be paid for missed appointments.

B. GA CLIENT ELIGIBILITY

1. The Provider must verify an individual's eligibility in the DMHAS GA Behavioral Health Program. Claims shall only be considered for payment for those services delivered during dates of recipient eligibility for State Administered General Assistance (SAGA) or General Assistance (GA).
2. If a Provider is unable to confirm that an individual is eligible for the SAGA program or GA at the time services are delivered, yet assesses that the individual is eligible for SAGA or GA, the provide shall follow the authorization process described in this manual.
3. Authorization by DMHAS or its designated agent of services requested by the provider is not a guarantee of payment. The Provider shall conform to all other applicable requirements specified in this manual.

C. CLAIM FILING REQUIREMENTS

1. **Paper Claims** that include all required data elements must be submitted on one of two national industry standard billing forms:
   - Center for Medicare and Medicaid Services/CMS-1500 (formerly known as HCFA-1500); OR
   - Uniform Billing Form/UB92 or HCFA-1450

2. Completed claim forms may be mailed to:

DMHAS GA Behavioral Health Program
c/o Advanced Behavioral Health
P.O. Box 1325
Middletown, CT 06457

3. A separate claim form must be submitted for each recipient.
4. Claim line items must indicate exact dates of service when billing for multiple units of the same procedure code.
5. **Web-based single claims data entry** is available to providers with authorized access to the ABH Claims Entry System (ACES) through the ABH website (www.abhct.com). Providers with authorized access will also be able to review claims status for previously submitted claims. Providers wishing to obtain access to the web-based claims system should contact the ABH Customer Service staff at 1-800-606-3677, Option 2 to request a user-specific login and password.
6. **Electronic Batch Claims** may be submitted in the standardized HIPAA 837 format that is compliant with current transaction code standards required by the Health Insurance Portability and Accountability Act (HIPAA). Specific information regarding file formats and submission method are available in the ABH Companion Guide located on the GABHP resource page of the ABH website at www.abhct.com. Providers will also have access to claims status for previously submitted claims. Providers interested in submitting batch-file claims should contact the ABH Customer Service staff to request a user-specific login and password and to schedule test submissions.

D. CLEAN CLAIMS

1. All claims for covered services must be submitted within 180 days that include but are not limited to the following required data elements:
   a. Client's name and date of birth
   b. EMSID Number
   c. Provider's name, address, Tax ID, Organization and Vendor ID numbers
   d. Date(s) and place of service
   e. Diagnosis (DSM-IV or ICD-9 code)
   f. Procedure code (CPT or Revenue Code) and quantity
   g. Provider charges
   h. Other information that may be required (i.e. Other Insurance information or the EOB for COB payment)
2. Specific instructions by line item appear below in the detailed description for the CMS-1500 and the UB92 forms.

E. TIMELINESS

All claims for services rendered must be submitted within one hundred eighty (180) days of the date(s) of service or date of discharge. Claims that are not submitted within the above time frames will be denied reimbursement.

F. INCOMPLETE CLAIMS

Claims will be returned to the provider if the required data elements are not provided. The provider will be notified via a completed Explanation of Benefits form or a Response File that will outline the incomplete or invalid information. To receive reimbursement for these claims, the Provider must resubmit them within the 180 day filing limit and with the identified fields corrected or completed. The required data elements for both CMS (HCFA) 1500 and UB 92 forms are listed below.

G. GA CLIENT HELD HARMLESS

Providers may NOT, under any circumstances, bill or balance bill GA-eligible Recipients for any services provided under the GA Behavioral Health program.

H. THIRD PARTY LIABILITY

1. The Provider must make a reasonable effort to determine whether or not GA clients have any other insurance or health care coverage and to promptly report any duplicate coverage to ABH.
2. The Provider must exhaust all avenues of other insurance coverage and payment prior to billing for covered services.
3. When a decision regarding reimbursement has been made by another Insurance carrier, a copy of the disposition of payment or explanation of benefits (EOB) must accompany the CMS-1500 (HCFA-1500).
4. Attachment of the disposition of payment or EOB is not required with the UB92. However, fields 50, 54, 58b and 58c must denote the disposition from the other insurance carrier.
5. All timely filing rules are enforced from the date of disposition from the other insurance carrier.
6. The Provider agrees and understands that the DMHAS GA Behavioral Health Program will not be obligated to pay the provider any portion of a secondary payment when the sum of the primary payment plus the secondary payment exceeds the compensation specified in the GABHP reimbursement schedule.

7. Claims involving coordination of benefits (COB) will require medical review and authorization. In order to receive payment, Provides must obtain clinical authorization for care from both the primary insurer and ABH at the time of treatment.

I. SERVICE LIMITATIONS

1. **Missed Appointment Policy –** An authorization for treatment issued by ABH does not authorize payment for missed appointments. Claims for missed appointments will be denied.
2. **Initial Evaluations –** An initial evaluation (CPT Code 90801) will be reimbursed no more frequently than once per provider organization per six-month period. Facilities may be reimbursed for an authorized initial evaluation if the client is not admitted to a level of care higher than outpatient (MH I.1, SA I.1) at the same organization within ten (10) calendar days.
3. **Maximum Visits Per Day**
   a. Reimbursement of outpatient therapy is limited to one session per provider, per day.
   b. Organizations can receive reimbursement for more than one level of care per day, but cannot receive payment for more than one unit of the same procedure/revenue code for the same service date.
   c. Medication management services will not be reimbursed separately from individual, family or group therapy if those services are performed by the same practitioner, on the same day, for the same GA recipient, unless authorized in advance by ABH.
4. **Neuropsychological Evaluation and Psychological Testing –** Reimbursement of Neuropsychological Evaluation and/or Psychological Testing, if authorized and approved by ABH, is limited to one such episode of testing per GA recipient during a 12-month period.
5. **Laboratory Services –** Reimbursement for laboratory services is limited to one (1) unit per allowable procedure per day per GA recipient.
6. **Excluded Services –** Refer to Section III (Covered Services) for a complete listing of Service Limitations and Exclusions.

J. RECONSIDERATION OF PAID CLAIMS

A Provider may request reconsideration of a claim thought to be paid incorrectly by submitting a completed Claim Reconsideration Form within 180 days of the original date of service. Incomplete Claim Reconsideration Forms will not be processed. Completed forms may be either mailed or

faxed to ABH. Any adjustment in payment will be reflected in and applied to the next weekly payment cycle following processing.

K. CLAIM INQUIRIES AND APPEALS

A Provider with a claim inquiry (seeking information concerning the status of a submitted claim, an explanation of a paid claim or clarification of a claim denied for administrative reasons) should either log on to www.abhct.com and access the real time on-line status inquiry system or contact ABH through the toll free GABHP line at 800-606-3677. ABH representatives will research the inquiry and provide a response/answer immediately, or refer the inquiry to the ABH Claims Department for further investigation. In the latter case, the Provider will receive a telephonic response within three business days.

A Provider that is not satisfied with the outcome of an inquiry concerning a claim denied for administrative reasons may file a claim appeal. When an appeal is filed, in writing, the following information is requested from the Provider:

- Provider Name
- EMSID Number
- Client/Patient Name
- Date(s) of Service
- Billing Code(s)
- Claim Number (initial and subsequent submissions)
- Rationale for Complaint

Appeal letters must be submitted to ABH within 180 days of the original date of service. Claims denied because they fall outside of the timely filing requirement may be appealed within thirty (30) days of receipt of the notice of the denial. ABH may request additional information before rendering a decision. The Provider will be notified in writing of the final decision within thirty (30) days of receipt of all required documentation.

L. PHARMACY CLAIMS

Claims for behavioral health Pharmacy costs or services will be handled through CHNCT, as part of the medical services benefit. Pharmacy claims are to be submitted to CHNCT in accordance with the established procedures.

M. BILLING CODES

The listing of the CPT Codes and UB 92 Revenue Codes eligible for reimbursement with a standard Outpatient Behavioral Health Authorization is provided in the Appendix. Please note that coding may vary by Provider and/or service level. Therefore, it is recommended that you refer to your Participating Provider Agreement with DMHAS for coding specific to you or your facility. Claims submitted with codes other than those listed on the rate schedule of your Agreement will be rejected. The codes requiring special authorization are listed separately. If you have questions concerning coding, it is recommended that you call ABH at 800-606-3677 prior to submitting a claim.

SECTION 6
SUPPORT OF CONTRACTED PROVIDERS

A. CREDENTIALING AND CONTRACTING

Providers interested in becoming a participating provider in the GA Behavioral Health Program Provider Network must be credentialed and contracted by DMHAS through its designated agent, ABH. Interested Providers may contact the ABH Provider Relations Department to inquire whether the network is open to new applicants. If the network is open, a credentialing packet will be sent to the Provider organization. Completed packets will be returned to ABH within thirty (30) days of receipt. The credentialing process is initiated upon successful receipt of the application and required associated documents. Once the Provider is credentialed, the contracting process may begin. DMHAS retains the right to approve all providers credentialed and contracted to provide services for GA Behavioral Health Program recipients.

Re-credentialing of participating providers is done bi-annually.

1. **Credentialing**
   Credentialing includes the assessment and validation of qualifications of a hospital, mental health, or substance abuse treatment facility to determine whether the Provider is capable of offering a specific type of care and whether requirements have been met for Provider enrollment. Required documentation includes, but is not limited to:
   a. Status of licensure/certification or accreditation
   b. Experience in providing services to GA recipients
   c. Insurance/liability coverage
   d. Descriptions detailing programmatic and staffing information for each service/level of care for which the Provider is requesting to be contracted

2. **Contracting**
   A contract specifies conditions and terms that govern the Provider and to which the Provider is mandated to adhere in order to participate in the GA Behavioral Health Program.

   DMHAS shall bear no financial responsibility for services that are rendered in the absence of a fully executed contract, unless DMHAS finds that good cause has been demonstrated, or services were rendered by an out of state Provider.

3. **Termination of Contracted Providers**
   A contract can be terminated after written notice by DMHAS. Termination may be **Automatic** (upon loss of required credentials, or as a result of fraud); may be for **Cause** (service quality: if DMHAS believes there is imminent harm to recipients; or administrative: problems with Medical staff privileges, failure to maintain malpractice

insurance, loss of DEA certification, evidence of fraud or malpractice, etc.); or may be the result of a DMHAS decision not to renew the contract.

B. ASO RESPONSIBILITIES

DMHAS and ABH recognize the value each contracted Provider adds to the statewide continuum of care. The ABH Provider Relations staff will offer support regarding completion of the application, credentialing and contracting process. In addition, training requests for the Electronic Registration System (ERS), claims submissions, or any other inquiries related to participation in the GA Behavioral Health Program, can be made by contacting an ABH Customer Service or Provider Relations staff member at 1-800-606-3677.

C. PROVIDER RESPONSIBILITIES

Providers are responsible for notification to ABH if:

1. there are changes to the status of any license, certification or accreditation;
2. if there are any legal actions pending;
3. if there are changes to medical director or medical staff licenses or privileges;
4. if there is a change in ownership;
5. if there is a service location change; or
6. if there is any change in the ability to provide contracted services.

Providers are responsible for reporting Critical Incidents to ABH within one (1) business day of the event identified as the Critical Incident.

Providers are expected to allow access to clinical records of recipients, programmatic and fiscal records for Quality audits in accordance with policy.

Providers must submit timely and accurate information, in a format specified by DMHAS or its designated agent, ABH. This information includes, but is not limited to, the following:

1. demographic data regarding the GA recipients served;
2. descriptions of services provided;
3. descriptions of provider staff, sufficient for DMHAS to assess their cultural competency; and
4. outcomes of treatment.

SECTION 7
APPEALS, COMPLAINTS, AND GRIEVANCES

A. APPEALS

There are two types of appeals that may be submitted as a result of a denial of request for services: Administrative and Clinical. The ASO maintains a denial process for resolving disputes regarding the authorization process. This process was developed by DMHAS and is reflected in policy.

1. Administrative Appeals

An administrative denial is issued when there has been a failure to follow protocol for administrative procedures; for example, a late request for initial (prior) or continued stay authorization, or the requested service falls outside of those covered by the State Administered General Assistance Program.

The first level appeals process can be initiated by telephone, or may be the sent via letter to the ASO. The appeal must be made within seven (7) calendar days of the receipt of the denial. Appeals submitted after seven calendar days will not be considered for review.

The appeal should contain additional information, or should demonstrate "good cause" for the non-compliance with the required administrative procedure.

The ASO will be required to render a written appeal decision within seven (7) business days of receipt of the appeal. The written notification will include the primary rationale for the decision. If the denial is overturned, the Provider can expect that an authorization will be issued within one business day of the decision to overturn. In those cases where the denial is upheld, the notification will contain instructions as to how to proceed with a second level appeal.

Second level appeal requests are made directly to DMHAS, and need to be submitted to DMHAS within seven (7) days of receiving notice that the denial has been upheld at the first level. The appeal must be accompanied by information necessary and sufficient to render a decision. In those cases where DMHAS elects to overturn the administrative denial, the ASO will be instructed to reprocess the request for authorization, and to issue the authorization. In those cases where the denial is upheld on second level, the appeals process will be considered concluded.

2. Clinical Appeals

Before behavioral healthcare services are authorized, the Clinical Care Manager will review the clinical information offered by the Provider, and will

ascertain whether the information presented meets service necessity criteria for the requested level of care. If the information presented does not appear to meet service necessity criteria, the Clinical Care Manager will refer the case to the ABH Medical Director or Physician Reviewer to assist in making a final determination.

A clinical denial is issued when, in the judgment of the ASO Medical Director or Physician Reviewer, service/medical necessity criteria for the requested level of care has not been met. The Provider may request to speak with the Medical Director/Physician Reviewer prior to the determination to discuss additional information that supports the service request. The clinical denial decision may occur at the time of the request for admission to services, or at the time of continued stay review. The clinical denial decision serves to notify the provider that the information presented has failed to meet service necessity requirements; the final decision related to provision of treatment is determined by the treatment provider.

The Provider, the recipient, or an authorized representative of the recipient may initiate the appeals process by telephone or in writing. Any appeal request should also include any new or additional clinical information and documentation that will support the provider's request for reversal of the clinical denial. The appeal request must be submitted to ABH within seven (7) calendar days after receipt of the decision to clinically deny behavioral healthcare services. Appeals received more than seven (7) days following the receipt of the clinical denial will not be considered for review.

A Physician not involved with the original clinical denial will review the information submitted through the appeal. The ASO will notify the Provider, the recipient, or an authorized representative of the recipient within four (4) business hours after review of the all information sufficient and necessary to render an appeal decision. Providers will be notified telephonically regarding the appeal decision in situations when the provider has requested an expedited or urgent appeal request. A letter will follow the notification, and will contain the elements of the decision to reverse or to uphold the denial.

When the decision is made at the first level to overturn the clinical denial, an authorization will be issued within one business day. When the decision is made to uphold the denial on the first level, the letter will include information about how to make an appeal at the second level.

Requests for second level appeals should be made directly to DMHAS, and must be submitted to DMHAS within seven (7) days of receipt of the first-level appeal decision. The appeal must be accompanied by information necessary and sufficient to render a decision. In those cases where DMHAS elects to overturn the clinical denial, the ASO will be instructed to reprocess the request for authorization, and to issue the authorization. In those cases where the denial is upheld on second level, the appeals process will be considered concluded.

All first level administrative and clinical appeals correspondence may be sent to:

DMHAS GA Behavioral Health Program
c/o Advanced Behavioral Health, Inc.
213 Court Street, 10th floor
Middletown, CT 06457

All second level administrative and clinical appeals correspondence may be sent to:

DMHAS GA Behavioral Health Program
Department of Mental Health and Addiction Services
410 Capitol Avenue, MS #14MCP
P.O. Box 341431
Hartford, CT 06134

B. COMPLAINTS AND GRIEVANCES

For the purposes of this section, grievances are defined as a complaint against a Provider in matters other than the denial, reduction, or termination of covered services.

A recipient receiving services under the DMHAS GA Behavioral Health Program, or his/her authorized representative, may utilize the established grievance procedure to seek resolution of complaints concerning the quality or level of services provided. Complaints can be offered by contacting the ASO at 1-800-606-3677, Option 2 or recipients may contact the Community Liaison at 1-866-213-4759. Complaints received by the ASO will be forwarded to DMHAS for review and consideration.

SECTION 8
GLOSSARY OF TERMS

AEVS – *Automated Eligibility Verification System* – a system accessible to Providers, which allows for verification of eligibility for General Assistance, and the existence of third party liability for a recipient.

ASAM PPC– *American Society of Addiction Medicine Patient Placement Criteria* – DMHAS and its designated agent utilize the most current version of this nationally accepted level of care criteria for substance abuse services to render service necessity decisions.

ASO – *Administrative Services Organization* – An entity, operated by a private vendor that provides utilization management, claims processing, and other administrative assistance to the Department of Mental Health and Addiction Services to facilitate the purchase and provision of mental health and addiction services for recipients.

BNP – *Basic Needs Program* – a program that provides for recovery support services (housing, bus passes, personal care items, etc.) for recipients who are compliant with their treatment.

Clinical Care Manager – A licensed, clinical professional with experience in the review and authorization of requested behavioral health services.

Case Manager – persons hired to support the recipient as s/he moves through the continuum of care.

CCPC – *Connecticut Patient Placement Criteria* – clinical criteria adapted from the American Society of Addiction Medicine Patient Placement Criteria-2 in 1997 for the Connecticut treatment community.

CHNCT – *Community Health Network of Connecticut* – CHNCT serves as the ASO for SAGA medical. Provider inquiries call 800 – 440 – 5071; Recipient inquiries call 866 – 361 – 7242.

Critical Incident – any incident that results in the risk or injury to, or the death of, a recipient; or, any serious adverse treatment response, or serious impact on service delivery. This includes, but is not limited to:

- Death of a recipient, including any death that occurs within thirty (30) days of discharge from treatment (if known).
- Elopement of a recipient from a hospital or unexplained absence from regular programming where there is

substantial concern that the recipient is a danger to self or others.

- Serious injury to a recipient, or serious physical illness of a recipient, that results in the admission to a general hospital; including any serious injury that occurs within thirty (30) days of discharge from treatment (if known).
- Any serious suicide attempt, including suicide attempts that occur up to thirty (30) days of discharge from treatment (if known).
- Suspected or documented client abuse, or allegations of client abuse, or violation of recipient confidentiality that has, or may have, serious consequences.
- Serious adverse reaction to medication.
- Threats by a recipient who has been assessed as representing a credible risk to staff or to other recipients, or to others.
- Any event involving a recipient where it appears reasonable to expect media coverage will occur.
- Escape from a hospital of any recipient under the jurisdiction of the Psychiatric Security Review Board, or of any recipient confined pursuant to Section 54-56d of the Connecticut General Statutes, or any recipient who escapes during a correctional transfer who is still under sentence at the time of the escape.

DCF – *Department of Children and Families* – the state agency responsible for oversight of programs that impact the physical and behavioral health of children and adolescents.

DMHAS – *Department of Mental Health and Addiction Services* – the state agency responsible for oversight of behavioral health programs for adults.

DSS – *Department of Social Services* - the state agency responsible for enrolling eligible persons on various programs and entitlements.

EMS – *Eligibility Management System* – the information system utilized by DSS to record eligibility information for recipients of General Assistance and Medicaid for the State of Connecticut. An EMS ID number is a unique identifier assigned to persons who meet eligibility criteria for assistance under the Department of Social Services programs.

Entitlements Specialist – an ABH staff person working with the Intensive Case Management Program who can assist the recipient in

application for entitlements such as Medicaid and, in some cases, General Assistance.

ERS – *Electronic Registration System* – a secure Internet based system that allows Providers with authorized access to register recipients for various levels of care, view open episodes that are site specific, and enter discharges. Training is required prior to obtaining access to that system.

FQHC – *Federally Qualified Health Care Clinic* – clinics located throughout the state that serve to meet the medical needs of SAGA recipients.

GA – *General Assistance* – a program providing medical assistance to low-income persons who do not qualify for, or are awaiting an eligibility determination, for other state or federal programs. The Department of Social Services provides cash and/or medical assistance to individuals who are unable to work for medical or other prescribed reasons, and who do not qualify for other Department of Social Services programs. Also known as *State Administered General Assistance.*

GABHP – *General Assistance Behavioral Health Program* – developed by the Department of Mental Health and Addiction Services to coordinate the provision of behavioral health services to General Assistance recipients.

GAICM – *General Assistance Intensive Case Management Program* – case management program designed to assist high-risk clients including high utilizers in engaging and moving through the recovery continuum.

High Utilizer – a recipient who has had four or more admissions to an acute care setting in a six-month period, which makes him/her eligible for case management services.

LOC – *Level of Care*

Medical necessity – services identified as appropriate and necessary to assess and manage the symptoms, diagnosis, or treatment of a mental health or substance abuse condition, or both, as defined by the DSM-IV-TR or its successor, the ASAM PPC-2R or its successor, the CCPC or its successor, or the DMHAS Clinical Protocol for Mental Health Levels of Care. Services are to be delivered in the most appropriate, least restrictive level of care. Medical Necessity is synonymous with Service Necessity.

SAGA – *State Administered General Assistance* – see **GA**.

Service necessity – see **Medical Necessity**

APPENDIX

APPENDIX A – DMHAS UM MODEL

DMHAS UM MODEL DMHAS Level of Care	Level	Included in UM Process	Is Prior Auth Required?	Authorized LOS at PA	How Is It Done?	When Is C/Stay Performed?	LOS At Cont'd Stay	How Is It Done?	Is A D/C Review Required?
Acute Inpatient Mental Health	MH IV.2	Yes	Yes	Up to 5 days	Phone	By last day	Up to 3 days	Phone	Yes
Medically-Managed Inpatient Detoxification	SA IV.2-D	Yes	Yes	Up to 3 days*	Phone	By last day	Up to 2 days	Phone	Yes
Med. Monitored Residential Detoxification	SA III.7-D	Yes	Yes	Up to 3 days*	Phone	By last day	Up to 2 days	Phone	Yes
Intensive Residential Treatment	SA III.7	Yes	Yes	Up to 10 days	Phone	Up to 1 day prior to end of auth	Up to 7 days	Phone	Yes
Intermediate/Long-Term Residential Treatment	SA III.3	Yes	Yes	Up to 30 days	Phone	Up to 2 days prior to end of auth	Up to 45 days	Phone	Yes
Intensive Crisis Stabilization (Respite beds)	MH II.9	Yes	Yes	Up to 7 days	Phone	Up to 1 day prior to end of auth	Up to 7 days	Phone	Yes
Observation/23-hour bed	MH II.7 SA II.7	Yes	Yes	Up to 23 hrs Or 1 day	Phone	N/A	None	N/A	Yes
MH Partial Hospital or SA Day/Evening Treatment	MH II.5 SA II.5	Yes	Yes	Up to 5 visits Up to 5 visits	Phone	Up to 1 day prior to end of auth	Up to 5 visits Up to 5 visits	Phone	Yes
Intensive Outpatient	MH II.1 SA II.1	Yes	Yes	Up to 10 visits	ERS**	Up to 1 day prior to end of auth	Up to 7 visits	ERS**	Yes
Methadone Maintenance	SA I.3	Yes	Yes	Up to 52 weeks	ERS**	Up to 2 days prior to end of auth	Up to 52 weeks	ERS**	Yes
Opioid Dependence Detox (outpatient)	SA I.2	Yes	Yes	Up to 21 days	ERS**	Up to 2 days prior to end of auth	Up to 45 days	ERS**	Yes
Ambulatory Detox w/on-site monitoring	SA II.D	Yes	Yes	Up to 7 days	Phone	Up to 1day prior to end of auth	Up to 7 days	Phone	Yes
Ambulatory Detox	SA I.D	Yes	Yes	Up to 7 days	ERS**	Up to 1 day prior to end of auth	Up to 7 days	ERS**	Yes
Outpatient	MH I.1 SA I.1	Registration***	PA Required, must register w/in 10 business days	Up to 26 visits	ERS**	Up to 2 days prior to end of auth	Up to 26 visits	ERS**	Yes

*Up to 3 days for detoxification from alcohol or alcohol & cocaine; up to 5 days for detoxification from all other substances.

**Providers unable to utilize ERS must submit requests for authorization via fax transmittal using the GABHP ERS OTR form.

APPENDIX B - UB-92 Facility Codes

Psychiatric Services

Service	DMHAS LOC	UB-92 Revenue Code
Acute Psychiatric Inpatient	MH IV-2	124
Acute Inpatient Services Pilot II.0 Dual Diagnosis	Pilot II.0	121
Observation / Flex Bed	MH II.7	762, 760
Intensive Crisis Stabilization	MH II.9	769
Partial Hospitalization	MH II.5	913
Intensive Outpatient MH	MH II.1	912
Emergency Room	MH I.I	450

Substance Abuse Services

Service	DMHAS LOC	UB-92 Revenue Code
Observation / Flex Bed	SA II.7	762, 760
Partial Hospitalization	SA II.5	913
Intensive Outpatient SA	SA II.1	912
Ambulatory Detox w/ On-Site Monitoring	SA II.D	191
Ambulatory Detox	SA I.D	190
Emergency Room	SA I.1	450

APPENDIX C - Tips for Completing the UB-92/HCFA 1450 Claim Form

Field Number	Field Description	Data Type	Instructions
1	Provider name, address and telephone number	Required	Enter the name of the facility submitting the bill and the complete billing address, telephone number, Organization and Vendor ID numbers.
2	Unlabeled field	Not required	Not applicable.
3	Patient control number	Optional	Enter the unique number assigned by the facility for the client.
4	Type of bill	Required	Enter a valid 3-digit Type of Bill code, that provides specific information about the services rendered. Refer to the UB92 Reference Codes following this document.
5	Federal tax number	Required	Enter the nine-digit Employer Identification Number (EIN) for the Provider indicated in box 1 assigned by the Internal Revenue Service (IRS).
6	Statement covers period "From" and "Through"	Required	Enter the beginning and ending date of services for the period reflected on the claim in MMDDYY format. The date of discharge is not a covered day for an inpatient stay.
7	Covered days	Not required	Enter the number of inpatient days covered for the billing period noted in Field 6.
8	Non-covered days	Not required	Enter the number of inpatient days not covered by the primary payer.
9	Coinsurance days	Not required	Enter the number of the inpatient Medicare days occurring after the 60th day and before the 91st day in a single episode.
10	Lifetime reserve days	Not required	Enter the number of lifetime reserve days used during the billing period noted on the claim.
11	Unlabeled field	Not required	Not applicable.
12	Patient's name (last, first name, middle initial)	Required	Enter the Client Name (Last, First Name, and Middle Initial).

13	Patient's address	Required	Enter the complete mailing address of the Client. Include the street number and name, post office box or rural route number and apartment number if applicable, city, state and zip code.
14	Birth date	Required	Enter the Client's Date of Birth in MMDDYY format.
15	Sex	Required	Enter the code for the gender status of the client. Refer to the UB92 Reference Codes following this document.
16	Marital status	Not required	Enter the marital status of the Client on the date of the admission. Refer to the UB92 Reference Codes following this document.
17	Admission date	Required	Enter the original date the Client was admitted for care in MMDDYY format.
18	Admission hour	Conditional	If this is an inpatient claim, enter the admission hour in Military Standard Time (e.g., 00:00 to 24:00), if applicable.
19	Admission type	Conditional	If this is an inpatient claim, enter the code for the admission type if applicable. Refer to the UB92 Reference Codes following this document.
20	Admission source	Conditional	If this is an inpatient claim, enter the appropriate Admission Source Code. Refer to the UB92 Reference Codes following this document.
21	Discharge hour	Conditional	If this is an inpatient claim, enter the hour at which the Client was discharged from inpatient care if applicable.
22	Patient status	Not required	Enter the appropriate code indicating the Client's disposition as of the ending date of service for the period of care. Refer to the UB92 Reference Codes following this document.
23	Medical record number	Optional	Enter the number assigned by the Provider to the Client's medical or health record.
24-30	Condition codes	Not required	Enter a valid condition code if applicable.
31	Unlabeled field	Not required	Not applicable.

32	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
33	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
34	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
35	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
36	Occurrence span code and "From/Through" date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
37	Unlabeled field	Not required	Not applicable.
38	Responsible party name and address	Not required	Enter the name and address of the party responsible for payment of the bill.
39	Value codes/amount	Not required	Enter a valid Value code and amount.
40	Value codes/amount	Not required	Enter a valid Value code and amount.
41	Value codes/amount	Not required	Enter a valid Value code and amount.
42	Revenue code	Required	Enter the applicable revenue codes for the services rendered. There are 23 lines available and should include the total line for revenue code 0001.
43	Description	Not required	Enter the corresponding description of the revenue code(s) indicated in Field 43 lines 1-23.
44	HCPCS/Rates	Required	Enter a valid HCPC or CPT procedure code for the ancillary services for outpatient or the accommodation rate for inpatient claims.
45	Service date	Required	Enter the date the service was rendered in MMDDYY format.
46	Service units	Required	Enter the service units for each service billed.

47	Total charges	Required	Enter the amount equal to the per unit charge to the related revenue codes billed for the statement from and through dates. This amount includes both the covered and non-covered charges.
48	Non-covered charges	Not Required	Enter the total non-covered charges for the Primary Payer, if applicable, for each service billed.
49	Unlabeled field	Not required	Not applicable.
50	Payer	Required	Enter the name(s) of the Primary, Secondary and Tertiary Payers as applicable. Provider should list multiple Payers in priority sequence according to the priority the provider expects to receive payment from these Payers.
51	Provider number	Required	Enter your plan assigned provider number.
52	Release of information certification indicator	Required	Enter the appropriate code denoting whether the Provider has on file a signed statement from the beneficiary to release information. Indicate a "Y" for yes, an "R" for restricted or modified release or an "N" for no release.
53	Assignment of benefits	Required	Enter the applicable code to indicate whether the Provider has a signed form authorizing the third party insurer to pay the Provider directly for the services rendered.
54	Prior payments	Conditional	Enter any prior payment amount the Facility has received toward payment of this bill for the Payer indicated in Field 50 lines a,b,c.
54P	Due From Patient	Not required	Enter the amount due from the client.
55	Estimated amount due	Not required	Enter the estimated amount due from the Payer indicated in Field 50 lines a,b,c.
56	Unlabeled field	Not required	Not applicable.
57	Unlabeled field	Not required	Not applicable.
58	Insured's name) last, first name, middle initial	Required	Enter the Insured's Name (Last, First Name, Middle Initial).

59	Patient's relationship to insured	Required	Enter the applicable code that indicates the relationship of the client to the insured noted in Field 58. Refer to the UB92 Reference Codes following this document.
60	Certificate Number - Social Security Number - Health Insurance Identification Number	Required	Enter the Insured's EMS ID in Box 60a and the ID number assigned by secondary or tertiary insurance as applicable.
61	Group name	Not required	Enter the group or plan name of the Primary, Secondary and Tertiary Payer through which the coverage is provided to the insured if applicable.
62	Insurance group number	Not required	Enter the plan or group number for the Primary, Secondary and Tertiary Payer if applicable.
63	Treatment authorization codes	Not required	Enter the authorization number assigned by ABH.
64	ESC (Employment Status Codes)	Not required	Enter the applicable code that defines the employment status code of the insured indicated in Field 50. Refer to the UB92 Reference Codes following this document.
65	Employer name	Not required	Enter the name of the Primary Employer that provides the coverage for the insured indicated in Field 58.
66	Employer location	Not required	Enter the specific location of the Primary Insured individual identified in Field 58.
67	Principal diagnosis code	Required	Enter a valid ICD-9 or DSM diagnosis code (including the fourth and fifth digits if applicable) that describes the principal diagnosis for the services rendered. Please exclude the decimal point.
68-75	Other diagnosis code	Conditional	If there are additional diagnoses, enter a valid ICD-9 or DSM diagnosis code (including the fourth and fifth digits if applicable) for any other conditions that exist for the services rendered. Please exclude the decimal point.
76	Admitting diagnosis code	Required	Enter a valid ICD-9 or DSM diagnosis code (including the fourth and fifth digits if applicable) that describes the diagnosis at the time of the admission. Please exclude the decimal point.

DRAFT

77	E-code	Not required	Enter a valid ICD-9 diagnosis code (including the fourth and fifth digits if applicable) for the external cause of injury, poisoning or adverse effect. Please exclude the decimal point.
78	Unlabeled field	Not required	Not applicable.
79	Procedure method used	Not required	Enter the corresponding code that denotes the medical coding system used to complete the claim form.
80	Principal procedure code/date	Not required	Enter a valid ICD-9 code and date for the principal procedure performed during the period covered by the bill.
81	Other procedure code/date	Not required	Enter additional ICD-9 codes and dates to identify significant procedures performed during the period covered by the bill.
82	Attending physician identification number	Required	Enter the name and/or the assigned number of the licensed Physician who has primary responsibility for the Client's care.
83	Other physician identification number	Not Required	Enter the name and/or the assigned number of the licensed Physician, other than the attending physician, who treated the Client.
84	Remarks	Not required	Not applicable.
85	Provider representative	Required	Enter the signature of an authorized representative noting the Physician's certification is in effect. A stamp or facsimile of the Provider's representative signature is acceptable.
85	Date	Required	Enter the date the bill is submitted to the Payer organization in MMDDYY format.

APPENDIX D - UB-92/HCFA 1450 Reference Material

Patient Status (Field 22)

Definition	Code
Discharged to home or self-care (routine discharge)	01
Discharged/transferred to another short-term general hospital	02
Discharged/transferred to a skilled nursing facility	03
Discharged/transferred to an intermediate care facility	04
Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution	05
Discharged/transferred to home under care of organized home health service organization	06
Left against medical advice or discontinued care	07
Discharged/transferred to home under care of organized home health service organization	09
Admitted as an inpatient to this hospital	09
Expired (or did not recover-Christian Science patient)	20
Still a patient or expected to return for outpatient services	30
Reserved for National Assignment	31-39
Expired at home (for hospice care only)	40
Expired in a medical facility such as a hospital, SNF, ICF or free-standing hospice (for hospice care only)	41
Expired, place unknown (for hospice care only)	42
Discharged/Transferred to a Federal Hospital	43
Discharged to hospice, home	50
Discharged to hospice, Medical Facility	21

Release of Information Indicator Codes (Field 52)

Definition	Code
Yes	Y
Restricted or modified release	R
No release	N

Member's Relationship to the Insured Codes (Field 59)

(Date of Service is before October 16, 2003)

Definition	Code
Patient is the insured	01
Spouse	02
Natural child/insured has financial responsibility	03
Natural child/insured does not have financial responsibility	04
Stepchild	05
Foster child	06
Ward of the court	07
Employee	08
Unknown	09
Handicapped dependent	10
Organ donor	11
Cadaver donor	12
Grandchild	13
Niece/nephew	14
Injured plaintiff	15
Sponsored dependent	16
Minor dependent of a minor dependent	17
Parent	18
Grandparent	19
Life partner	20

Member's Relationship to the Insured Codes (Field 59)

(Date of Service is after October 16, 2003)

Definition	Code
Spouse	01
Grandfather or Grandmother	04
Grandson or Granddaughter	05
Niece/nephew	07
Foster Child	10
Ward	15
Stepson or Stepdaughter	17
Self	18
Child	19
Employee	20
Unknown	21
Handicapped Dependent	22
Sponsored Dependent	23
Dependent of a Minor Dependent	24
Significant Other	29
Mother	32
Father	33
Emancipated Minor	36
Organ Donor	39
Cadaver Donor	40
Injured Plaintiff	41
Child where insured has no financial responsibility	43
Life Partner	53
Other Relationship	G8

Valid Employment Status Codes (Field 64)

Definition	Code
Employed full-time	1
Employed part-time	2
Not employed	3
Self-employed	4
Retired	5
On active military duty	6
Unknown	9

DRAFT

APPENDIX E - CMS (HCFA) 1500 - Professional Ambulatory Codes Standard OP-BEH Auth

CPT Code	Description
90804	Individual Therapy - (20-30 min.)
90805	Individual Therapy w/ Med Management (20-30 min.)
90806	Individual Therapy (45-50 min.)
90807	Individual Therapy w/ Med Management (45-50 min.)
90846	Family Therapy without patient
90847	Family Therapy with patient
90853	Group Therapy
90862	Psychopharmacology Management
90875	Individual Psychophysiological Therapy w/Biofeedback (20-30 min.)
90876	Individual Psychophysiological Therapy w/Biofeedback (45-50 min.)
90880	Medical Hypnotherapy
99241	Office or Other Outpatient Consultation (15 min.)
99242	Office or Other Outpatient Consultation (30 min.)
99243	Office or Other Outpatient Consultation (40 min.)
99244	Office or Other Outpatient Consultation (60 min.)
99245	Office or Other Outpatient Consultation (80 min.)
99251	Inpatient Consultation (20 min.)
99252	Inpatient Consultation (40 min)
99253	Inpatient Consultation (55 min.)
99254	Inpatient Consultation (80 min.)
99255	Inpatient Consultation (110 min.)
99261	Follow-up Inpatient Consultation (10 min.)
99262	Follow-up Inpatient Consultation (20 min.)
99263	Follow-up Inpatient Consultation (30 min.)
99271	Confirmatory Consultation, Focused
99272	Confirmatory Consultation, Expanded
99273	Confirmatory Consultation, Detailed
99274	Confirmatory Consultation, Comprehensive, Moderate Complexity
99275	Confirmatory Consultation, Comprehensive, High Complexity

APPENDIX F - CMS (HCFA) 1500 - Professional Ambulatory Codes Requiring Special Authorization

CPT Code	Description
90801	Initial Psychiatric Interview Examination
90870	Electroconvulsive Therapy, Single Seizure
90871	Electroconvulsive Therapy, Multiple Seizures
90899	Unlisted Psychiatric Service or Procedure
96100	Psychological Testing
96115	Neurobehavioral Status Exam
96117	Neuropsychological Testing Battery
J1630	Injection, Haloperidol, up to 5 mg.
J1631	Injection, Haloperidol Decanoate, per 50 mg.
J2680	Injection, Fluphenazine Decanoate, up to 25 mg.

Psychiatric Services

Service	DMHAS LOC	UB-92 Revenue Code
Intensive Crisis Stabilization	MH II.9	S9485
Partial Hospitalization	MH II.5	H0035
Intensive Outpatient MH	MH II.1	S9480

Substance Abuse Services

Service	DMHAS LOC	UB-92 Revenue Code
Residential Detox – Medically Managed	SA III.7-D	H0011
Intensive Residential – Level III.7	SA III.7	H0018
Residential Long Term Care	SA III.3	H0019
Observation / Flex Bed	SA II.7	H0010, H0047
Partial Hospitalization	SA II.5	S0201
Intensive Outpatient SA	SA II.1	H0015
Ambulatory Detox w/ On-Site Monitoring	SA II.D	H0013, H0014
Ambulatory Detox	SA I.D	S9475
Methadone Maintenance	SA I.3	H0020
Methadone Detox	SA I.2	H0012

Tips for Completing the CMS (HCFA) 1500 Claim

Claims for non-facility based professional services must be filed on an accurately completed CMS 1500 (HCFA 1500) claim form. A downloadable training program on how to complete the form can be obtained through the HCFA Web site at www.hcfa.gov or at www.medicaretraining.com.

Field Number	Field Description	Data Type	Instructions
Client / Member Information (Fields 1-13)			
1	Coverage	Not required	Check the appropriate box with an "X".
1a	Insured's ID number	Required	Enter the client's EMS ID number.
2	Patient's Name	Required	Enter the client's full name – last name first, first name second, middle initial last.
3	Patient's birth date and gender	Required	Enter the client's birth date, and check the box that corresponds to the client's gender.
4	Insured's name	Conditional	If patient is not the insured, enter the insured's name (last name, first name, middle initial).
5	Patient's address, city, state, zip code and telephone number	Required	Enter the client's address (apartment/PO box number, street, city, state, zip code).
6	Patient's relationship to the insured	Required	Place and "X" in the box indicating the patient's relationship to the insured.
7	Insured's address, city, state, zip code and telephone number	Conditional	If patient is not the insured, enter the insured's address (apartment/PO box number, street, city, state, zip code) and telephone number with area code.
8	Patient status	Not required	Place an "X" in the box indicating the client's marital status and an "X" in the box indicating whether client is employed or a full/part-time student.
9	Other insured's name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.
9a	Other insured's policy or group number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.

9b	Other insured's date of birth	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the date of birth in MMDDYY format and put an "X" in the box indicating the other insured's gender.
9c	Other insured's employer's name or school name	Not required	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name. If another payer is involved and the other insured is eligible by virtue of employment or a policy provided through a school that they are attending, enter the name of the school or employer.
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program.
10	Is the patient's condition related to: employment? Auto accident? Other accident?	Not Required	Place an "X" in the box indicating whether or not the condition for which the client is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question.
10d	Reserved for local use	Not required	Please leave blank.
11	Insured policy group or FECA number	Not required	Insured's group number.
11a	Insured's date of birth	Conditional	Required if the client is not the insured. Enter in MMDDYY format.
11b	Employer name or school name	Not required	Enter the insured employer's name. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name.
11c	Insurance plan name or program name	Not Required	Enter the insured's insurance company or program name.
11d	Is there another health benefit plan?	Required	Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.

12 & 13	Patient's or authorized person's signature	Required	The patient **must** sign and date the claim if authorizing the release of medical information and/or if authorizing payment to the undersigned physician/supplier/organization listed below. If "signature on file" is indicated, the provider **must** maintain a signed release form or CMS-1500 (HCFA 1500) form.
Provider / Supplier Information (Fields 14 - 33)			
14	Date of current illness, injury or pregnancy	Not required	Not applicable.
15	If patient has had same or similar illness, give first date	Not required	Not applicable.
16	Dates patient unable to work in current occupation	Conditional	Required if the client is eligible for disability or worker's compensation benefits due to this illness. Write the "From" and "To" dates the client was unable to work in MMDDYY format.
17	Name of referring physician or other source	Not required	Not applicable.
17a	ID number of referring physician	Not required	Not applicable.
18	Hospitalization dates related to current services	Not required	Print the admission and discharge dates for services related to a hospitalization.
19	Reserved for local use	Not required	Not applicable.
20	Outside lab/charges	Not Required	Enter if lab tests performed and billed on this claim were processed by a lab outside the provider's premises.
21.1	Diagnosis or nature of illness or injury	Required	Enter a valid ICD-9 diagnosis code (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Please exclude the decimal point.
21.2-4	Diagnosis or nature of illness or injury	Conditional	If there are additional diagnoses, enter a valid ICD-9 diagnosis code (include fourth and fifth digits if applicable) that describes additional diagnoses for services rendered. Please exclude the decimal point.

22	Medicaid resubmission code/original reference number	Not required	Not applicable.
23	Prior authorization number	Not required	Print the prior authorization number.
24a	Dates of service	Required	Enter "Form" and "To" dates of service in MMDDYY format. Line items can include no more than one date of service for the same procedure code.
24b	Place of service	Required	Enter the appropriate HCFA place of service code.
24c	Type of service	Not required	Print the appropriate type-of-service code.
24d	Procedures, services or supplies: CPT/HCPCS	Required	Enter a valid CPT or HCPCS code for each service rendered.
24d	Procedures, services or supplies: modifier	Conditional	Enter a valid CPT or HCPCS code modifier for each service entered.
			HIPAA Billing Code Modifiers When submitting a CPT or HCPCS code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below.
			#1 Modifier - This field is dedicated for modifiers that affect or define the service (e.g.,TG modifier to identify a 'complex high level of care')
			#2 Modifier - This field is dedicated for modifiers that identify pricing (e.g., HN modifier to identify 'bachelors level').
			#3 - #4 Modifiers - These fields are dedicated for modifiers that identify statistics (e.g., HV - 'funded by State Addictions Agency'
			If you have any questions regarding the use of Modifiers, call ABH's Provider Relations Department.

DRAFT

24e	Diagnosis code	Required	Enter the number (1,2,3,4) of the diagnosis code entered in Field 21 for which this service was rendered. Do not enter the ICD-9 diagnosis code.
24f	Charges	Required	Enter the provider's billed charges.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the "Form" and "To" dates indicated in Field 24a.
24h	EPSDT family plan	Not required	If service was rendered as part of or in response to an EPSDT panel, mark and "X" in this block.
24i	EMG	Not required	Not applicable
24j	COB	Conditional	Enter a "Y" if another payer has already paid on this service: otherwise, leave blank.
24k	Reserved for local use/other insurance payment	Conditional	Enter the amount paid by the client for this service, otherwise leave blank.
25	Federal Tax ID number and type: Social Security Number or Employer Identification Number	Required	Enter the 9-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered.
26	Patient's account number	Not required	Enter the unique number assigned by the provider for the patient.
27	Accept Assignment?	Required	Enter an "X" in the appropriate box.
28	Total Charge	Not required	Enter the total charge for this claim. This is the total of all charges or each service noted in Field 24f.
29	Amount paid	Not required	Enter the total amount paid by the patient and/or another payer for services billed on this claim.
30	Balance due	Not required	Enter the total balance due for the services less any amount entered in Field 29.

31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician/therapist/supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care must sign or have the signature on file and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter the site name and address and include Vendor ID number.
33	Physician's/supplier's billing: name, address, zip code and phone number	Required	Enter the appropriate billing information.
33	PIN number	Required	Enter the Organization ID number
33	Group number	Required	Enter the Vendor ID number

APPENDIX G – CMS (HCFA) 1500 Reference Material

Place of Service Codes (Field 24B HCFA 1500)

Definition	Code
Office	11
Home	12
School	19
Inpatient hospitalization	21
Outpatient hospitalization	22
Emergency room, hospital	23
Ambulatory surgical center	24
Birthing center/free-standing facility	25
Military treatment facility	26
Skilled nursing facility	31
Nursing facility	32
Custodial care facility	33
Hospice	34
Ambulance, land	41
Ambulance, air or water	42
Federally qualified health center	50
Inpatient psychiatric facility	51
Psychiatric facility partial hospitalization	52
Community mental health center	53
Intermediate care facility/mental retardation	54
Residential substance abuse treatment facility	55
Psychiatric residential treatment center	56
Comprehensive inpatient rehabilitation facility	61
Comprehensive outpatient rehabilitation facility	62
End-stage renal disease treatment facility	65
State or local public health	71
Rural health clinic	72
School	80
Independent laboratory	81
Court	82
Correctional facility	83
Other community setting	84
Drop-in center	85
Foster home	86
Place of employment	87
Other unlisted facility	99

DRAFT

SELECT ONE:
Initial Registration ☐ Continued Stay Review ☐

Advanced Behavioral Health, Inc. Outpatient Treatment Review Form

Client Name (Last, First):______________________
EMS ID# or Social Security Number:______________
Client's Date of Birth:__________ Admission Date:__________
Client's Address:______________________
Provider Name:______________________
Provider Service Address:______________________

Service Type (MUST select one):
☐ OP Substance Abuse (SA I.1)
☐ Ambulatory Detox (SA I.D)
☐ OP Methadone Detox (SA I.2)
☐ Methadone Maintenance (SA I.3)
☐ Ambulatory Detox w/OSM (SA II.D)
☐ SA Intensive Outpatient (SA II.1)
☐ Recovery House Services
☐ MH Crisis Stabilization (MH II.9)
☐ OP Mental Health (MH I.1)
☐ MH Intensive Outpatient (MH II.1)

DIAGNOSES – AXIS I – V (Required)
Axis I: (1)__________ (2)__________
(3)__________
Axis II: __________
Axis III: __________
Axis IV: __________
Axis V: Current GAF: ______ Highest GAF/Past Yr: ______ Lowest GAF/Past Yr: ______
Treatment Plan:______________________
____

Frequency of Visits (FOR IOP LEVEL OF CARE ONLY):
☐ 3 Days Per Week ☐ 4 Days Per Week ☐ 5 Days Per Week

Type of Visits Requested (Required for Level I.1 only – MUST check at least one):
☐ Initial Evaluation ☐ Group Therapy ☐ Family Therapy
☐ Individual Therapy ☐ Medication Management

Requested Number of Units (Required): __________

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

Substance Use History (Required for all SA & Dual Admissions except Level I.1):

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

Date/Results of Drug Toxicology (required for Continued Care, Levels I.2SA, I.3SA):
Date of Most Recent Drug Toxicology: __________

Results: ☐ Positive ☐ Negative

If Positive, MUST select at least one:
☐ Opiates ☐ Benzodiazepines
☐ Cannabis ☐ Cocaine

Symptom Checklist (Select at least one – Required
☐ Isolation
☐ Eat/Sleep Disturbance
☐ Manic Behavior
☐ Inadequate Self Care
☐ Recent Relapse
☐ Current symptoms of withdrawal
☐ Delusions/Hallucinations
☐ Peer/Relationship Difficulty
☐ Suicidal/Homicidal Ideation
☐ Sexually Inappropriate Behavior
☐ Active Substance Abuse
☐ Paranoia
☐ Bizarre Behavior
☐ Violent/Aggressive Behavior
☐ Attention/Impulse Disorder
☐ Confusion/Disorientation
☐ Early Recovery Issues
☐ Obsessive/Compulsive Behaviors
☐ Depression
☐ Nightmares/Flashbacks
☐ Anxiety/Panic Attacks
☐ Recent suicide attempt(s)
☐ Intense/Frequent Drug Cravings
☐ Cognitive Impairment
☐ Substance-related Medical Issues
☐ Acute psychosocial stressors
☐ Thought Disorder
☐ Inappropriate Affect

Form Completed By:______________________ Telephone #:__________ Date:__________

GABHP Reviews may be faxed to: Advanced Behavioral Health, Inc. at (860) 704-6145Please keep a record of this transaction for your records

Updated 5/9/05

\FT

GA Behavioral Health Program

Discharge Notification Form*

Client Name:		Provider Name:	
Client EMS ID# or Social Security Number:		Provider Service Location:	
		Admission Date:	
Client's Date of Birth:		Discharge Date:	

Level of Care (Service Type) Client is discharging from:

DIAGNOSIS – AXIS I: (1) (2)

DISCHARGE TYPE

- ☐ Regular (Completed Treatment)
- ☐ AMA (Against Medical or Clinical Advice)
- ☐ Transfer (transfer to higher level of care, or same level of care at a different location)
- ☐ Other (Please describe):
- ☐ Refused Care (Refused Treatment Referrals
- ☐ No Care (No Discharge Referrals/Plan Made)
- ☐ Noncompliance (Did not follow treatment recommendations)
- ☐ Administrative (Violation of program rules)
- ☐ AWOL (Left inpatient level of care without permission/staff knowledge)

Did the client complete treatment? ☐ Yes ☐ No Number of Outpatient/IOP/PHP Sessions Attended (if known) ________________

DISCHARGE PLAN

Provider Name: ____________________

Service/Level of Care: ____________________

Date of 1st Appointment: ____________________

Discharge Medications: ____________________

____

If there was no Plan, please explain why: ____________________

____

Form Completed By:________________________ Telephone #:______________ Date:________________

*Discharge Notifications may be submitted via the internet-based Electronic Registration System (ERS) or by fax to: Advanced Behavioral Health, Inc. at (860) 704-6145. If you are a provider who does not yet have access to ERS, please contact the GA Behavioral Health Program at (800) 606-3677 to request access. Additional information about ERS can be viewed at www.abhct.com.

Discharge Notification is required by the GA Behavioral Health Program for ALL authorized services.

Advanced Behavioral Health, Inc.
Fax: (860) 704-6145

DRAFT

DMHAS GA Behavioral Health Program

Advanced Behavioral Health, Inc.
Phone: 800-606-3677 Fax: 860-704-6145

Psychological Evaluation Request (PER) Form
Request for Pre-Authorization of Neuropsychological or Psychological Testing

Psychological testing is encouraged where it is clearly indicated and necessary for diagnostic or treatment planning purposes. Requests for testing will only be considered when normal clinical evaluation fails to resolve questions that directly impact on the choice of treatment modalities for covered conditions. **This report must be received and authorized by Value Options/ABH prior to testing.** Return the completed form to:

DMHAS GA Behavioral Health Program
c/o Advanced Behavioral Health
213 Court Street 10th floor
Middletown, CT 06457

Patient's Name:	Date of Birth:
Patient's Social Security #:	Patient's EMS ID#:
Patient's Address:	
Provider's Name/Discipline:	
Provider's Address:	
Provider's Tax ID #:	Phone #:

1. **Who initiated this referral?**

2. **What are the referral questions?**

3. **Brief psychiatric and substance abuse history of patient (including any previous psychiatric or substance abuse admissions/treatment, and/or any previous psychological testing):**

4. **Describe how the treatment plan is going to be affected by the results of testing:**

5. **Current diagnoses under evaluation (DSM-IV):**
   Axis I: (1)________________ (2)__________________ (3)_____________
   Axis II: (1)________________ (2)__________________
   Axis III: ____
   Axis IV: ____
   Axis V: (HGAF):______ (LGAF):_____ (Current):_____

6. **List the test(s) that most appropriately describe the question(s) to be answered:**

Clinical Questions	Specific Test(s) Planned to Address this Question	*Office Use Only*
a. Organic/neuropsychological factors related to disturbances in functioning		
b. Learning disabilities		
c. Disturbances in reality testing (psychosis)		
d. Degree of affective/behavioral disturbance manifested		
e. Nature of personality structure		
f. Intellectual functioning		

How many units (hours) are you requesting authorization for?

Name of Psychologist performing testing: ______________________________
(Please Print)

Connecticut License Number:_____________________________

____
(Signature of Psychologist) **(Date)**

GA BEHAVIORAL HEALTH PROGRAM
Internet-Based Electronic Registration System (ERS)
Claims Submission and Inquiry Function
ACCESS REQUEST FORM

PLEASE PRINT

Agency Name: ____________________

Address: ____________________

City, CT Zip Code: ____________________

Agency Contact: ____________________

Contact Phone: ____________________

Contact Fax: ____________________

		Date Requested
Trainee Name (First, Middle Initial, Last)	☐ Submit Batch *Please choose only one batch type* ☐ 837I (UB-92) ☐ 837P (HCFA-1500) ☐ Retrieve Responses (Error files/835s)	
Claim Inquiry/Claim Data Entry:	☐ One Site *please provide street address* ☐ Multiple Sites	
Electronic Registration System:	☐ One Site *please provide street address* ☐ Multiple Sites	
Trainee Name (First, Middle Initial, Last)	☐ Submit Batch *Please choose only one batch type* ☐ 837I (UB-92) ☐ 837P (HCFA-1500) ☐ Retrieve Responses (Error files/835s)	
Claim Inquiry/Claim Data Entry:	☐ One Site *please provide street address* ☐ Multiple Sites	
Electronic Registration System:	☐ One Site *please provide street address* ☐ Multiple Sites	
Trainee Name (First, Middle Initial, Last)	☐ Submit Batch *Please choose only one batch type* ☐ 837I (UB-92) ☐ 837P (HCFA-1500) ☐ Retrieve Responses (Error files/835s)	
Claim Inquiry/Claim Data Entry:	☐ One Site *please provide street address* ☐ Multiple Sites	
Electronic Registration System:	☐ One Site *please provide street address* ☐ Multiple Sites	

Facts to know when registering for access

- Agency staff must receive a small amount of training in order to obtain their own login and password.
- To better ensure confidentiality and integrity of the system, *each* staff member using the electronic registration/review system or claims submission/inquiry must have their own login and password.
- For agencies with multiple site locations (for ERS and/or Data Entry/Claims Inquiry), staff may obtain a login/password that allows them to perform functions for one site only or for all active sites of the same agency.
- Upon request, Advanced Behavioral Health, Inc. will provide a list of agency staff possessing active access, but will not release actual login and password information.
- If you have any questions or concerns -- please contact ABH toll-free at 1-800-606-3677 Ext. 6440.

Please FAX completed form to:	***or mail completed form to:***
(860) 704-6145	GA Behavioral Health Program c/o Advanced Behavioral Health, Inc. 213 Court Street 10th Floor Middletown, CT 06457

DRAFT

COMMISSIONER'S POLICY STATEMENT ON CULTURAL COMPETENCY

Effective Date: August 29, 2003

COMMISSIONER'S POLICY STATEMENT NO. 76

Purpose: The purpose of this policy is to formally designate cultural competence as an essential characteristic and defining quality that must be embedded in all aspects of the DMHAS healthcare service system. The single overarching goal of the DMHAS, a healthcare service agency, is promoting and achieving a value-driven, recovery oriented system of care. The fullest attainment of that goal is simply not possible if the service design, delivery and evaluation are not culturally competent.

Definition: **Cultural competence** is a set of congruent practice skills, attitudes, policies and structures which come together in a system, agency or among professionals and enable that system or those professionals to work effectively in cross cultural situations. **Cultural competency** is the acceptance and respect for difference, continuing self assessment regarding one's own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations *(Cross, Brazron, Dennis, & Isaacs. 1998)*

Policy Statement: The DMHAS healthcare service system shall function with cultural competency that responds effectively to the needs and differences of all individuals, based on their race, gender, age, physical or mental status, sexual orientation, and ethnic or cultural heritage. Both the population of Connecticut and the demographic profile of persons served by DMHAS operated or funded agencies reflect significant changes toward greater diversity. Further, findings in the professional literature point to patterns indicating disparities in access and other indices of the quality of healthcare for some racial, cultural and low-income groups in systems of care such as DMHAS. Consequently, there must be a special focus on identifying persons or groups who, while in need of the behavioral healthcare services, are either not well or unserved by the DMHAS system. Once identified, informed and strong steps must then be taken to assure provision of effective quality and parity of healthcare to these persons/groups. Such populations, as must be the case for all persons involved with any aspect of the DMHAS public/private system, must be equitably served and have full access to a culturally competent DMHAS healthcare system. An established system-wide environment of support and education related to cultural competence must exist in order to assist the public/private workforce to be culturally competent.

DMHAS Tools For Implementing the Policy:

A. Behavioral Health Initiatives

To promote effective implementation of this policy as part of the overarching goal and Strategic Action Plan of DMHAS, the agency's policies shall require all services to be culturally appropriate, and to be supported by the provision of multicultural professional training for all planned services so as to achieve the desired quality outcomes for any of DMHAS' behavioral health initiatives. The latter may include:

1. **Quality Care, described as the commitment to a statewide culturally appropriate, quality care** management system, designed to achieve defined service outcomes and the continued improvement of the integrated DMHAS healthcare system.
2. **Recovery,** identified as the process in which an individual of any cultural/ethnic/racial heritage served by the DMHAS healthcare system is supported in their effort to restore or develop a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.
3. **Evidence Based Healthcare,** described as a culturally appropriate clinical practice that is "...an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best". *Source: Muir Gray JA. (1997) Evidence-based Healthcare: How to Make Health Policy and Management Decisions. London: Churchill Livingstone.*

4. **Health Disparities,** defined as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

A. The Multicultural Advisory Council (MCAC)

The late Commissioner Albert J. Solnit, M.D. established the DMHAS Multicultural Advisory Council (MCAC) in 1995. The MCAC since that time has served the Department of Mental Health and Addiction Services as a creative resource in the area of multiculturalism that develops and recommends culturally appropriate system change. This specially chosen group of professionals shall continue to take initiatives that promote embedding cultural awareness into the language, spirit and structure of the DMHAS service delivery and management system.

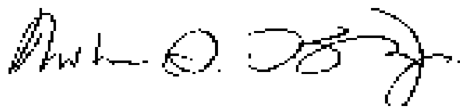
The MCAC shall be comprised of a diverse membership, especially with representation of underserved populations throughout the regions, agencies and consumer/person in recovery populations across Connecticut. It shall help foster best culturally appropriate health practices. It will be supportive of multicultural training of the DMHAS system workforce. It shall identify opportunities to be used as instruments to permeate cultural competence throughout the DMHAS public/private network of services.

The MCAC shall assist in identifying that which is culturally appropriate in programs as well as approaches that produce replicable effective quality outcomes. Such programs/approaches are models that can be validated by research and replicated as standard practice throughout the healthcare system.

The MCAC shall assist DMHAS in identifying underserved groups. This will be accomplished by examining demographics of the DMHAS public/private workforce and of those persons and groups in need of behavioral healthcare services but who are either unserved or underserved by the DMHAS healthcare service system. It shall identify barriers to quality service delivery and recommend how to remove those barriers.

The MCAC shall provide support to the Office of Multicultural Affairs in the search and recognition of individuals qualified for appointment to the MCAC membership and shall decide by vote whether to approve any candidates for referral to the Commissioner for appointment. This process shall emphasize the diversity of membership and be representative of the persons/populations who should entrust their care and recovery to the DMHAS healthcare service system.

The Department of Mental Health and Addiction Services is fully and enthusiastically committed to adhering to the principles and spirit of this Policy Statement. It will be critical in assisting us to improve the health of Connecticut's citizens and in helping those who develop mental illness or substance use disorders to be treated with respect and to recover their lives.



Thomas A. Kirk, Jr., Ph.D.
Commissioner
This directive replaces Commissioner's Policy Statement No. 76 dated January 1, 1997.

COMMISSIONER'S POLICY STATEMENT NO. 83 PROMOTING A RECOVERY-ORIENTED SERVICE SYSTEM

Effective Date: September 16, 2002

Purpose

The purpose of this policy is to formally designate the concept of "recovery" as the overarching goal of the service system operated and funded by the Department of Mental Health and Addiction Services ("Department"). This action is consistent with the fact that the Department is a healthcare service agency. Thus, it is most appropriate that one should hope and expect that, as a result of active involvement with this healthcare system, they will be better able to manage their illness and improve the quality of their life.

Policy Statement

The concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-run services that comprise the Department's healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. As one of its foremost priorities, the Department shall promote recovery for persons at risk of, or who have psychiatric or substance use disorders by creating a recovery-oriented service system.

Recovery is a process rather than an event. Thus, the service system shall address the needs of people over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders, especially those for who selected or indicated prevention strategies are appropriate.

The concept of recovery is embodied in the Recovery Core Values articulated by the addiction and mental health recovery communities in Connecticut. In keeping with this vision, and in partnership with the recovery communities, the Department shall create new and make necessary revisions to existing policies, procedures, programs, and services, and shall ensure that all new initiatives are consistent with a recovery-oriented service system. Finally, the Department shall ensure that future strategic planning and resource development efforts build upon existing strengths and continue to move the Department in the direction of promoting recovery as a core concept. In so doing, we shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.

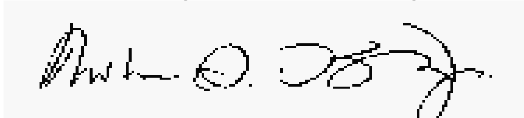
The recovery-oriented service system shall be notable for its quality. It thus will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery. Whenever possible, services shall be provided within the person's own community setting, using the person's natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

Definition:

"Recovery" is a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.

Recovery is a person-centered approach and it thus may vary from person to person and within the mental health and addiction communities. Just a few examples of recovery include:

- Returning to a healthy state evidenced by improving one's mood and outlook on life following an episode of depression;
- Managing one's illness such that the person can live independently and have meaningful employment and healthy social relationships;
- Reducing the painful effects of trauma through a process of healing;
- Attaining or restoring a desired state such as achieving sustained sobriety;
- Building on personal strengths to offset the adverse effects of a disability.



Thomas A. Kirk, Jr., Ph.D.
Commissioner