The State of Connecticut
Department of Mental Health & Addiction Services

Behavioral Health Recovery Program

– Clinical Recovery Supports –

– Basic Recovery Supports –

PROVIDER MANUAL 2012

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SECTION 1: GENERAL INFORMATION

WELCOME! The Connecticut Department of Mental Health and Addiction Services (DMHAS), together with Advanced Behavioral Health, Inc. (ABH), are pleased to welcome you to the Behavioral Health Recovery Program (BHRP).

As a provider in the DMHAS BHRP, your organization joins a statewide network of providers to deliver a continuum of clinical and recovery support services. Embracing a recovery orientation in the treatment of mental health and substance use disorders, the network is devoted to ensuring access to a comprehensive, quality-driven and progressive delivery system.

This manual has been developed to answer your questions about the Behavioral Health Recovery 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 for clinical and recovery support services, 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 any aspect of BHRP, please call us on our toll free number.

Clinical Services Line

1 – 800 – 606 – 3677

Option 1 **Clinicians and Authorizations**
Option 2 **Customer Service/Provider Relations**
Option 3 **Case Management Referrals**
Option 4 **Claims**

Basic Recovery Supports Line

1 – 800 – 658 – 4472

Important Notice *– DMHAS reserves the right to interpret terms and provisions of this manual and to amend the manual 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 Regulations governing the Program, the Provider Agreement and Regulations shall apply.*

BEHAVIORAL HEALTH RECOVERY PROGRAM
PROGRAM OVERVIEW

Advanced Behavioral Health (ABH) has been contracted by the Department of Mental Health and Addiction Services (DMHAS) to act as the Administrative Services Organization (ASO) for the Behavioral Health Recovery Program (BHRP). DMHAS and ABH share a vision: *The Behavioral Health Recovery Program will meet the goals of enhancing access ` to care and providing HUSKY D recipients with the clinical and basic recovery supports that will assist individuals in their movement toward a meaningful and productive life.* Integrating recovery as a value and an orientation will ensure a dynamic, responsive, and progressive client-centered service delivery system.

ABH transacts the following BHRP activities from our main site in Middletown, Connecticut:

- **Care Management and Authorization** activities for clinical and basic recovery supports services
- **Case Management** activities occur both in the field and in offices located throughout Connecticut
- **Credentialing, Contracting, and Claims Adjudication** through the Customer Service and Provider Relations Departments
- **Information Systems** offering technical support to the staff of ABH and to web portal users
- **Quality Management** functions with a constant interface with Providers and with DMHAS

Care and case management are coordinated for HUSKY D recipients who are in need of support and assistance, to ensure appropriate coordination and continuity of care for those individuals who are frequent users of behavioral health care services. ABH routinely coordinates care with other programs and ASOs that provide behavioral health and medical services to HUSKY D recipients such as the Connecticut Behavioral Health Partnership and the HUSKY Health Program.

HUSKY D recipients may concurrently be involved in other programs for which ABH has oversight. Such programs include Access to Recovery III, Project SAFE, the Military Support Program, and Women's Behavioral Health Services. Every effort is made to ensure high quality coordination of care between programs.

BEHAVIORAL HEALTH RECOVERY PROGRAM
PROGRAM GOALS

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 Behavioral Health Recovery Program (BHRP) are to:

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

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

- Provide timely access to the residential care, acute care behavioral health, case management and basic recovery support services managed by the BHRP;

- Assist individuals in restoring and/or maximizing independent functioning through the coordination of behavioral health with vocational services and/or entitlements assistance;

- Integrate recovery core values, recovery principles, and recovery language into all aspects of treatment delivery. To achieve a high 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 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 behavioral health providers in the State of Connecticut.

BEHAVIORAL HEALTH RECOVERY PROGRAM
STAFF FUNCTIONS

Care Management staff performs utilization review for initial requests for clinical recovery support services, as well as requests for continued stay, and will seek discharge information. This staff includes Clinical Care Managers and Utilization Review Support Staff.

Intensive Case Management staff work with high-risk target population clients to assist individuals in engaging in and moving through the recovery continuum. This staff includes Regional Coordinators, Lead Case Managers, and Recovery Specialists.

Basic Recovery Supports Program staff process requests for recovery support services for those HUSKY D recipients who are engaged in treatment. This staff includes Determination Coordinators and Eligibility Coordinators.

Customer Service staff provides general information and answer questions from HUSKY D recipients and BHRP Providers related to benefits, authorizations, and claims payment.

Provider Relations staff works closely with providers in credentialing, contracting, and various other administrative and management issues.

Claims Operations staff process, adjudicate, generate Explanations of Payments (EOP), and pay claims.

Quality Management staff interfaces with ABH operations, providers, and DMHAS functions to provide reporting analyses on performance and outcomes.

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

BEHAVIORAL HEALTH RECOVERY PROGRAM
CONTACT FACT SHEET

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

Clinical Recovery Supports Main Telephone Number: (800) 606 – 3677

Option 1 – Clinical Department
Option 2 – Customer Service/Provider Relations
Option 3 – Case Management Referrals
Option 4 – Claims Inquiries

Requests for prior authorization, continued stays, discharge information, questions regarding referrals, or other inquiries of clinical recovery support services can be made between the hours of 8:30 AM and 5:00 PM, Monday through Friday.

Clinical Recovery Supports Fax Number: (860) 704 – 6145

Discharge Notifications can be submitted by fax at: (860) 704 – 6145, or may be submitted by authorized ERS users at: www.abhct.com

Basic Recovery Supports Main Telephone Number: (800) 658-4472

Basic Recovery Supports Fax Number: (866) 249 - 8766

Claims submitted on paper are to be sent to:
DMHAS Behavioral Health Recovery Program
c/o Advanced Behavioral Health
P.O. Box 735
Middletown, Connecticut 06457

Claims submitted by fax are to be sent via:
(860) 704 – 6145

Claims submitted on-line should go through
www.abhct.com
Select the "Login" tab
Select "BHRP (GABHP)" for Login

SECTION 2: ELIGIBILITY VERIFICATION

DETERMINING ELIGIBILITY FOR CLINICAL AND BASIC RECOVERY SUPPORT SERVICES

In order to be eligible for the Behavioral Health Recovery Program, an individual must be determined eligible by the Department of Social Services (DSS) for benefits under the HUSKY D Medicaid program in accordance with Connecticut General Statute Section 17b-261n, as amended by Public Act 11-44.

Providers must verify an individual's eligibility for HUSKY D benefits by using the Automated Eligibility Verification System (AEVS) each time there is a request for clinical or basic recovery supports. Because an individual's eligibility status requires periodic redetermination by DSS, 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/application for recovery supports. 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.

Automated Eligibility Verification System (AEVS) NUMBER
(800) 842-8440 (in-state, toll-free)
(860) 269-2028 (Hartford area)
(866) 604-3470 (TTY/TDD line)

The AEVS 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.

DSS also offers providers the capacity to verify eligibility electronically. More information about other methods used by providers to confirm eligibility is available at the DSS website at www.ctdssmap.com.

If, as a provider, you believe that the individual will meet criteria for eligibility for HUSKY D, but has not yet been enrolled as a HUSKY recipient, you should still contact ABH to obtain an authorization for clinical services. If the individual is subsequently found to be eligible for HUSKY D, the Provider can ONLY be paid on a retroactive basis when there is a prior authorization on record for the requested dates of service.

To be eligible to receive basic recovery supports through the Behavioral Health Recovery Program, an individual must be determined to meet the following requirements by a treatment or supported recovery housing provider to be:

1. Actively engaged in behavioral health treatment services;

2. Employable and not receiving cash assistance; and

3. In need of basic recovery supports and have no available resources to meet such needs.

Employment readiness is an integral part of receiving BHRP Basic Recovery Supports. One of the goals of the program is to assist individuals in restoring independent functioning, including returning to work so that recovery supports can be maintained independently. Employment readiness encompasses many things such as: job search, vocational training, treatment-related employment groups, on-line education, online resume posting, work therapy, etc. Applicants may describe their employment readiness on the applicant statement portion of the web-based Assessment and Request Form.

Individuals who have become employed within the last thirty (30) days may be re-authorized for basic recovery supports if sufficient information is submitted detailing employment start date, hours and rate of pay.

Individuals who are no longer eligible for HUSKY D benefits, are no longer in treatment, or have begun receiving direct cash assistance may not be re-authorized for basic recovery supports.

MEDICAL SERVICES for HUSKY D MEMBERS

Community Health Network of Connecticut (CHNCT) is the medical Administrative Services Organization for Husky Health in Connecticut and is responsible for the medical management, network management, pharmaceutical management and claims processing functions for primary, specialty and ancillary services. Eligible recipients receive a card at the time of their enrollment.

When a HUSKY D recipient has questions about their medical benefit, they should call the CHNCT Member Services Department. The CHNCT Member Services Department will be able to assist with:

- Learning about covered and/or non-covered services
- Finding a doctor
- Accessing necessary medical services
- Speaking with an intensive case manager about special needs
- Learning whether there will be a cost for particular medical services
- Filing an appeal or complaint

CHNCT Member Services Department
(866) 859 – 9889
Monday through Friday, 9:00 am to 7:00 pm

Provider questions about the HUSKY Health Program should be directed to:

CHNCT Call Center
(800) 440 – 5071
Monday through Friday, 9:00 am to 6:00 pm

Laboratory Services: Laboratory services provided as part of ongoing medical care are handled by CHNCT, while laboratory services provided as part of ongoing behavioral health care will be submitted to and processed by HP Enterprise Services.

Pharmacy Services: Providers should direct questions about pharmacy coverage to the CT Pharmacy Assistance Program at (866) 409 – 8430.

Transportation Services: If a HUSKY D recipient requires transportation to a routine medical appointment, the recipient may call Logisticare at (888) 248-9895.

OTHER BEHAVIORAL HEALTH SERVICES FOR HUSKY D RECIPIENTS

The Behavioral Health Recovery Program is responsible for responding to requests for prior authorization and continued stay authorization of basic recovery supports and the following clinical services for HUSKY D recipients: 23-Hr Observation Beds (substance abuse), intensive residential, co-occurring intensive residential, intermediate/long-term residential, medically-managed inpatient detoxification at IMD hospitals and acute inpatient psychiatric services for members with pending eligibility or those not meeting criteria for the Medicaid IMD demonstration pilot at Natchaug Hospital treatment.

ValueOptions Connecticut is the Administrative Services Organization for the CT Behavioral Health Partnership and is responsible for providing clinical management, quality management, and provider and member services for all other types of behavioral health services. Providers wishing to obtain authorization for any other type of behavioral health services should contact ValueOptions CT by calling (877) 552-8247.

HP Enterprise Services is responsible for the following activities related to all other behavioral health services not managed by the Behavioral Health Recovery Program: provider enrollment, member eligibility, claims processing, and electronic claims submission. Providers wishing to obtain information about provider enrollment or claims submission for all behavioral health services other than clinical and basic recovery supports should contact HP by calling (800) 842-8440.

OUT OF STATE/OUT-OF-NETWORK PROVIDERS

Coverage for clinical recovery support services is limited to treatment services provided through a provider network that have been credentialed and contracted by the DMHAS Behavioral Health Recovery Program. Benefits for clinical services are not available for in-state or out-of-state providers who are not credentialed and contracted by the BHRP.

SECTION 3: COVERED SERVICES

A. CLINICAL RECOVERY SUPPORTS

This section describes services available to HUSKY D recipients who meet service necessity criteria through the Behavioral Health Recovery Program. For all levels of care, it is expected that discharge planning should begin at the time of admission. The following clinical recovery supports are covered by the Behavioral Health Recovery Program:

1. ***Acute Psychiatric Hospitalization Services (MH IV.2)*** – A medically necessary, inpatient behavioral health treatment service delivered in an institute for mental disease (IMD) that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to treatment of a psychiatric disability or co-occurring disorder, where an individual's admission is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. Acute psychiatric hospitalization is used when 24-hour medical and nursing supervision is required to deliver intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. Acute psychiatric hospitalization may be delivered to individuals committed under a physician's emergency certificate (PEC), pursuant to section 17a-502 of the Connecticut General Statutes, and may occur on a locked psychiatric unit. ***Special Note:*** *Coverage of this service is limited to those individuals who have pending eligibility for HUSKY D benefits at the time of presentation for admission OR those individuals who otherwise do not meet criteria for the Medicaid IMD Pilot Demonstration at Natchaug Hospital. Payment for this service will be contingent upon meeting medical necessity criteria for the hospital stay and subsequent determination of eligibility for HUSKY D benefits.*

2. ***Medically Managed (Inpatient) Detoxification (SA IV.2) –*** A medically necessary, inpatient substance use disorder service delivered in an institute for mental disease that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to the treatment of substance use disorders, where the individual's admission is the result of a serious or dangerous condition that requires rapid treatment for a substance use disorder. Medically managed inpatient detoxification is used when on-site, 24-hour medical and nursing supervision is required to deliver intensive

evaluation, medication titration, symptom stabilization and intensive, brief treatment. Medically managed inpatient detoxification shall deliver evaluation for substance use disorders and withdrawal management. For individuals who have co-occurring disorders, psychiatric assessment and management shall be available. Medically managed inpatient detoxification may be delivered to patients committed under a physician's emergency certificate (PEC) pursuant to Section 17a-684 of the Connecticut General Statutes.

3. ***Observation Bed (SA II.7)*** - A medically necessary substance use disorder service delivered in a freestanding residential detoxification facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to supervised stabilization, clinical monitoring, and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable treatment program for an individual who is in urgent need of care and treatment for a substance use disorder. Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required.

4. ***Intensive Residential Treatment (SA III.7)*** – A medically necessary residential substance use disorder service delivered in a facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to intensive residential treatment services. Services are delivered in a 24-hour setting to treat individuals with a substance use disorder or a co-occurring disorder who require intensive residential treatment. Intensive residential treatment services are delivered within a fifteen (15) to thirty (30) day period and include a minimum of thirty (30) hours of substance use disorder services per week.

5. ***Intensive Co-Occurring Residential Treatment (SA III.7R(e)) –*** A medically necessary residential substance use disorder service delivered in a facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to intensive residential treatment services. Services are delivered in a 24-hour setting to treat individuals with a substance use disorder or co-occurring disorder who require intensive residential treatment. Intensive co-occurring residential treatment services are delivered within a twenty-one (21) to thirty (30) day period and include a minimum of thirty (30) hours of substance use disorder services per week. A strong emphasis is placed on serving individuals with co-occurring disorders. The program will have the ability and capacity to provide care to individuals with

moderate to high symptom acuity, including those with a history of suicidal behaviors and ideation. Specifically, programs will serve individuals that fall within the National Association of State Alcohol/Drug Abuse Directors (NASMHPD) Quadrant III – High severity of substance use disorder and low severity of psychiatric disorder. The program will include motivational interventions, substance use disorder counseling, interventions with mental health content, group treatment, and education about specific mental health and substance use disorders, their treatment (including medication education), and interactions.

6. ***Intermediate Residential Treatment (SA III.3) –*** A medically necessary residential substance use disorder service delivered in a facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to intermediate or long-term treatment or care and rehabilitation. Intermediate or long-term residential treatment services are delivered in a 24-hour setting to treat individuals with a substance use disorder or a co-occurring disorder who require intermediate/long term residential treatment. Services are delivered in a structured recovery environment and comply with the following requirements: a) if the facility is licensed for and delivers intermediate or long-term residential treatment, a minimum of twenty (20) hours per week of substance use disorder services shall be delivered to each individual; b) if the facility is licensed for care and rehabilitation and delivers long-term care, a minimum of twenty (20) hours of substance use disorder services are delivered to each individual per week; and c) if the facility is licensed for intermediate or long-term residential care and delivers transitional or halfway house services, a minimum of four (4) hours per week of substance use disorder services are delivered to each individual.

7. ***Other Services –*** Other services as identified and approved by the Department of Mental Health and Addiction Services.

B. BASIC RECOVERY SUPPORT SERVICES

This section describes recovery support services available to HUSKY D recipients that are intended to assist the client in engaging in continuing care and recovery. The following services are covered under the Behavioral Health Recovery Program:

1. ***Independent Housing –*** Assistance provided to secure and maintain affordable and safe housing via a lease agreement with a landlord;

2. ***Livery Transportation –*** Taxi transportation provided to and from Behavioral Health Recovery Program clinical services and supported recovery housing services;

3. ***Shelter Housing –*** A clean, safe, drug and alcohol-free non-permanent, shelter-based living environment;

4. ***Supported Recovery Housing –*** A clean, safe, drug and alcohol-free transitional living environment with on-site case management services available at least eight (8) hours per day, five (5) days per week;

5. ***Basic Needs –*** Goods which are provided to eligible HUSKY D recipients through the issuance of a gift card;

6. ***Other Supports –*** Any other support deemed appropriate by DMHAS or ABH that is intended to and has a high likelihood of enhancing the eligible recipient's recovery.

C. Intensive Case Management Support Services

Intensive case management is provided to eligible individuals who have a recent history of over utilizing acute behavioral healthcare services or are determined to be in need of intensive support due to special or complex care needs. Recovery Specialists work with recipients identified as at risk (including those individuals who have had four or more admissions to acute care in a six 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 through a collaborative effort between the BHRP Intensive Case Management Program and the Connecticut Behavioral Health Partnership. The ***Eastern Region Service Center*** **(ERSC)** is a provider network in Region 3 that assists individuals on HUSKY D and other indigent persons living in the Region 3 area. ERSC offers intensive case management and outreach services as well as offering vouchers for taxi service to detoxification services within the southeastern region of the state.

D. SPECIAL SERVICE INITIATIVES

1. ***The Opioid Agonist Treatment Protocol*** **(OATP)** was initiated in April 2001 to help the opioid dependent individual having difficulty engaging in the recovery continuum due to frequent inpatient admissions. This care initiative offers alternatives that would assist the individual in accessing and engaging in continuing care. This protocol is the result of a unique collaboration between DMHAS, residential detox providers, ambulatory opioid treatment providers, ABH and the CT Behavioral Health Partnership. Individuals with three or more admissions to inpatient detoxification within a ninety-day period or four or more admissions within a six-month period and a primary diagnosis of opioid dependence will, upon presentation for a 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 medication-assisted opioid agonist treatment. If the recipient expresses interest in induction to Methadone Maintenance, they are inducted rather than detoxified, and given priority access to ongoing Methadone Maintenance services. Intensive case management services and priority access to a Recovery House bed will be offered to eligible individuals.

2. ***The Mental Health Case Management Initiative*** was launched in January 2002 to identify and offer support for those individuals experiencing repeated or lengthy acute inpatient mental health services. Individuals with three or more admissions to an inpatient setting within a ninety-day period, or having one episode of care lasting thirty or more days, are offered intensive case management. Individuals participating in this initiative are introduced to a Recovery Specialist, who will assist them in accessing the necessary clinical and recovery support services to facilitate their movement through the recovery continuum.

3. ***The Alternatives-To-Hospitalization Initiative*** was launched in November 2005 to assist individuals presenting to emergency departments with expressions of suicidal ideation with alternatives to an admission to acute inpatient mental health services. Individuals assessed by emergency department or mobile crisis staff to meet criteria are assisted by a Lead Mental Health Case Manager to locate and obtain access to appropriate alternatives to acute inpatient mental health care such as intensive residential, observation beds, residential detoxification or sober housing.

SECTION 4: SERVICE LIMITATIONS AND EXCLUSIONS

A. SERVICE LIMITATIONS – CLINICAL RECOVERY SUPPORTS

Covered services and procedures are limited to those listed in the DMHAS Behavioral Health Recovery Program clinical recovery supports fee schedule.

1. Group therapy sessions shall be limited to a maximum of twelve (12) individuals per group session, excluding the supervising clinician(s).
2. Education groups shall be limited to a maximum of twenty-four (24) individuals per group session, excluding the supervising professional(s).

B. SERVICE LIMITATIONS – BASIC RECOVERY SUPPORTS

1. Basic recovery supports are limited to goods and services intended to assist the eligible recipient to progress towards recovery goals; and
2. Basic recovery supports will only be authorized when no other available resources are identified.

C. EXCLUSIONS – CLINICAL RECOVERY SUPPORTS

The following exclusions and non-payment for clinical recovery supports shall apply:

1. Any clinical recovery supports delivered to an eligible 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 inclusive or 307.90 to 315.99, inclusive;
2. Services that DMHAS or ABH, as its designated agent, determines to be "experimental" in nature;
3. Services that DMHAS or ABH determines are not medically necessary;
4. Concurrent services or procedures that DMHAS or ABH determines to be similar or identical to services provided to the same eligible recipient;
5. Activities that DMHAS or ABH determines are primarily for vocational or educational guidance that relate solely to a specific employment opportunity, job skill, work setting, or development of an academic skill;
6. Therapies, treatments or procedures related to transsexual or gender-change medical or surgical procedures;

7. Activities, treatment or items furnished to an eligible recipient for which the Provider does not usually charge others.

D. EXCLUSIONS – BASIC RECOVERY SUPPORTS

The following exclusions and non-payment for basic recovery supports shall apply:

1. Service locations that do not comply with all applicable laws, regulations, and ordinances regarding zoning, building, fire, health and safety;
2. Independent housing:
    a. When the eligible recipient is not named in the lease as the lessee or an authorized occupant;
    b. Located outside of the State of Connecticut;
    c. At a licensed behavioral health treatment services facility;
    d. At a contracted supported recovery or shelter housing location; and
    e. Where the eligible recipient must follow written or stated rules that are not part of the rental agreement or that are not permissible by law.
3. Supported recovery or shelter housing:
    a. Not currently certified and contracted by ABH;
    b. Not authorized by ABH;
    c. The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;
    d. A leave of absence that occurs without staff permission;
    e. A leave of absence or pass if the absence is longer than twenty-four hours, unless authorized in advance by DMHAS or ABH; and
    f. Services that cannot be substantiated by appropriate documentation.
4. Livery transportation:
    a. To providers not currently contracted by DMHAS; and
    b. To locations other than the recovery supports provider contracted by the Behavioral Health Recovery Program.
5. Basic recovery supports goods other than clothing and personal items for the intended eligible recipient.

E. NON-REIMBURSABLE SERVICES – CLINICAL RECOVERY SUPPORTS

1. The day of discharge or transfer from inpatient services unless the eligible 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 ABH;
4. Electroconvulsive therapy, unless delivered by a licensed psychiatrist and pre-authorized by DMHAS or ABH;
5. Hypnosis, unless delivered by a licensed psychiatrist or psychologist and pre-authorized by ABH;
6. Clinical recovery supports delivered by a staff member who is not a licensed behavioral health professional or who is not a Connecticut certified alcohol and drug counselor, unless the following conditions are met:
    a. The staff member is employed by, or under contract with, a licensed facility whose medical or clinical supervisor has determined that the staff member is qualified to deliver behavioral health treatment services to eligible recipients;
    b. For acute psychiatric hospitalization, the staff member is actively pursuing behavioral health licensure and is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the delivery of behavioral health treatment services; and
    c. The supervising clinician has signed the eligible recipient's recovery plan.
7. Clinical recovery supports delivered by staff of a licensed facility at a location other than that which is specified on the facility's license.

SECTION 5: AUTHORIZATION OF CLINICAL RECOVERY SUPPORT SERVICES

This section describes how and when to obtain an authorization for all types of clinical recovery support services. ***Services not authorized will not be reimbursed.***

Service authorizations must be obtained for any recipient eligible or potentially eligible for HUSKY D 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 HUSKY D, but the client has not yet been enrolled as a HUSKY D recipient, the provider 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 ABH confirm that the clinical information provided meets the medical necessity requirements for the requested service. ***An authorization does not confirm eligibility for HUSKY D benefits and is not a guarantee of payment.***

A prior authorization is required at the time of admission to ALL clinical recovery support services. 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 internet technology to provide a safe and secure method for authorized users to view current and historical authorization information, provide discharge information for any level of care, monitor authorization information in order to ensure timely re-authorization of and view the status of claims submissions.

Access to the ERS is granted upon completion of a brief training session 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 discharge notifications 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.

Discharge notification can be completed via the ERS and requires data entry of a limited amount of clinical information. Users who have difficulty completing the discharge notification using ERS, are encouraged to contact ABH for assistance. If you are interested in obtaining access to ERS and are a contracted BHRP 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:

- Acute Psychiatric Hospitalization (MH IV.2) at facilities classified as "Institutions of Mental Disease" (Only for HUSKY D members with pending eligibility or those not meeting eligibility for Medicaid Pilot Waiver)
- Medically Managed Inpatient Detoxification (SA IV.2) at facilities classified as "Institutions of Mental Disease"
- Residential Services (SA III.7, SA III.7R(e), SA III.3)
- 23-Hour Observation Beds (SA II.7)

ABH may require a DMHAS designated mobile crisis team or another organization identified by DMHAS to collect information necessary for prior authorization of psychiatric hospitalization, following a face-to-face evaluation of the potentially eligible or eligible recipient.

All pre-certification requests or continued stay authorization can be made via telephone Monday through Friday (except holidays), 8:30 am to 5:00 pm.

Discharge Notification is required for every authorized clinical recovery support service. Discharge information can be entered via the ERS, by telephone, or through faxed

notification. Discharge notifications entered using the Electronic Registration System (ERS) can be entered 24 hours/day, 7 days/week, 365 days/year.

C. INFORMATION NECESSARY TO OBTAIN PRIOR AUTHORIZATION

Information related to the client's current clinical status is required at the time of the request for prior 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 individual, as well as the solution-focused, recovery-oriented plan for intervention and care. The length of stay and treatment plan for the client should be individualized. Because the focus on continued care is critical in engaging and assisting the individual to move through the recovery continuum, discharge planning should begin at the time of admission to the current episode of care.

The following are key information elements necessary during the prior authorization review process:

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

2. **Clinical Information**
    The information identified below contributes to the decision of medical necessity and authorization of care.
    a. Level of care requested;
    b. Presenting Problem;
    c. Current symptoms of psychiatric disability and/or substance use disorder;
    d. Clinical risk assessment and relapse potential;
    e. Mental Status;
    f. Medical history, status of current medical issues;
    g. Psychiatric history, including current and past medications;
    h. Substance use history;
    i. Natural supports and strengths;
    j. Legal status;
    k. Whether the individual is voluntarily agreeing to the treatment;
    l. The individual's preference for clinical recovery supports and provider;

m. Previous treatment history;
n. Recovery plan objectives;
o. DSM-IV-TR provisional or admitting Axis I – V Diagnoses;
p. Projected Aftercare Plan;
q. Clinical justification for the requested service; and
r. Projected length of stay or date of discharge.

D. INFORMATION NECESSARY TO OBTAIN CONTINUED STAY AUTHORIZATION

The continued stay authorization review will determine whether previously authorized covered clinical recovery support services continue to be medically necessary. If a provider of a previously authorized clinical recovery support service, except for observation beds, determines that additional care may be necessary beyond that which has been previously authorized, the provider should contact ABH by telephone, not less than four (4) hours prior to the expiration of the existing authorization, for acute psychiatric hospitalization and medically managed detoxification and not more than forty-eight (48) hours prior to expiration of the existing authorization for other clinical recovery support services in order to obtain a continued authorization.

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 a continued stay review:

1. Client identifying information such as name and Medicaid ID number;
2. Current DSM-IV Axis I diagnosis or diagnoses;
3. Level of care requested;
4. Current clinical presentation of the individual in care and justification for the requested clinical recovery support, including factors such as mental status and strengths;
5. Recovery plan objectives;
6. Current symptoms of mental illness or substance use disorders, or both;
7. Clinical risk assessment and/or relapse potential;
8. Medication(s) used;
9. Whether the individual in care is voluntarily agreeing to continued treatment;
10. Progress, or lack of progress, made towards the goals identified by the individual in care and the treatment team;

11. The recipient's preference for clinical recovery supports and provider;
12. Provisional discharge or aftercare plan;
13. Projected date of discharge; and
14. All other information that ABH may require to determine medical necessity.

Continued authorization of a clinical recovery support service is confirmation that the member meets medical necessity criteria for that level of care and is not a guarantee of payment.

E. DISCHARGE REVIEWS

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

1. 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;
2. Follow-up Level of Care;
3. Aftercare Provider;
4. Date of first aftercare appointment;
5. Medications prescribed at time of discharge; and
6. 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 recipient violates facility or program rules;
    d. Noncompliance: 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; or
    h. Other: this category should be used when the discharge does not fit other discharge type descriptions (e.g., client incarcerated).

SECTION 6: AUTHORIZATION OF BASIC RECOVERY SUPPORTS

This section describes how and when to obtain an authorization for all types of basic recovery support services. *Services not authorized will not be reimbursed.*

A. APPLICATION FOR SERVICES

Behavioral health treatment providers are the key link between the eligible recipient and the Behavioral Health Recovery Program. It is crucial that the treatment provider work with the eligible recipient throughout the basic recovery supports application process until a determination is received. Clinical treatment or supported recovery housing providers apply on behalf of eligible recipients through submission of the application to ABH, only after ensuring that all required fields have been populated on the BHRP web portal application.

At a minimum, the application should include all of the following:

1. Identifying demographic information for the eligible recipient for whom the basic recovery supports are being requested;
2. A description of the type of basic recovery supports being requested, as documented by the treatment provider in collaboration with the eligible recipient;
3. Behavioral health treatment information, including the eligible recipient's admission date, type of treatment, provider identifying information; and
4. A valid consent form provided by ABH, signed by the eligible recipient authorizing the release of confidential information.

ABH may require additional information relevant to the type of recovery supports being requested and will request such information when necessary.

The treatment provider shall ensure that an application for recovery supports is submitted to ABH no later than thirty (30) business days after the treatment provider has conducted an assessment to determine the eligible recipient's need for basic recovery support(s).

B. AUTHORIZATION OF REQUEST FOR BASIC RECOVERY SUPPORTS

Upon receipt of a properly completed application for basic recovery supports, ABH may authorize such request, provided the following determinations have been made:

1. The eligibility information as outlined in Section 2 of this manual has been verified by ABH; and
2. The requested supports fall within available categories of covered basic recovery supports; and
3. ABH has determined that there are no community resources accessible to meet the need for which supports are being requested; and
4. The eligible recipient has not exceeded the maximum basic recovery supports program allowance within the last twelve (12) months; and
5. The requested supports can be provided within the available resources of the Behavioral Health Recovery Program.

ABH will notify the treatment provider and eligible recipient for whom supports are being requested, or that person's authorized representative, regarding the disposition of the request for basic recovery supports no later than five (5) business days after the request was received.

The determination notification for both initial and continued authorization contains:

1. Name, address and phone number of the entity and contact person making the authorization decision;
2. Date of the authorization determination;
3. Amount and type of the basic recovery support(s) requested;
4. Amount and type of the basic recovery support(s) authorized, if any;
5. Date, location, and time during which the recovery support(s) will be available; and
6. Rationale for any recovery supports that were not authorized.

Authorization of requests for basic recovery supports may extend for a period not to exceed thirty (30) days. After the first approved thirty-day period, eligible recipients may request basic recovery supports for additional periods in accordance with the Eligibility and Authorization sections of this manual.

Prior authorization of covered basic recovery supports is not a guarantee of payment.

When a determination is made on the request, a determination notification will be completed and forwarded via fax to the provider. In order to reinforce the availability of basic recovery supports as a recovery tool and not an entitlement, it is the responsibility of the treatment provider to review the determination notification with the recipient. The determination notification will provide instructions to the applicant indicating how to proceed to obtain the approved recovery supports.

Applications that contain inaccurate or missing information may be placed in a pending file for up to five (5) business days while awaiting the necessary information to complete the review/processing of the application. If the application is held in a "pending status" because of missing or inaccurate information, this time will not be considered to be part of the five-day processing limit. If the necessary information is not received within the "pending period", the application will be denied.

C. CONTINUED AUTHORIZATION – BASIC RECOVERY SUPPORTS

The behavioral health treatment services provider or supported recovery housing provider may apply for continued authorization of basic recovery supports on behalf of an eligible recipient through submission of the web-based application to ABH, after ensuring that all fields have been completed accurately.

At a minimum, the request for authorization of additional basic recovery supports should include:

1. The eligible recipient's identifying information;
2. The type of basic recovery supports being requested;
3. Behavioral health treatment services information, including the individual's admission date, type of treatment, provider, and provider identifying information;
4. A valid release of information, provided by ABH, signed by the individual consenting to the release of confidential information related to the basic recovery supports application;
5. Evidence of specific steps taken by the individual toward independent functioning and job readiness; and
6. Any other information requested by ABH needed to determine ongoing qualification.

ABH will notify the provider regarding the disposition of the request for authorization for basic recovery supports not more than five (5) business days after a complete application is received. Individuals who no longer meet the eligibility requirements as specified in Section 2 of this manual will not be re-authorized for basic recovery supports.

SECTION 7: CLAIMS SUBMISSION

A. GENERAL RULES

Claims will only be paid when BHRP services are delivered to recipients who have been determined to be eligible as specified in Section 2 of this manual and the service provider received all applicable authorizations and continued authorizations as specified in this manual. Acceptance of a service provider's claim for payment will not be a guarantee of payment.

The minimum rules for reimbursement of covered clinical and basic recovery support services include the following:

Providers shall:

1. Hold and executed BHRP Provider Agreement with DMHAS or ABH;
2. Be reimbursed at the rate established by DMHAS for each covered services, or at the billed rate, whichever is lower; and
3. Shall not be reimbursed for excluded or unauthorized services.

B. CLAIM FILING REQUIREMENTS

1. **Paper Claims** for clinical recovery support services that include all required data elements must be submitted on one of two national industry standard billing forms:
   a. Center for Medicare and Medicaid Services/CMS-1500 (formerly known as HCFA-1500); OR
   b. Uniform Billing Form/UB92 or HCFA-1450.
2. Completed clinical recovery support service claim forms may be mailed to:

DMHAS Behavioral Health Recovery Program
c/o Advanced Behavioral Health
P.O. Box 735
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 clinical recovery support providers with authorized access to the ABH Claims Entry System (ACES) through

the ABH website (www.abhct.com). Web-based single invoice data entry is available for housing and shelter providers with authorized access to the BHRP-Basic web portal through the ABH website (www.abhct.com). Providers with authorized access will also be able to review claims status for previously submitted claims. Clinical recovery support providers wishing to obtain access to the web-based claims system should contact the ABH Customer Service staff at (800) 606-3677, Option 2 to request a user-specific login and password. Basic recovery support providers requiring access or assistance in submitting claims for housing and shelter services should contact the Basic Recovery Supports hotline at (800) 658-4472;

6. **Electronic Batch Claims** may be submitted by participating clinical recovery support providers 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 BHRP resource page of the ABH website at www.abhct.com. Providers will also have access to claims status for previously submitted claims. Clinical recovery support 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. Electronic batch claim submission is not available for housing and shelter providers;
7. Payments for basic recovery supports such as personal care, clothing, security deposits, livery services, bus passes or utility payments are made either through gift card or voucher distribution. Instructions regarding distribution of this type of payment are provided to the client and behavioral health treatment provider at the time of authorization of the support.

C. CLEAN CLAIMS – CLINICAL RECOVERY SUPPORTS

1. All claims for covered clinical recovery support services must be submitted within 180 days that include but are not limited to the following required data elements:
    a. Individual's name and address;
    b. Medicaid ID Number or Social Security 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; and

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.

D. INVOICE SUBMISSION – HOUSING AND SHELTER SERVICES

1. All invoices for basic recovery supports must be submitted within 60 days of the service period and must contain all of the required data elements:
    i. Client's name and date of birth;
    ii. Medicaid ID number;
    iii. Vendor's name, address, Tax ID, Organization and Vendor ID numbers;
    iv. Start and end dates of service; and
    v. Number of units.

E. TIMELINESS

All claims for clinical recovery support services rendered must be submitted within one hundred eighty (180) calendar days of the date(s) on which the clinical recovery supports were delivered unless there is a delay due to the need for coordination of benefits or DMHAS finds good cause. If the clinical recovery supports provider is unable to file a timely claim for payment because DSS has not yet determined an individual's eligibility for medical services, the clinical recovery supports provider should submit a claim for payment no later than three hundred sixty-five (365) calendar days after the date on which the clinical recovery supports were delivered.

The basic recovery support provider should submit invoices for payment no later than sixty (60) calendar days after the date on which the basic recovery supports were delivered.

Claims/invoices that are not submitted within the above time frames will be denied reimbursement.

F. INCOMPLETE CLAIMS

Claims/invoices 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 clinical recovery support service 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 in Appendix B of this manual. To receive reimbursement for basic recovery support claims, the provider must submit invoices no later than 60 calendar days after the date on which the services were provided.

G. BHRP SERVICE RECIPIENT HELD HARMLESS

Providers may NOT, under any circumstances, bill or balance bill eligible recipients for any services provided under the Behavioral Health Recovery Program.

H. THIRD PARTY LIABILITY – CLINICAL RECOVERY SUPPORTS

1. The Provider must make a reasonable effort to determine whether or not eligible recipients 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 UB-92. 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 Behavioral Health Recovery 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 BHRP reimbursement schedule;
7. Claims involving coordination of benefits (COB) will require medical review and authorization. In order to receive payment, the Provider must obtain clinical authorization for care from both the primary insurer and ABH at the time of treatment.

I. RECONSIDERATION OF PAID CLAIMS – CLINICAL RECOVERY SUPPORTS

A provider may request reconsideration of a claim thought to be paid incorrectly by either calling the Clinical Recovery Supports line or 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.

J. CLAIMS FOR PAYMENT GRIEVANCES

1. A clinical recovery supports 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 BHRP line at (800) 606-3677.

2. A basic recovery supports provider with a payment or invoice inquiry should contact ABH by calling the Basic Recovery Supports line at (800) 658-4472.

3. ABH representatives will research the inquiry and provide a response immediately, or refer the inquiry for further investigation. In the latter case, the provider will receive a telephonic response within three (3) business days.

4. If a clinical or basic recovery supports provider's claim/invoice for payment is denied by ABH, the clinical or basic recovery supports provider may file a claim payment grievance with ABH. Clinical or basic recovery supports providers may initiate a first-level claim for payment grievance to ABH not later than thirty (30) calendar days after the date of the denial decision.

5. The first-level claim for payment grievance must include the following information:
    a. Provider Name
    b. Medicaid ID Number
    c. Client/Patient Name
    d. Date(s) of Service
    e. Billing Code(s)
    f. Claim Number (initial and subsequent submissions)

g. Rationale for Complaint

6. The clinical or basic recovery supports provider will be notified in writing of the determination made on its first-level claim for payment grievance within thirty (30) calendar days of receipt of all information as determined necessary by ABH to render a decision.

7. A clinical or basic recovery supports provider may initiate a second-level claim for payment grievance not later than seven (7) calendar days following the date of the first-level claim for payment grievance denial decision. The second-level claim for payment grievance should be submitted in writing and accompanied by all information determined necessary by DMHAS to render a decision on the second-level claim for payment grievance.

8. DMHAS will neither accept, nor review, a second-level claim for payment grievance that does not conform with the submission requirements as specified in this section of the manual, unless ABH has failed to respond to the clinical or basic recovery supports provider within the timeframe as specified in this section.

9. Any second-level claim for payment grievance decision issued by DMHAS will be final and will conclude the claim for payment grievance process. The second level claim for payment grievance shall not include any right to a hearing from either DMHAS or ABH.

K. BILLING CODES – CLINICAL RECOVERY SUPPORTS

The listing of the CPT Codes and UB-92 Revenue Codes used for claims submission and reimbursement for authorized clinical recovery services is provided in Appendix B and E of this manual. Please note that coding may vary by Provider and/or service level. Therefore, it is recommended that you refer to your Provider Agreement with DMHAS for coding specific to 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 billing codes, it is recommended that you call ABH at (800) 606-3677 for claims assistance.

SECTION 8: SUPPORT OF CONTRACTED PROVIDERS

A participating provider in the Behavioral Health Recovery Program must be credentialed and hold an executed contract with DMHAS (clinical recovery supports) or with ABH (basic recovery supports).

A. Credentialing

Credentialing includes the assessment and validation of provider qualifications to determine capability of providing services and whether requirements have been met. Required documentation includes but is not limited to:

1. Licensure, certification and/or accreditation;
2. Experience providing services;
3. Insurance; and
4. Programmatic and staffing details.

Credentialing of new providers may be done via a competitive procurement process. DMHAS and ABH retain the right to deny credentialing and determine the current needs of the BHRP.

Re-credentialing of participating providers will be done every three (3) years.

B. Contracting

A contract specifies conditions and terms to which the clinical or basic recovery supports provider must adhere in order to participate in the BHRP. DMHAS shall bear no financial responsibility for services that are rendered in the absence of an executed contract.

C. Termination of Contracted Providers

DMHAS or ABH may terminate a contract with a provider after giving the provider a thirty (30) calendar day written notification or such notice as otherwise required by contract or regulation. DMHAS or ABH may terminate the contract for reasons that include, but are not limited to, the following:

1. Loss, revocation, suspension, surrender or non-renewal of any credential required, such as the facility license or another credential required as a condition of eligibility;

2. The provider has a diminished ability to provide services legally, including disciplinary action by a governmental agency or licensing board that impairs the contracted provider's ability to operate;
3. Failure to comply with DMHAS/ABH credentialing and re-credentialing requirement criteria;
4. Failure to notify ABH of any event that would affect or modify the information contained in the provider's credentialing application for participation in the BHRP;
5. Disciplinary action by any other state, governmental agency or licensing board;
6. Termination of, or failure to maintain, adequate insurance coverage;
7. Fraud, such as, the provider:
    a. Presents a false claim for payment;
    b. Accepts payments for services delivered that exceeds the amount due;
    c. Solicits to deliver or delivers services for any eligible recipient, knowing that such eligible recipient is not in need of such services;
    d. Accepts payment for services that were covered by another payor; or
    e. Presents a claim for payment to DMHAS or ABH for services that were not delivered to an eligible recipient;
8. Failure to comply with the terms and conditions established in the contract;
9. Failure to deliver services to eligible recipients in an ethical manner;
10. Failure to implement corrective action required by DMHAS or ABH as the result of an audit;
11. Any other breach of the clinical or basic recovery supports provider contract that is not corrected by the provider not later than thirty (30) calendar days after receipt of notice from DMHAS or ABH; or
12. Failure to repay an overpayment made by DMHAS or ABH within the specified timeframe.

DMHAS may terminate a provider contract without prior notice, based upon any of the following circumstances:

1. Funding for the contract is no longer available; or
2. DMHAS determines that the provider poses imminent potential harm to the health or welfare of eligible recipients. DMHAS will provide written notification to the provider of the specific reasons for taking such action in writing within five (5) business days of contract termination.

D. ABH – DMHAS 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 credentialing and contracting process. In addition, training requests for the Electronic Registration System (ERS), clinical recovery supports claims submissions, or any other inquiries related to participation in the clinical recovery supports portion of the BHRP, can be made by contacting an ABH Customer Service or Provider Relations staff member at (800) 606-3677. Requests for training related to basic recovery supports service request or invoice submission or any other inquiries related to participation in the basic recovery supports portion of the BHRP can be made by contacting the Basic Recovery Supports line at (800) 658-4472.

E. PROVIDER RESPONSIBILITIES

Providers will:

1. Comply with all state and federal requirements pertaining to the communication, storage, dissemination, and retention of confidential information regarding potentially eligible recipients and eligible recipients including the Health Insurance Portability and Accountability Act (HIPAA); 45 CFR 164, 45 CFR 2; and 17a-688(c) and Chapter 899 of the Connecticut General Statutes; and other such laws and regulations as may apply. Additionally, the provider will assume responsibility for obtaining any release of information that may be necessary to meet contractual data transmittal and service coordination requirements;
2. Report every critical incident to DMHAS;
3. Submit to DMHAS or ABH timely and accurate information in the specified format. This information includes, but is not limited to, the following:
    a. Demographic data regarding the eligible recipients served;
    b. Descriptions of the services delivered;
    c. Descriptions of the provider's staff sufficient for DMHAS to assess the provider's cultural competency;
    d. Service recipient outcomes;
    e. Census counts; and
    f. Service recipient service records or charts;
4. Providers must report to ABH any event that would affect or modify the information contained in the provider's credentialing application for participation in the BHRP. Clinical recovery support providers may contact the ABH Provider Relations Department at (800) 606-3677, Option 2 to report any changes. Basic recovery support providers may contact the Basic Recovery Supports Help Line at (800) 658-4442 to report any changes.

SECTION 9: APPEALS, COMPLAINTS AND GRIEVANCES

There are two levels of appeals that may be submitted as a result of a denial of request for clinical or basic recovery support services. This process is reflected in DMHAS Behavioral Health Recovery Program Policies.

This appeal process is available to a recipient or his/her authorized representative, who is dissatisfied with the decision of ABH to deny, reduce or terminate a covered behavioral health treatment service based on failure to meet medically necessary criteria, or failure to follow administrative guidelines for seeking authorization of covered services, or the decision of ABH to deny, reduce or terminate a recipient's application for basic recovery support services.

Providers who wish to appeal denial of claims/invoice payments may do so by following the procedures outlined in Section 7 of this Provider Manual - Claims for Payment Grievances.

A. First-level Appeal

A first-level appeal may be filed by the individual or his/her authorized representative. The first-level appeal should be filed with ABH no later than seven (7) calendar days after the decision by ABH to deny, reduce or terminate covered clinical or basic recovery supports, unless good cause is shown for late filing as determined by ABH. A first-level appeal is not a "contested case" pursuant to Section 4-166(2) of the Connecticut General Statutes.

A first-level appeal should be filed in writing with all supporting information or records. (An appeal for basic recovery supports should be submitted on the "Appeal Request and Disposition Form for Basic Recovery Supports" found in the appendix of this manual, or downloaded from www.abhct.com.) All records relating to a first-level appeal will be kept confidential unless disclosure is otherwise required by law or authorized in writing by the individual. The first-level appeal should be submitted to:

DMHAS Behavioral Health Recovery Program
Advanced Behavioral Health, Inc.
213 Court Street, 8th floor
Middletown, CT 06457
ATTN: Appeals Department

A first-level appeal may also be filed with ABH via FAX at:
(a) Clinical recovery supports FAX# (800) 704 – 6145
(b) Basic recovery supports FAX# (866) 249 – 8766

If the first-level appeal is related to a denial of clinical recovery supports due to failure to meet criteria used to determine medically necessary benefits, the decision will be made by a board-certified psychiatrist who was not previously involved in reviewing the service request.

ABH will send written notice of the first-level appeal decision by ABH to the individual or his/her authorized representative and to the provider not more than seven (7) calendar days after ABH has determined it has received all information necessary to render a decision.

If ABH fails to issue a first-level appeal decision within seven (7) calendar days, the individual or his/her authorized representative may treat it as a denial and request further review by filing a second-level appeal.

B. Second-level Appeal

The individual or his/her authorized representative may file a second-level appeal of a first-level appeal decision that denies, reduces or terminates covered behavioral health treatment services. The second-level appeal must be filed with DMHAS not later than seven (7) calendar days after the first-level appeal decision, unless good cause is shown for a late filing, as determined by DMHAS. A second-level appeal is not a "contested case" within the meaning of Section 4-166(2) of the Connecticut General Statutes.

The second-level appeal should be filed in writing with all supportive documentation. All records relating to the second-level appeal will be kept confidential, unless disclosure is otherwise required by law or authorized in writing by the individual.

All second-level appeals correspondence should be sent to:

Department of Mental Health & Addiction Services
Managed Services Division
410 Capitol Avenue, 4th Floor
PO BOX 341431
Hartford CT 06134

The individual or his/her authorized representative and the provider will be sent written notice of the second-level appeal decision by DMHAS not later than seven (7) calendar days after DMHAS determines it has received all information necessary to render a decision. DMHAS will neither accept nor review a second-level appeal request if the first-level appeal request submitted to ABH is still being reviewed within the time period stated in this section.

C. FAIR HEARINGS

Any individual who requested a covered service from ABH and had the covered service denied or, if delivered, reduced or terminated without the individual's consent and who has received an unfavorable second-level appeal from DMHAS, may request a fair hearing. The individual's request must be made within fifteen (15) calendar days of the second-level appeal decision. Fair Hearings must be requested in writing to the Department of Mental Health & Addiction Services at the address below:

Department of Mental Health & Addiction Services
Managed Services Division
410 Capitol Avenue, 4th Floor
PO BOX 341431
Hartford CT 06134

D. 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 Behavioral Health Recovery 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 related to clinical recovery supports can be offered by contacting ABH at (800) 606-3677, Option 2.

Complaints related to basic recovery supports can be offered by contacting the Basic Recovery Supports Line at (800) 658-4442.

SECTION 10: GLOSSARY OF TERMS

AEVS: *Automated Eligibility Verification System* – a system accessible to Providers, which allows for verification of eligibility for HUSKY benefits, and/or the existence of third party liability for a recipient.

Appeal: A formal request for review of a clinical or basic recovery support provider's service authorization or payment decision.

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. Advanced Behavioral Health, Inc. (ABH) is the ASO for the Behavioral Health Recovery Program.

Authorization: the approval of a request for clinical or basic recovery supports.

Authorized Representative: a person designated by the eligible recipient or a person authorized by law to act on behalf of an eligible recipient for the purposes of filing an appeal or grievance.

Basic Recovery Supports: transitional supportive services provided as an adjunct to clinical treatment services to assist individuals to achieve and maintain recovery.

Basic Recovery Supports Provider: an entity that has been contracted or otherwise recognized by DMHAS to provide basic recovery supports under the Behavioral Health Recovery Program.

Care Management: The prospective, retrospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to an individual who is eligible or potentially eligible for HUSKY D benefits.

Case Management: an assessment followed by recovery planning and discharge planning intended to link individuals to clinical recovery supports and/or basic recovery supports.

Cash Assistance: financial assistance provided by the state or federal government to individuals who are considered disabled or unemployable.

CFR: Code of Federal Regulations.

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

Clinical Recovery Supports: services under the Behavioral Health Recovery Program that are provided in a licensed residential substance abuse treatment facility or in an institution for mental disease.

Clinical Recovery Supports Provider: an entity that has been contracted to provider clinical recovery supports by the Behavioral Health Recovery Program.

Critical Incident: critical incidents, as defined by The Connecticut Department of Mental Health & Addiction Services Commissioner's Policy Statement No.81, are incidents that may have a serious impact on DMHAS clients, staff, funded agencies or the public, or may bring about adverse publicity.

DMHAS: Department of Mental Health and Addiction Services.

DSS: Department of Social Services.

Discharge Plan: the written summary of an individual's behavioral health services needs, developed in order to arrange for appropriate care after discharge or upon transfer from one level of care to another.

Eligible Recipient: an individual who receives clinical or basic recovery supports through the Behavioral Health Recovery Program under HUSKY D pursuant to Connecticut General Statutes, Section 17a-485i as enacted by Public Act 10-60.

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

Institution for Mental Disease (IMD): means a hospital, nursing facility or institution of more than sixteen (16) beds that is primarily engaged in providing

diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services.

Intensive Case Management: a case management program designed to assist high-risk clients including high utilizers, in engaging and moving through the recovery continuum.

Livery Transportation: taxi transportation provided to and from behavioral health recovery program clinical recovery supports services and supported recovery and shelter housing services.

Payor of last resort: a state agency that will only make payments for clinical or basic recovery supports services to the extent that no other source of payment is available.

Recovery: 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 Plan: a written, individualized plan based on the individual's needs, strengths and preferences, and developed with the involvement of the recipient or his/her authorized representative.

Shelter Housing: a facility with the primary purpose to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless.

Supported Recovery Housing: a clean, safe, drug and alcohol-free transitional living environment under the Behavioral Health Recovery Program with on-site case management services available at least eight (8) hours per day, five (5) days per week.

Supported Recovery Housing Provider: an entity under contract with ABH to provide supported recovery housing for the Behavioral Health Recovery Program.

SECTION 11: APPENDICES, FORMS, POLICY STATEMENTS

Appendices

Forms

Policy Statements

APPENDIX A – DMHAS UM MODEL FOR CLINICAL RECOVERY SUPPORTS

Service Description	DMHAS Level	Is Service Included in UM Process?	Is Prior Auth Required?	Authorized LOS at Prior Authorization	How Is Review Done?	When Is Continued Stay Performed?	LOS At Continued Stay	How Is Review 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 Detox	SA IV.2-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
Co-Occurring Intensive Residential Treatment	SA III.7R(e)	Yes	Yes	Up to 14 days	Phone	Up to 1 day prior to end of auth	Up to 14 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
Observation/23-hour bed	SA II.7	Yes	Yes	Up to 23 hours 1 day	Phone	N/A	None	N/A	Yes

APPENDIX B - UB-92 FACILITY CODES

Psychiatric Service	DMHAS LOC	UB-92 Revenue Code
Acute Psychiatric Inpatient	MH IV-2	124
Acute Inpatient Services	Pilot II.0	121

Substance Abuse Service	DMHAS LOC	UB-92 Revenue Code
Medically-Managed Detoxification	SA IV.2	126
Acute Inpatient Services	Pilot II.0	121

APPENDIX C - TIPS FOR COMPLETING THE UB-04/CMS 1450 CLAIM FORM

(Instructions available at www.nucc.org)

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	Pay-to name, address and Secondary Identification Fields	Conditional	Required when the pay-to name and address information is different than the Billing Provider information in Field 1. If used, the minimum entry is the provider name, address, city, State and ZIP code.
3a	Patient Control Number	Optional	Enter the unique number assigned by the facility for the client.
3b	Medical/Health Record Number	Optional	Enter the number assigned to the patient's medical/health record by the provider (not Field 3a).
4	Type of Bill	Required	Enter a valid 4-digit Type of Bill code that provides specific information about the services rendered. A three-digit code is entered after a leading zero. 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. The format is NN-NNNNNNN.
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	Untitled	Not required	N/A
8a	Patient's Name	Required	Enter the Client Name (Last, First Name, and Middle Initial).

Field Number	Field Description	Data Type	Instructions
8b	Patient's ID (if different)	Not required	Enter the Client's ID if different than the Subscriber ID – Not applicable.
9	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.
10	Patient's Birth Date	Required	Enter the Client's Date of Birth in MMDDCCYY format.
11	Patient's Sex	Required	Enter an "M" (male) or an "F" (female) for the gender status of the client.
12	Admission Date	Required for Inpatient and Home Health	Enter the date the Client was admitted for inpatient care in MMDDYY format.
13	Admission Hour	Required for Inpatient	If this is an inpatient claim, enter the admission hour in Military Standard Time (e.g., 00:00 to 24:00), if applicable.
14	Admission Type	Required for Inpatient	If this is an inpatient claim, enter the code for the admission type if applicable. Refer to the UB92 Reference Codes following this document.
15	Source of Admission	Required	If this is an inpatient claim, enter the appropriate Admission Source Code. Refer to the UB92 Reference Codes following this document.
16	Discharge Hour	Required	Enter the hour at which the Client was discharged from inpatient care if applicable.
17	Patient Status	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.

Field Number	Field Description	Data Type	Instructions
18-28	Condition Codes	Not required	Enter a valid condition code if applicable.
29	Accident State	Not required	Not used.
30	Untitled	Not required	Not used.
31 - 34	Occurrence Codes and Dates	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
35-36	Occurrence Span Codes and Dates	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
37	Untitled	Not required	Not used.
38	Responsible party name and address	Not required	Enter the name and address of the party responsible for payment of the bill.
39-41	Value Codes and Amounts	Not required	Enter valid Value codes and amounts.
42	Revenue Code	Required	Enter the applicable revenue codes for the services rendered. There are 23 lines available and should include the total and # of pages in line 23.
43	Description	Not required	Enter the corresponding description of the revenue code(s) indicated in Field 43 lines 1-22.

Field Number	Field Description	Data Type	Instructions
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 on each line 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 each service billed.
49	Untitled	Not required	Not used.
50A	Payer Name	Required	Enter the name of the Primary Payer, as applicable. Provider should list multiple Payers in priority sequence according to the priority the provider expects to receive payment from these Payers.
50B	Payer Name	Conditional	Enter the name of the Secondary Payer as applicable.
50C	Payer Name	Conditional	Enter the name of the Tertiary Payer as applicable.
51A	Health Plan ID	Required	Enter your NPI or your plan assigned provider number.

Field Number	Field Description	Data Type	Instructions
51B	Health Plan ID	Conditional	Enter your NPI or your plan assigned provider number.
51C	Health Plan ID	Conditional	Enter your NPI or your plan assigned provider number.
52 A-C	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 A-C	Assignment of Benefits	Not Required	Not used
54 A-C	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.
55 A-C	Estimated Amount Due	Not required	Enter the amount due from the patient. Not Required.
56	NPI	Required	Enter the NPI number of the facility where the services were rendered.
57 A	Other Provider ID	Conditional	Use either this field to indicate the Provider's "B" Number or 57B or C.
57B	Other Provider ID	Conditional	Use either this field to indicate the Provider's "B" Number or 57A or C.
57C	Other Provider ID	Conditional	Use either this field to indicate the Provider's "B" Number or 57A or B.

Field Number	Field Description	Data Type	Instructions
58 A-C	Insured's name) last, first name, middle initial	Required	Enter the Insured's Name (Last, First Name, and Middle Initial) that corresponds with the Payer information entered in Box 50 A-C.
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 A-C. Refer to the UB92 Reference Codes following this document.
60	Insured's Unique ID	Required	Enter the Insured's EMS ID in Box 60a and the ID number that corresponds with the Payer information entered in Box 50 B-C as applicable.
61	Group Name	Not required	Enter the group or plan name of the Insurer that corresponds with the Payer information entered in Box 50 A-C, if applicable.
62	Insurance Group Number	Not required	Enter the group number of the Insurer that corresponds with the Payer information entered in Box 50 A-C, if applicable.
63 A-C	Treatment Authorization Codes	Not required	Enter the authorization number assigned by ABH in the corresponding box and the number assigned by any other Payers listed in Box 50 A-C, if applicable.
64 A-C	Document Control Number	Not required	Enter the control number assigned to the original bill by the health plan.
65	Employer Name	Not required	Enter the name of the Primary Employer that provides the coverage for the insured indicated in Field 58 A-C.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Not required	Enter the qualifier that denotes the version of the ICD reported (9 or 0).
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.

Field Number	Field Description	Data Type	Instructions
67 A-Q	Other Diagnosis Codes	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.
68	Untitled	Not Required	Not used.
69	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.
70 A-C	Patient's Reason for Visit	Not required	Used for all un-scheduled outpatient visits for outpatient bills.
71	PPS Code	Not required	Not used.
72	External Cause of Injury Codes (ECI)	Not required	Not used.
73	Untitled	Not required	Not used.
74	Principal Procedure Code and Date	Not required	Used on inpatient claims when a procedure was performed. Not used on outpatient claims.
74 A-E	Other Procedure Codes and Dates	Not Required	Used on inpatient claims when additional procedures must be reported.
75	Untitled	Not Required	Not used.

Field Number	Field Description	Data Type	Instructions
76	Attending Provider Name and Identifiers	Not Required	Required when a surgical procedure code is listed on the claim. Enter the name of the Attending Provider and the corresponding NPI and other Provider numbers.
77	Operating Provider Name and Identifiers	Not Required	Required when a surgical procedure code is listed on the claim. Enter the name of the Surgeon and the corresponding NPI and other Provider numbers.
78 -79	Other Provider Name and Identifiers	Not Required	Enter the name and ID number of the individual corresponding to either DN – Referring Provider, ZZ – Other Operating Physician or 82 – Rendering Provider.
80	Remarks	Not Required	The provider may enter any remarks needed to provide information that is not shown elsewhere on the bill, but is necessary for proper payment.
81 a-d	Code to Code	Not Required	Used to report additional codes related to a field or to report an external code list approved by the NUBC for inclusion to the institutional data set.

APPENDIX D - UB-04/CMS 1450 REFERENCE MATERIAL

Type of Bill Codes (Field 4)

The first digit is a leading zero and will be ignored.
The second digit identifies the type of facility (i.e. 1 = Hospital)
The third digit identifies the bill class or type of service (i.e. 1 = Inpatient or 3 = Outpatient)
The forth digit identities the frequency of the bill (i.e. 1 = Admit through discharge)

2nd Digit: Type of Facility (Field 4)	Code	3rd Digit: Bill Classifications Except Clinics & Special Facilities (Field 4)	Code
Hospital	1	Inpatient including Medicare Part A	1
Skilled nursing facility	2	Inpatient (Medicare Part B only)	2
Home health	3	Outpatient	3
Religious Non-medical (Hospital)	4	Other (Part B)	4
Reserved for National Assignment	5	Intermediate Care - Level 1	5
Intermediate care	6	Intermediate Care - Level 2	6
Clinic/Hospital Based Renal Dialysis Facility	7	Reserved for National Assignment	7
Special facility or hospital ASC surgery	8	Swing Bed	8
Reserved for National Assignment	9	Reserved for National Assignment	9

3rd Digit: Bill Classifications Clinics only (Field 4)	Code	3rd Digit: Bill Classifications Special Facilities only(Field 4)	Code
Rural Health Clinic	1	Hospice (Non Hospital Based)	1
Hospital Based or Independent Renal Dialysis Center	2	Hospice (Hospital Based)	2
Free Standing Provider-Based Federally Qualified Health Center	3	Ambulatory Surgical Center Services to Hospital Outpatients	3
Other Rehabilitation Facility	4	Free Standing Birthing Center	4
Comprehensive Outpatient Rehabilitation Facility	5	Critical Access Hospital	5
Community Mental Health Center - CMHC	6	Reserved for National Assignment	6-8
Reserved for National Assignment	7-8	Other	9
Other	9		

Type of Bill Codes (Field 4) Continued

4th Digit Frequency (Field 4)	Code	4th Digit Frequency (Field 4)	Code
Non-Payment/ Zero Claim	0	Late Charte Only	5
Admit Through Discharge Claim	1	Reserved	6
Interim: First Claim	2	Replacement of Prior Claim	7
Interim: Continuing Claims	3	Void/ Cancellation of Prior Claim	8
Interim: Last Claim	4	Final Claim for a Home Health PPS Episode	9

Type of Admission Codes (Field 14)	Code
Emergency	1
Urgent	2
Elective	3
Newborn	4
Trauma Center	5
Reserved for National Assignment	6-8
Information Not Available	9

Source of Admission Codes (Field 15)	Code
Physician Referral	1
Clinical Referral	2
Managed Care Plan Referral	3
Transfer From a Hospital (different facility)	4
Transfer From a Skilled Nursing Facility	5
Transfer From Another Health Care Facility	6
Emergency Room	7
Court/Law Enforcement	8

Information Not Available	9
Transfer from a Critical Access Hospital	A
Transfer From Another Home Health Agency	B
Readmission to Same Home Health Agency	C
Transfer From Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer	D
Reserved for National Assignment	E-Z

Patient Status (Field 17)	**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 not defined elsewhere in this code list.	05
Discharged/ transferred to home under care of organized home health service organization	06
Left against medical advice or discontinued care	07
Reserved for National Assignment	08
Admitted as a inpatient to this hospital	09
Reserved for National Assignment	10-19
Expired (or did not recover – Religious Non Medical Health Care Patient)	20
Reserved for National Assignment	21-29
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 claims only)	42
Discharged/Transferred to a Federal Hospital	43
Reserved for National Assignment	44-49
Discharged/transferred to Hospice - home	50

Patient Status (Field 17) CONTINUED	*Code*
Discharged/transferred to Hospice - Medical Facility	51
Reserved for National Assignment	52-60
Discharged/transferred within this institution to swing bed	61
Discharged/transferred to an inpatient rehabilitation facility	62
Discharged/transferred to long term care hospitals	63
Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	64
Discharged/transferred to a psychiatric hospital or psychiatric district part unit of a hospital	65
Discharged/transferred to a Critical Access Hospital	66
Reserved for National Assignment	67-99

Release of Information Indicator Codes (Field 52)	**Code**
Yes	Y
Restricted or modified Release	R
No Release	N

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

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

APPENDIX E - CMS (HCFA) 1500 - SUBSTANCE ABUSE SERVICES

BHRP Clinical Program Service / DMHAS LOC		**CMS-1500 Code**
Intensive Residential Treatment	SA III.7R	H0018
Co-Occurring Residential Treatment	SA III.7-R(E)	H0017, T2048
Residential Long Term Care	SA III.3R	H0019, H2036

BHRP Basic Program Service/ DMHAS LOC	**CMS-1500 Code**
Shelter Housing Services	SHELT
Supported Recovery Housing Services	SRHSV

APPENDIX F - TIPS FOR COMPLETING THE CMS 1500 CLAIM FORM

Claims for non-facility based professional services must be filed on an accurately completed CMS 1500 (HCFA 1500) claim form. Instructions may be found at www.nucc.org

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 in MMDDYY format, 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	Not required	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	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	Not required	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	Enter "Signature on File", "SOF", or legal signature. Enter date signed in either a 6-digit format (MMDDYY) or an 8-digit format (MMDDYYYY). If "Signature on File" or "SOF" 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.
17b	NPI #	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.
24	Claim Detail Lines	Conditional	The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another proprietary identifier during the NPI transition, if necessary, and to accommodate the submission for supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information (not required). It is not intended to allow the billing of 12 lines of service.
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. **The number of days must correspond to the number of units in 24G.**
24b	Place of service	Required	Enter the appropriate HCFA place of service code.
24c	EMG	Not required	Emergency Indicator. If required enter Y for "Yes" or leave blank if "NO".
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, if applicable.
24e	Diagnosis Pointer	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. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the "From" 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	ID Qualifier	Not required	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider is reported in 24J in the shaded area. Refer to the list below.
24j	Rendering Provider ID#	Not Required	The individual rendering the service is reported in 24J. Enter the non-NPI number in the shaded area of the field. Enter the NPI number in the un-shaded area of the field.
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 for each service noted in Field 24f.
29	Amount paid	Conditional	Enter the total amount paid by the patient and/or another payer for services billed on this claim.
30	Balance due	Conditional	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	Enter the legal signature of the practitioner or supplier, or the legal signature of the practitioner or supplier representative, "Signature on File" or "SOF". NOTE: The person rendering care must sign or have the signature on file and indicate licensure level.
32	Service Facility Location Information	Required	Enter the site name and address and include the GA assigned "B" number if it is not possible to place it in 32 b.
32a	NPI Number	Required	Enter the NPI number of the Service Facility Location.
32b	Other ID Number	Required	Enter the GA assigned Provider "B" number for the service location.

33	Billing Provider Info & PH #	Required	Enter the provider's or supplier's billing name, address, zip code, phone number.
33a	NPI Number	Required	Enter the NPI number of the billing provider.
33	Other ID Number	Not Required	Enter the two-digit qualifier identifying the Provider Taxonomy Code (ZZ) followed by the Taxonomy ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

Appendix G – CMS (HCFA) 1500 Reference Material

Place of Service Codes (Field 24B CMS - 1500	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

Place of Service Codes (Field 24B CMS – 1500) CONTINUED	*Code*
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

ID QUALIFIERS (FOR BOX 24 I)	Code
State License Number	0B
Blue Shield Provider Number	1B
Medicare Provider Number	1C
Medicaid Provider Number	1D
Provider UPIN Number	1G
CHAMPUS Identification Number	1H
Employer's Identification Number	EI
Provider Commercial Number	G2
Location Number	LU
Provider Plan Network Identification Number	N5
Social Security Number (Do not use for Medicare)	SY
State Industrial Accident Provider Number	X5
Provider Taxonomy	ZZ

BEHAVIORAL HEALTH RECOVERY 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	

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:

(860) 704-6145

or

Mail completed form to:

Behavioral Health Recovery Program
c/o Advanced Behavioral Health, Inc.
213 Court Street 8th Floor
Middletown, CT 06457

Behavioral Health Recovery Program (BHRP) – Basic

JOB READINESS INFORMATION

APPLICANT'S NAME:_____

Please include information explaining job readiness efforts. This may include job searches, vocational training, posting resumes online, treatment related employment groups, online education, etc.

_____

_____

_____

_____

_____

List all job search contacts:

	Date	**Company & Position**	**Contact Person & Phone #**	**Type of Contact** *i.e.: Sent resume or interviewed*
1				
2				
3				
4				
5				

List all vocational training contacts:

	Date	**Type of Training**	**Contact Person & Phone #**	**Dates of Training**
1				
2				
3				
4				
5				

Department of Mental Health and Addiction Services (DMHAS)
Behavioral Health Recovery Program – Basic Supports

Consent to Disclosure and Release of Confidential Information and Records

I, _____ , DOB: _____ ,
(Name of Participant) (Date of Birth)

EMS# _____ , SS# _____ as a
(EMS Number) (Social Security Number)

participant in the DMHAS Behavioral Health Recovery Program, understand my treatment and support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing Behavioral Health Recovery Program basic recovery support requests:

1. **The DMHAS Administrative Service Organization; and**

2. _____
   [Referring Treatment Provider/Program]

3. _____
   [Requested Service Vendor(s)]

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, BHRP Basic Recovery Supports program history and such other information as is necessary to provide effective coordination of the treatment and services I receive.

The purpose of the disclosure authorized herein is to facilitate the provision of Behavioral Health Recovery Program basic recovery support services.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire upon completion of this application, or:

_____
[Specific date, event or condition upon which this consent expires, only if different from above]

Date:_____ _____
[Signature of Participant]

_____
[Signature of parent, guardian or authorized representative where required]

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

State of Connecticut
Department of Mental Health and Addiction Services

Behavioral Health Recovery Program (BHRP)

Appeal Request and Disposition Form for Basic Recovery Supports

Please fax this form to:
Advanced Behavioral Health, Inc
Fax # (866) 249-8766

Name of applicant requesting appeal / reconsideration: _____

Phone #: _____ Encounter #: _____

Current address: _____

Treatment program: _____ Program phone #: _____

Name of treatment staff: _____ Program fax #: _____

If all or part of your application is denied, you can request an appeal of the decision with the help of your treatment provider or anyone else you choose. If you would like your request to be reconsidered, your first-level appeal must be received within 7 calendar days of the denial of the requested supports. Please state why you feel the decision should be reconsidered. You are welcome to continue on the back of this form or submit any additional supporting documentation:

_____

_____

_____

_____

_____

_____

Applicant's Signature: _____ Date: _____

Preparer's Signature: _____ Date: _____

Appeal Request Disposition completed by ABH, Inc.

Outcome: ☐ Upheld ☐ Reversed

Date Received _____/____/_____ Decision Date:____/____/_____ Effective Date ____/____/____

Service Type: _____ Amount:_____Rationale:_____

Narrative:_____

_____

You can appeal this decision through a second-level appeal. The second-level appeal must be filed with DMHAS no later than seven (7) calendar days after the first level appeal decision. All second-level appeals correspondence should be directed to:

Department of Mental Health & Addiction Services
Managed Services Division
Fax: (860) 418-6730