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

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

Sec. 17b-262-817. Scope

Sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of [accepted methods of treatment performed by behavioral health clinics for clients who are determined eligible to receive such services under Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes] behavioral health clinic services for CMAP members.

Sec. 17b-262-818. Definitions

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

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

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

(A) [A licensed or certified practitioner performing within the practitioner's scope of practice in any of the professional and occupational license or certification categories pertaining to behavioral health covered in title 20 of the Connecticut General Statutes] A psychologist, a licensed clinical social worker, a licensed marital and family therapist, a licensed professional counselor, a licensed alcohol and drug counselor, a certified alcohol and drug counselor, advance practice registered nurse or physician assistant; or

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

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

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

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

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

[(4)] (7) "Behavioral health clinic" or "clinic" means a facility that provides services to outpatients, is not part of a hospital and is licensed as one of the following:

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

[(5)] (8) "Behavioral health clinic service" means preventive, diagnostic, therapeutic, rehabilitative or palliative items or services within the behavioral health clinic's scope of practice provided by one or more of the following individuals employed by or under contract to the behavioral health clinic, each of whom shall work within such individual's scope of practice:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(15)] (21) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services provided in accordance with section 1905(r)(5) of the Social Security Act, as amended from time to time;

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

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

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

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

[(19)] (26) "Formulation" means a clinical assessment of information obtained that is used to provide the framework for developing the appropriate treatment approach for a specific [client] member;

[(20)] (27) "Group psychotherapy" means a type of behavioral health care in which [clients] membersmeet in [groups] facilitated groups for the purpose of discussing their psychiatric or substance use disorders, the impact of these disorders and the barriers that may be overcome in order to progress in their recovery;

[(21)] (28) "Intensive Outpatient Program" or "IOP"means an integrated program of outpatient psychiatric services or outpatient substance use disorder services that are designed for more intensive treatment than routine outpatient psychiatric services or outpatient substance use disorder services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance [abuse] use or an outpatient psychiatric clinic for children;

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

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

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

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

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

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

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

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

[(24)] (36) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

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

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

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

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

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

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

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

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

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

[(31)] (46) "Plan of care" means a written individualized plan that contains the [client's] member's diagnosis; the type, amount, frequency and duration of services to be provided; and the specific goals and objectives developed subsequent to an evaluation and diagnosis in order to attain or maintain a [client's] member's achievable level of independent functioning;

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

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

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

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

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

the Connecticut General Statutes;

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

[(36)] (53) "Registration" means the process of notifying the department of the initiation of a behavioral health clinic service that includes information regarding the evaluation findings and plan of care. Registration may serve in lieu of authorization if a service is designated in writing by the department as requiring registration only;

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

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

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

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

Sec. 17b-262-819. Provider participation

(a) Providers shall meet and maintain all department enrollment requirements, as described in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies, to receive payment from the department.

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

(c) Programs serving [clients] members under [18 years of] age eighteen that are primarily for the treatment of psychiatric conditions shall be licensed by the Department of Children and Families as an Outpatient Psychiatric Clinic for Children as provided in section 17a-20 of the Connecticut General Statutes.

(d) Programs serving [clients 18 years of] members age eighteen and older that are primarily for the treatment of psychiatric conditions shall be licensed by the Department of Public Health as a day treatment facility or psychiatric outpatient clinic [for adults] as provided in section 19a-495-550 of the Regulations of Connecticut State Agencies.

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

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

Sec. 17b-262-820. Eligibility

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

Sec. 17b-262-821. Services covered

(a) The department shall pay providers for those procedures listed in the department's behavioral health clinic fee schedule, provided such services are:

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

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

(3) Furnished in [the clinic or a satellite site] a licensed location of the clinic.

(b) When a procedure or service requested by a provider is not on the department's behavioral health clinic fee schedule, prior authorization is required. In such instances, the provider shall submit a prior authorization request to the department [or its agent] with supporting documentation, including, but not limited to, documentation showing the medical necessity for the service or procedure.

(c) The department shall pay for behavioral health clinic services and for EPSDT special services subject to sections 17b-262-817 to 17b-262-828, inclusive, of the Regulations of Connecticut State Agencies.

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

Sec. 17b-262-822. Service limitations

(a) General

(1) Payment for individual, group, family or multiple-family psychotherapy is limited to one visit of each type per day, per provider, per [client] member.

(2) [Family] Each session of family, multi-family and group psychotherapy [sessions] shall be not less than [45] forty-five minutes [in length], except in an intermediate care program, where each session of family, multi-family and group psychotherapy [sessions] shall be not less than [30] thirty minutes.

(3) More than one psychiatric diagnostic interview examination shall only be provided in a single episode of care under the following circumstances:

(A) When it is necessary to have a psychologist perform an interview to initiate or determine the need for psychological testing; or

(B) When a [client's] member's presentation requires that a qualified physician, [or a psychiatric] advanced practice registered nurse or physician assistant evaluate the need for medication for a [client] member who is in the care of a non-medical practitioner.

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

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

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

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

(7) Family therapy shall be reimbursable only for one identified [client] member per encounter, without regard to the number of family members in attendance or the presence of behavioral health conditions among other family members in attendance.

(b) Case Management.

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

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

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

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

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

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

(2) [Payment shall be available only for services provided at the clinic. Payment shall not be made for weeks when no face-to-face services are provided.] Payment for chemical maintenance shall be a weekly rate that includes at least one unit of the following categories of service per day for seven days: in-person medication administration, take-home medication doses or any in-person clinical service provided at the clinic that meets the billing code clinical and minimum time definitions for individual, group or family psychotherapy or any combination thereof. On each claim, in a form and manner specified by the department, the clinic shall specify the number of daily units of each service that are actually provided to each member in each week. For any week for which such a service is provided on fewer than seven days, the department shall prorate the rate to pay only for the number of days in the week during which such a service was provided. The behavioral health clinic shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) [Clients] Members may attend day treatment, IOP or PHP for a maximum of five days per week.

(6) A treatment day at a day treatment program or PHP shall include a minimum of four hours of scheduled programming, of which not less than three and one half hours shall be documented behavioral health clinic services as defined in section 17b-262-818 of the Regulations of Connecticut State Agencies.

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

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

(8) [Psychotherapy] Each psychotherapy or [and] psycho-educational group [size] in an intermediate care [programs] program shall [be limited to 12] not exceed twelve participants, regardless of payer, except that psycho-educational group size for substance [abuse] use disorder related conditions shall [be limited to 24] not exceed twenty-four participants, regardless of payer, and may comprise no more than one and one-half hours of an intermediate care program.

(9) The department shall pay for partial hospitalization services only when provided in a CMHC.

(f) Autism Spectrum Disorder Services.

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

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

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

(h) Group Tobacco Cessation Counseling.

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

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

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

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

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

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

(3) Each group tobacco cessation counseling session shall:

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

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

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

(4) Provider Qualifications.

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

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

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

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

The department shall not pay for the following:

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

(2) Cancelled services and appointments not kept;

(3) Any services, treatment or items for which the provider does not usually charge;

(4) Any procedures or services whose purpose is solely educational, social, research, recreational, experimental or generally not accepted by medical practice;

(5) Any behavioral health clinic service in excess of those deemed medically necessary by the department to treat the [client's] member's condition; or for services not directly related to the [client's] member's diagnosis, symptoms or medical history;

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

(7) Any service requiring authorization or registration for which the provider did not obtain such authorization or registration; or

(8) Off-site and certain other services, including but not limited to: Emergency mobile psychiatric services; home and community based rehabilitation services; and extended day treatment provided only as children's rehabilitation services, as described in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies. Such services are reimbursed as part of the rehabilitation option services rather than as a behavioral health clinic service.

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

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

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

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

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

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

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

(4) Current medications, if indicated, medication history, or updated medication history for [clients] members who have previously been in the provider's care;

(5) Orders for and medical interpretation of laboratory or other medical diagnostic studies, if indicated;

(6) The initial diagnosis, functional status and formulation of the plan of care; and

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

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

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

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

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

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

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

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

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

Sec. 17b-262-825. Authorization

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

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

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

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

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

(3) A provider shall present medical or social information adequate for evaluating medical necessity when requesting authorization. The provider shall maintain documentation adequate to support requests for authorization including, but not limited to, medical or social information adequate for evaluating medical necessity;

(4) Requests for authorization for the continuation of services shall include the progress made to date with respect to established treatment goals, the future gains expected from additional treatment and medical or social information adequate for evaluating medical necessity;

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

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

(6) The department may require a review of the discharge plan and actions taken to support the successful implementation of the discharge plan as a condition of authorization.

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

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

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

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

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

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

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

Sec. 17b-262-826. Billing requirements

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

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

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

Sec. 17b-262-827. Payment

(a) The commissioner shall establish fees in accordance with section 4-67c of the Connecticut General Statutes. Fees shall be the same for in-state, border and out-of-state providers.

(b) If the [client] member is present for up to half of the intermediate care program day and attends [at least] not fewer than one individual, family or group session, the provider may bill half of the applicable [Medicaid] CMAP fee or rate. If the [client] member is present for more than a half of the intermediate care program day but less than a full day and attends [at least] not fewer than two individual, family or group sessions, the provider may bill the full day charge on file. If the [client] member does not attend [at least one] any individual, [group or] family or group session, the provider is not entitled to any payment from the department.

(c) A single per diem fee shall be billed for intermediate care programs inclusive of all medication evaluation or management services, treatment and rehabilitative services, administrative services and coordination with or linkages to other health care services. A provider may bill separately for medically necessary individual or family psychotherapy services provided outside of the program

hours of operation if such services are medically necessary for the purpose of [client] member transition or continuity of care, as documented in the member's plan of care.

(d) If a session includes a combination of individual and family psychotherapy, the provider shall bill for the type of psychotherapy that comprises the greater part of the session. Individual and family psychotherapy shall not both be billed for the same date of service unless each type of session individually meets the minimum time requirement for [the modality] each such category of psychotherapy.

(e) Practitioners who are clinic-based either on a full-time or part-time basis are not entitled to individual payment from the department for services rendered to [clients] members at the clinic. [The] Only the clinic shall bill for the services, except as otherwise specifically provided in section [17b-262-460 (c)], 17b-262-460(c), 17b-262-475(a) and 17b-262-922(a) of the Regulations of Connecticut State Agencies.

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

(g) The department shall pay at the [lower] lowest of:

(1) The amount in the applicable fee schedule;

(2) The amount on the provider's rate letter; [or]

(3) The amount billed by the provider[.];

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

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

(h) Enhanced Care Clinics. The department may establish higher reimbursement for providers that meet special requirements.

(1) The special requirements shall be established by the department and may vary by provider type and specialty. The department, in its sole discretion, shall determine whether a provider meets the requirements for the higher reimbursement.

(2) The special requirements shall be related to improvements in access, quality, outcomes or other service characteristics that the department reasonably determines may result in better care and outcomes.

(3) The department may grant provisional qualifications for higher reimbursement by means of an application process in which [providers submit] a provider submits a plan to the department that demonstrates the [feasibility of meeting] provider's ability to meet the special requirements for enhanced care clinics.

(4) The department shall conduct periodic qualifications reviews. If a provider fails to continue to meet the requirements, the department may grant a probationary period of not less than 120 days during which the provider continues to qualify for higher reimbursement and is permitted an opportunity to submit a corrective action plan and to demonstrate compliance to the department. If the department determines that the provider fails to comply with all applicable requirements after completing the probationary period and corrective action plan described in this subdivision, then the department shall remove the provider from eligibility for the higher payments described in this subsection.

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

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

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

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

(1) [Client's] Member's name, address, birth date and [Medicaid] CMAP identification number;

(2) Results of the initial evaluation and clinical tests, and a summary of current diagnosis, functional status, symptoms, prognosis and progress to date;

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

(4) Documentation of each service provided by the clinician, including types of service or modalities, date of service, location or site at which the service was rendered, [and] the start and stop time of the service and the date the documentation was entered;

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

(6) Medication prescription and monitoring.

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

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

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

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

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

[(f)] (g) For psychological testing, documentation shall include the tests performed, the time spent on the interview, the administration of testing and the completion of the clinical notes.

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

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

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

(k) The medication plan shall include instructions for administration for each medication prescribed by a clinic practitioner and a list of other medications that the [patient] member is taking that may be prescribed by non-clinic practitioners.

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

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

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

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

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

Statement of Purpose

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

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

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

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