

# *Behavioral Health Connecticut*

*A Provider-Sponsored Behavioral Healthcare Management Organization*

*Practitioner & Provider Manual*

*Effective 01/01/06*

# *Quick Reference Sheet*

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**Call BHC at (800) 741-4443**

To register outpatient care

Call for pre-authorization:

- Inpatient psychiatric or substance abuse admission—call before the admission; for emergencies, call within 24 hours
- Residential treatment admission—call before the admission
- Partial hospital admission—call before the admission
- Intensive Outpatient admission—call before the admission
- Psych testing
- ECT
- Ambulatory Detoxification

BHC's access standards for appointments are:

- Life-threatening Emergency—refer to E.R.
- Non-life-threatening Emergency—within 6 hours
- Urgent—within 48 hours
- Routine—within 10 business days (5 business days for AUSHC members)

**If you cannot schedule an appointment for a BHC member within BHC timeframes please call us.**

**Written information needed from you:**

- Outpatient Treatment Report -- if more than seven sessions are needed
- Outpatient Treatment Report--for additional sessions beyond authorization
- Psychological Testing Form--for Psych Testing Request
- Accurate claim form for services rendered

**BHC may call you:**

- **For additional clinical information**
- **For assistance in finding an appointment for a member**
- **To arrange for a treatment record review**
- **To arrange for a site visit**
- **To verify that a patient discharged from inpatient care kept an outpatient appointment**

**If you have any questions call BHC at (800) 741-4443**

# TABLE OF CONTENTS

## SECTION I:      *INTRODUCTION*

1.1	WELCOME .....	1
1.2	VISION .....	1
1.3	MISSION .....	1
1.4	VALUES .....	1
1.5	PROVIDER MANUAL .....	2
1.6	NEW PLANS & PROGRAMS .....	2
1.7	BHC SERVICES .....	3
1.8	NETWORK OPERATIONS .....	4
1.9	MEMBER SERVICES .....	4
1.10	CLAIMS PROCESSING .....	5
1.11	BHC WEBSITE .....	5
1.12	ACCESSING CARE .....	5
1.13	CONFIDENTIALITY .....	6

## SECTION II      NETWORK INFORMATION

2.1	PRACTITIONER NETWORK .....	7
2.2	FACILITY NETWORK .....	7
2.3	CREDENTIALING PROCESS .....	8
2.3.1	INDIVIDUAL PRACTITIONER CREDENTIALING .....	8
2.3.2	FACILITY/PROGRAM CREDENTIALING .....	9
2.3.3	RE-CREDENTIALING .....	10
2.4	PROVIDER SUMMARIES .....	10
2.5	PROVIDER PEER REVIEW .....	11

2.6	NETWORK TERMINATION .....	11
2.7	OBLIGATIONS UPON TERMINAION .....	11
2.8	MEMBERS RIGHT TO CONTINUE TREATMENT .....	11
2.9	OPEN DIALOGUE .....	12
2.10	CULTURAL COMPETENCE .....	12

**SECTION III: PROVIDER RESPONSIBILITIES**

3.1	PROVIDER RESPONSIBILITIES .....	13
3.2	INSURANCE .....	14
3.3	PROVIDER COVERAGE .....	14
3.4	DUTY TO WARN .....	14
3.5	REQUIRED REPORTING .....	15
3.6	SITE VISIT .....	15

**SECTION IV: MEMBERS RIGHTS & RESPONSIBILITIES**

4.1	NON-DISCRIMINATION POLICY .....	17
4.2	CONFIDENTIALITY OF PATIENT RECORDS .....	17
4.3	MEMBER RIGHTS & RESPONSIBILITIES .....	17

**SECTION V: CARE MANAGEMENT & QUALITY MANAGEMENT**

5.1	CARE MANAGEMENT/QUALITY MANAGEMENT PROGRAMS OVERVIEW .....	20
5.2	REFERRAL & TRIAGE .....	21
5.3	UTILIZATION REVIEW PROCESS .....	22
	❖ CONTINUED STAY REVIEW (Inpatient, Partial, IOP)	
	❖ DISCHARGE PLANNING	
	❖ OUTPATIENT TREATMENT REVIEW	
	◆ OUTPATIENT TREATMENT	
	◆ PSYCHOLOGICAL TESTING	

5.4	LEVELS OF CARE .....	25
	❖ ACUTE INPATIENT	
	❖ OBSERVATION/HOLDING BED	
	❖ ACUTE RESIDENTIAL	
	❖ PSYCHIATRIC PARTIAL HOSPITALIZATION	
	❖ PSYCHIATRIC INTENSIVE OUTPATIENT	
	❖ OUTPATIENT MENTAL HEALTH SERVICES	
	❖ MEDICALLY MANAGED DETOXIFICATION	
	❖ MEDICALLY MONITORED DETOXIFICATION	
	❖ RESIDENTIAL SUBSTANCE ABUSE REHABILITATION PROGRAM	
	❖ SUBSTANCE ABUSE PARTIAL HOSPITALIZATION PROGRAM	
	❖ SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM	
5.5	MEDICAL NECESSITY .....	31
5.6	CLINICAL CRITERIA .....	32
5.7	RESPONSE TIME FRAMES .....	32
5.8	COMPLAINTS/APPEALS .....	33
5.9	PRACTICE GUIDELINE .....	34
5.10	COORDINATION OF CARE .....	35
5.11	CLINICAL QUALITY IMPROVEMENT ACTIVITIES .....	36
5.12	TREATMENT RECORD REVIEW .....	36
5.13	TREATMENT RECORD STANDARDS .....	37
5.14	PROVIDER SATISFACTION SURVEY .....	40
5.15	PROGRAM EVALUATION .....	40

**SECTION VI:     *CLAIMS PROCEDURES***

6.1.	CLAIM SUBMISSION .....	41
6.2.	MEMBERS HELD HARMLESS.....	42
6.3.	MEMBER ELIGIBILITY .....	43
6.4.	CLAIMS TURNAROUND TIME .....	43
6.5.	CLAIM FILING LIMIT .....	43
6.6.	MISSED APPOINTMENT POLICY .....	44
6.7.	DIAGNOSTIC INTERVIEW EXAMINATION .....	44

6.8. MAXIMUM VISIT PER DAY ..... 44

6.9. SECONDARY COVERAGE/COORDINATION OF BENEFITS ..... 44

6.10. INCOMPLETE CLAIMS ..... 45

6.11. RESUBMISSION OF CLAIMS DENIED AS INCOMPLETE ..... 45

6.12. RECONSIDERATION OF CLAIMS ..... 46

6.13. CLAIM INQUIRIES AND COMPLAINTS ..... 46

6.14. BILLING CODES..... 47

6.15. HCFA-1500 CLAIM FORM INSTRUCTIONS..... 49

6.16. UB-92/HCFA-1450 CLAIM FORM INSTRUCTIONS..... 53

**SECTION VII: ATTACHMENTS ..... 60**

- A. CHANGE OF ADDRESS FORM
- B. PATIENT REGISTRATION FORM
- C. OUTPATIENT TREATMENT FORM (OTR)
- D. PSYCHOLOGICAL TESTING FORM
- E. PCP COLLABORATION OF CARE FORM

**SECTION VIII: GLOSSARY OF TERMS ..... i**

## **SECTION I: INTRODUCTION**

### **1.1 Welcome**

Welcome to the Behavioral Health Connecticut (BHC) network of Participating Providers. BHC is a provider-sponsored organization that strives to offer accessible, high quality services to covered members and to manage members' behavioral health care benefits consistent with standards set by the National Committee on Quality Assurance (NCQA).

### **1.2 Vision**

Behavioral Health Connecticut will be recognized by providers, health plans, and consumers as the organization providing the highest quality, most cost effective managed behavioral health care services in the Northeast.

### **1.3 Mission**

Behavioral Health Connecticut is committed to maintaining and enhancing the health of our communities. As a provider-sponsored organization, BHC works collaboratively with a network of practitioners and facilities to assure access by consumers to high quality, behavioral health care services. BHC is responsible for controlling administrative costs in order to maximize the resources available for direct care.

### **1.4 Values**

- ◆ We strive to empower consumers to be responsible for their personal health status.
- ◆ Staff members will feel responsible for the success of BHC. They will constantly strive to improve the delivery and outcomes of care.
- ◆ We view the execution of our mission as a partnership with our provider network.

- ◆ Consumers, providers, and co-workers deserve to be treated with respect and dignity.
- ◆ The quality of our work is paramount.

## 1.5 Provider Manual

Behavioral Health Connecticut provides its behavioral health care program for members enrolled in HMO, and Preferred Provider Organization (PPO) programs sponsored by several Connecticut-based health plans. This manual has been prepared as a guide to BHC's policies and procedures for individual practitioners, group practices, service programs and facilities. However, it is only meant to supplement your Participating Provider/Facility Agreement. In addition, some policies, procedures and requirements may vary by MCO, plan or product. When applicable, these variations are noted in this manual. **Please also refer to the MCO Manual for specific information and requirements on each product.** Updates to this manual will be posted on our website periodically. At such times, please remember to incorporate these changes in your manual.

This manual is meant to assist you in providing high quality, cost effective care to members of health plans with which you participate through BHC. Your participation as a provider of behavioral health services is important. We welcome your comments.

BHC reserves the right to amend this manual at any time, and to interpret any terms.

## 1.6 New Plans and Programs

When new programs or plans are introduced, at its discretion, BHC may choose to select current or new providers for participation. As stated in the terms of the Participating Provider/Facility Agreement, BHC will communicate to providers any new product.

## 1.7 BHC Services

BHC is located at:  
P.O. Box 775  
Middletown, CT 06457  
Toll-free (800) 741-4443 / Fax: (860) 704-6212  
[www.behavioralhealthct.com](http://www.behavioralhealthct.com)

BHC maintains a toll-free provider service line (800-741-4443) that is available to clinicians and facilities 24-hours/ 7days a week for:

- Assistance with access to Urgent/Emergent care
- Pre-authorization of Acute Care Services
- Triage
- Referral to network providers for acute services

For general inquires, providers may call BHC's dedicated staff during our regular business hours from 8:00 a.m. – 4:30 p.m., Monday-Friday at (800) 741-4443.

BHC staff is available during normal business hours for:

- Utilization review
- Information about authorization & certification of services
- Outpatient registrations
- Treatment authorizations
- Referral assistance to network providers for routine out-patient care
- Information about processes
- Information about quality improvement activities
- Assistance in answering any questions you may have
- Assistance with access to Urgent/Emergent care
- Pre-authorization of Acute Care Services
- Triage
- Referral to network providers for acute services
- Claim payment status (Aetna products only)
- Verification of Eligibility and Benefits (Aetna products only)

## 1.8 Network Operations

The BHC network consists of high quality facility and ambulatory providers covering the entire State of Connecticut. BHC seeks to include a sufficient range of providers to assure access and availability to members consistent with NCQA standards.

The Provider Relations staff is available from 8:00 a.m. to 4:30 p.m., Monday through Friday at (800) 741-4443. The Provider Relations Department is responsible for:

- Network membership and management
- Provider relations
- Provider education programs
- Contracting
- Credentialing

Network management includes, but is not limited to, provider changes and updates, credentialing and recredentialing, geographic and specialty access.

Providers can help keep files current by notifying network operations of new practice affiliations, changes in address or licensure, and facility or program involvement. (See **Attachment A** for a Change of Address/New Office Location Form that you may use to notify us of a change).

## 1.9 Member Services

**Member Services:** Member services are performed by the health plans with which you participate through BHC. The health plans are ready to work directly with you and your patients to address your concerns and solve problems. They can be contacted directly. BHC does verify behavioral health eligibility and benefits for Hartford Hospital Employees with the Aetna PPO Plan.

## 1.10 Claims Processing

BHC processes claims for the product listed above with dates of service on or after October 1, 2002. Claims for these products should be mailed directly to BHC.

**Please refer to Section 6 of this manual for additional information concerning claims and claim submission.**

## **1.11 BHC Website**

A website has been established to help communicate important information to members and providers. The web page ([www.behavioralhealthct.com](http://www.behavioralhealthct.com)) has our provider manual, levels of care criteria, utilization management program, outpatient treatment plan, and patient registration form. In addition, you will find general information about BHC and information regarding how to contact BHC.

## **1.12 Accessing Care**

Members are encouraged to access care by contacting a network provider directly or through referral by another provider, or by calling the BHC Access Line (1-800-741-4443 for Hartford Hospital PPO Members. For information regarding Aetna HMO members, please call the number listed on back of the patient's insurance identification card.

For Acute Care Services (Psychiatric or Chemical Dependency Inpatient, Residential, 23 Hour Observation, Partial Hospital, and Intensive Outpatient):

- Providers and/or facility representatives may obtain pre-authorization 24 hours a day, 7 days a week by calling (800) 741 - 4443.
- Utilization management staff will obtain clinical information in order to assess the medical necessity of the services requested and provide authorization as appropriate.
- In emergency situations, members in need of acute services may contact BHC 24 hours a day, 7 days a week. They will be directed to the nearest participating provider/facility for evaluation.

### **1.13 Confidentiality**

All information that BHC provides to participating providers (protocols, systems, policies, procedures, etc.) is to remain confidential and is only to be used by participating providers in connection with the performance of their responsibilities under their agreement with BHC. Upon termination of their network status, providers are to immediately terminate use of and return all proprietary information to BHC.

## **SECTION II: NETWORK INFORMATION**

BHC has established a network consisting of behavioral health professionals in the fields of psychiatry, clinical social work, clinical psychology, advanced practice nursing and other disciplines, and facilities which provide psychiatric and/or substance abuse services. Selection is based on skill, experience, geographic location, accessibility and ability to meet specific needs.

### **2.1 Practitioner Network**

Providers that are interested in joining the BHC network need to send a letter of intent and a copy of their curriculum vitae. If the individual provider meets BHC's standards and current network requirements, he/she is asked to formally apply for network status. The credentials that demonstrate the provider's competencies will be closely examined and verified.

Before a provider can begin to treat members, the provider is required to successfully complete the credentialing process, and sign a Participating Provider Agreement.

In addition, applicants must:

- Agree to follow BHC's policies, procedures, and treatment protocols and cooperate with quality programs.
- Agree to follow specific MCO's policies and procedures.
- Agree to treat patients in the least restrictive environment at the most appropriate level of care.

- Have an excellent community reputation with no history of serious ethical or malpractice complaints.

## **2.2 Facility Network**

Facilities must be state licensed, and be accredited by a recognized accrediting body such as JCAHO, CARF, COA, CHAP, or ACHC. If the facility is not accredited, the organizational provider must provide BHC the following additional items:

- Policies and procedures regarding confidentiality, informed consent, and consent for minors.
- Current Annual Quality Improvement Plan
- Nursing policies and procedures addressing patient safety
- Program Description for each program offered, including admission and discharge criteria
- Staffing information, including number of staff by discipline in each program and internal credentialing criteria and processes

In addition, the facility must agree to a BHC site visit. BHC may request the latest copy of the organization's on-site audit report from the appropriate state-licensing agency or from HCFA in lieu of a site visit.

Alternative programs that are not eligible for JCAHO or other accreditation must:

- Have earned the highest level of accreditation and licensure available
- Comply with BHC's clinical standards
- Maintain BHC's standards for malpractice and liability insurance
- Agree to regular site visits
- Comply with credentialing requirements for provision of outpatient clinical services
- Comply with all of BHC's quality activities

## **2.3 Credentialing/Recredentialing Process**

BHC adheres to all credentialing guidelines established by NCQA for both practitioners and facilities. BHC also follows NCQA guidelines regarding on-site visits. BHC conducts on-site visits of potential high volume offices before the provider's application is submitted to the Credentialing Committee.

### **2.3.1 Individual Practitioner Credentialing**

BHC conducts credentialing of practitioners through a certified Credentialing Verification Organization (CVO). Upon receipt of a completed application, the CVO issues inquiries requesting confirmation of each applicant's credentials represented on the complete application, as appropriate to the practitioner's specific discipline.

These include:

- State Licensure
- Board Certification
- Education & Training
- Current DEA/CDS certification
- Clinical Privileges
- Work History
- Malpractice Insurance
- Medicare/Medicaid
- Sanctions/Limitations

Applicant must also attest to the following:

- Ability to perform the required functions of the job, with or without accommodations
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation on privileges or disciplinary actions
- The accuracy of representations made on the application

### **2.3.2 Facility/Program Credentialing**

When credentialing a facility, the facility is required to submit a completed Facility Survey with the following attachments:

- JCAHO accreditation, CHAP, ACHC, CARF, or COA certification, if eligible
- State licenses required for each program
- Adequate malpractice insurance
- Malpractice claims history
- General liability insurance
- Any sanction activity information
- Accessibility and scope of available programs
- Facility Application Sheet
- Any outpatient clinic service must be provided by licensed clinicians as required in the Participating Facility Contract

JCAHO, COA, CARF, CHAP, or ACHC accreditation is required for all inpatient mental health and substance abuse facilities. Facilities that are not eligible for JCAHO, CARF, COA, CHAP or ACHC consideration must submit documentation-as described in Section 2.3.3

### 2.3.3 Recredentialing

- ◆ Facilities are formally recredentialled every *three* years.
- ◆ Practitioners are formally recredentialled every *three* years

Recredentialing begins six months before the expiration of the current credentialing cycle. An updated application is required and all information subject to change is verified according to BHC's credentialing policies.

Provider summaries, compiled from the preceding three years of network participation, are considered during the recredentialing process.

## 2.4 Provider Summaries

BHC collects data on participating providers as part of its Quality Improvement Program.

The data includes:

- Monitoring of utilization patterns
- Treatment record audits
- Review of member complaints
- Monitoring of access
- Outcomes of quality improvement activities

Provider data are incorporated into the recredentialing decision. If the Credentialing Committee identifies an area in need of improvement, the Committee may recommend approval contingent on a corrective action plan, or contract termination.

## **2.5 Provider Peer Review**

A provider may be subjected to disciplinary action or termination from network participation for substandard quality of care, service violation or failure to comply with the terms of BHC's Participating Provider Agreement, including failure to continue to meet credentialing standards and/or requirements. Actions to suspend or terminate participation allow for due process in a fair hearing before a peer review panel and an opportunity for appeal. Possible sanctions include: a letter of reprimand; a letter of warning; peer education and monitoring; suspension; or, termination of participating privileges.

## **2.6 Network Termination**

### **Without Cause**

Participation may be terminated by either party without cause upon ninety (90) days prior written notice to the other party. Notice must be delivered by certified mail.

### **With Cause**

Termination for cause shall take effect according to the terms outlined in the participating provider agreement.

## **2.7 Obligations Upon Termination**

Except for cases where providers are terminated for cause, the provider will continue to provide services to the members he or she is currently treating for the period of time set forth in the applicable Managed Care Agreement or sixty (60) days, whichever is longer. Furthermore, the provider will accept compensation for services rendered in accordance with the terms of the Participating Provider Agreement and the applicable Managed Care Agreement.

## **2.8 Members Right to Continue Treatment**

Members may continue to see a provider after the provider's network participation has been terminated according to BHC and/or MCO policy and procedure. This transition is used to conclude treatment and make arrangements for transitioning the member to an in-network-provider, who has agreed to accept BHC's fees and authorization procedures. Providers may contact BHC's staff for specific information pertaining to the individual member.

## **2.9 Open Dialogue**

Under no circumstances does BHC place any restriction of any kind on open communication between providers and their patients. Providers are free to discuss any treatment options and alternatives regardless of costs or coverage and may advocate on behalf of their patients or file complaints with BHC, MCOs, or government agencies about practices that are believed to affect the quality of care or services.

## **2.10 Cultural Competence**

It is important for members to have access to providers that are sensitive to and capable of meeting their special needs and preferences. Therefore, we ask that you assess your practice on the basis of racial, ethnic, gender, cultural, creed and linguistic requirements and take them into account when working with a member. In addition, if there are any special needs that you feel you are equipped to meet, please make BHC aware of them, so we can appropriately refer patients. If you do not have

the capacity to meet a specific need of a member, please feel free to contact BHC so we may better assist in an appropriate referral.

## **SECTION III: PROVIDER RESPONSIBILITIES**

### **3.1 Providers are Expected to:**

- Follow BHC's Care Management procedures
- Notify BHC of quality of care concerns or critical incidents
- Participate in BHC's Quality Assurance and Improvement Activities
- Abide by BHC's access standards
- Comply with record-keeping standards, treatment record review, and site visits.
- Respect the rights of members as patients
- Fully comply with all State/Federal laws and BHC policies protecting patients' privacy and handling of confidential treatment information
- Cooperate fully in BHC's Credentialing and Recredentialing Program
- Act in accordance with the terms of the Participating Provider/Facility Agreement
- Inform BHC of practice changes within 30 days
- Immediately inform BHC of any sanction or limitation on practice or privileges
- Adhere to BHC's administrative policies and procedures and those of the MCO
- Adhere to all policies and procedures regarding claims
- Comply with all applicable federal, state, and local laws and comply with all Medicare regulations when applicable
- Collect co-payment, deductibles and co-insurance as applicable, from Members and provide Members with notice of their financial obligations for non-covered services or missed appointments

- Without limitation, to look only to BHC Managed Care Organization or the plan for compensation for covered services (excluding co-payment, deductible, and co-insurance).

**This list serves only as a quick reference. Items are described in detail throughout this manual and in your provider agreement.**

## **3.2 Insurance**

Each participating provider is required to maintain a professional liability insurance policy of not less than \$ 1 million per occurrence and \$3 million in the aggregate. The policy must cover any claim that relates either directly or indirectly to the performance of a service to a covered member by the provider or any of provider's employees. In the event that the provider's participation agreement terminates, the provider is expected to maintain insurance that covers the provider for the period of the agreement. Finally, BHC must be notified within ten (10) business days of any change in coverage.

## **3.3 Provider Coverage**

If you use the services of another provider for coverage purposes, covering arrangements must be made with another Participating Provider except in unusual circumstances when approved in advance by BHC. Designated covering providers are subject to credentialing. In all cases, you should arrange with the covering provider that he/she would accept payment from BHC as payment in full, except for any applicable member cost share. The covering provider needs to contact BHC for separate authorization.

## **3.4 Duty to Warn**

As a provider, by law you are required to keep all information pertaining to a patient confidential, except in instances where the individual indicates or is in clear or imminent danger of doing harm to themselves, others or is suspected of child or

elderly abuse. In addition, the law requires that you disclose information relevant to the potential hazard to the appropriate authority.

### **3.5 Required Reporting**

As a participating provider it is important that you inform BHC within five (5) business days of any changes in the following:

- Any action to restrict, suspend or revoke any license or medical staff membership or clinical privileges required for the provider to render covered services
- Any final judgement or settlement in any legal action brought against the Provider for negligence in rendering covered services to members
- Any other situation which might materially and adversely affect the your ability to carry out duties and obligations under the Managed Care Agreement or the Participating Provider Agreement
- Any sanction against you or suspension or loss of your certification under the Medicare Program
- Any material change in the information set forth in any credentialing or re-credentialing information submitted by you
- The termination, reduction or cancellation of any of the insurance coverage required under the Participating Provider Agreement
- Any criminal actions against you

**You are also required to report to BHC, within 30 business days, any:**

- Changes in office or billing address [Please submit a new W-9 form]

### 3.6 Site Visits

BHC conducts on-site inspections of providers' offices to make sure that members are receiving quality care in a clean, safe and confidential environment, and to evaluate record keeping and appointment scheduling practices.

Site visits are conducted prior to the initial credentialing of potential high-volume providers. Multi-site practices will require separate visits. BHC will contact the selected location to schedule a time to visit that is mutually convenient. Following the site-visit, you will receive a written report detailing findings. The report may also be accompanied by a plan of corrective measures that would enable you to meet compliance standards.

#### Site Observation

- Signs clearly mark entrance, exits, & restrooms
- Adequate parking available
- Office is handicapped accessible or the practitioner/group makes arrangements for handicapped patients
- 24-hour on-call coverage
- Handicapped accessible restroom available
- Appointment availability
- Restrooms are clean and adequate
- Examining room is clean & soundproof
- Patient waiting area is clean and has adequate seating
- Emergency appointments available within standard
- Urgent appointments available within standard
- Routine appointments available within standard
- Office is free of safety hazards
- Medical records stored in locked file cabinets
- Fire extinguishers and smoke detectors are in place and operational

- Medication & prescription pads  
are secured
- Adequate record keeping practice
- An internal confidentiality policy  
is distributed to staff for  
signature
- Process in place for  
communication with PCPs

## **SECTION IV: MEMBERS RIGHTS & RESPONSIBILITIES**

### **4.1 Non-Discrimination Policy**

Providers are prohibited from discriminating against members in the services that they provide, either in the quality, quantity, or type of services based on a member's national origin, race, color, sex, disability, handicap, sexual orientation, age, religion, ancestry, Vietnam veteran status, health status, or payment source.

### **4.2 Confidentiality of Patient Records**

Federal and state laws govern the protection of patient confidentiality. BHC has adopted policies and procedures that ensure confidential handling of all member information. These policies and procedures extend to participating providers. We ask that you review the following procedures with your office personnel to guard against unauthorized or inadvertent disclosure of confidential information.

Confidential information includes member name, address, identification number, medical records including medical history, diagnosis, treatment history, claim information, lab reports, and pharmacy records.

- Member information should be marked as confidential, kept out of view or access to unauthorized individuals, maintained in secured locations under lock and key, and disposed of by shredding. Computers used to store member identifiable information must be password-protected. The monitor must be placed so that the screen is not visible to unauthorized individuals.
- Member information may be disclosed only with a signed release from the member, parent, legal guardian, or estate executor, except in cases of suspected child abuse, danger to self or others, or when reporting is permitted by law.

### **4.3 Member Rights & Responsibilities Statement**

The following is BHC's adaptation of NCQA's Member's Rights & Responsibilities Statement. Please review it carefully with your office staff.

## **Member's Rights & Responsibilities**

As a member you have certain rights regarding you and your treatment. Along with these rights you also have some responsibilities to consider. By working together BHC and members can ensure the best care.

### **Your Rights**

- You have the right to be treated with courtesy, dignity and respect for your privacy.
- You have the right to participate in decisions about your treatment.
- You have the right to discuss appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- You have the right to receive information about BHC's services and practitioners, clinical guidelines and members' rights and responsibilities.
- You have the right to voice complaints or appeals about the Managed Behavioral Healthcare Organization or care provided.
- You have the right to make recommendations about BHC's rights and responsibilities policies.

### **Your Responsibilities**

- You should help BHC and your providers care for you by giving complete and accurate information about your health.
- You should try your best to understand your behavioral health problems.
- You should participate with your providers in developing a plan and goals for your treatment.

- You should follow the plan and instructions for care that you have agreed upon with your provider. Ask questions if they are not clear to you.

**Your Subscriber Agreement explains your benefits and obligations. You may direct any questions regarding your behavioral health benefits to your Health Plans Member Service Department.**

## **SECTION V: CARE MANAGEMENT/QUALITY MANAGEMENT PROGRAMS**

### **5.1 Care Management/ Quality Management Programs Overview**

BHC is committed to coordinating and facilitating access to quality care throughout the entire continuum by ensuring that medically necessary services are delivered by licensed professional providers in the most appropriate setting. BHC views Care Management and Quality Management as a collaborative effort with providers, and utilizes a dynamic process to continuously monitor, evaluate, improve and promote quality behavioral healthcare services.

BHC is committed to communicating and collaborating with practitioners, providers and members in order to accomplish its objectives.

The objectives of the Quality Management and Care Management Program include:

- To facilitate positive clinical outcomes as a result of the management of care across the continuum and the integration of quality management activities.
- To improve customer satisfaction, incorporating feedback from patients and providers.
- To continually monitor, review and improve the quality of behavioral healthcare service delivery.
- To ensure compliance with state and federal utilization review laws and with NCQA standards.
- To administer benefits in a fair and consistent manner based on established criteria and relevant data.
- To ensure continued current relevancy of clinical criteria, thereby eliminating the potential for under/over utilization.
- To maintain the confidentiality of data relating to individual members and providers.

## 5.2 Referral and Triage

BHC maintains a toll-free access telephone line available 24 hours/7 days a week. During normal business hours, Monday through Friday from 8:00 a.m. to 4:30 p.m., all calls to the access line are answered by intake personnel. They are trained to answer administrative inquiries and to refer clinical calls to a BHC Care Manager who assesses the level of urgency of caller's needs and triages appropriately.

After hours calls to the access telephone line are answered directly by after hours Clinical Staff. Callers with administrative questions (e.g. claims payment, benefits) receive a follow-up call during the next business day.

Intake staff receiving calls at BHC will determine the caller's needs utilizing specific scripted questions related to the request for a referral. Any call requiring clinical judgment is immediately transferred to a Care Manager. The Care Manager conducts a risk assessment and utilizes the following criteria in facilitating a referral:

- Nature and severity of presenting problem(s)
- History
- Patient preferences and special needs (e.g. bilingual)
- Geographic accessibility
- Provider's clinical competence in a particular area
- Provider availability
- Provider's cultural competence

BHC utilizes the following definitions and standards for life threatening emergencies, non-life threatening emergencies, urgent needs and routine office visits:

- **Life Threatening Emergency Needs** – must be seen immediately or referred to the nearest Emergency Room. These include calls concerning members who are experiencing thoughts or feelings that are intolerable to the patient, or behavior that prompts urgent action by others, such as violent or self-injurious behavior, threats of harm to self or others, failure to care for oneself,

deterioration of mental status, bizarre or confused behavior or intense expression of distress.

- **Non-Life Threatening Emergency Needs –must be seen within 6 hours.** These include calls concerning a member with symptoms that are intolerable, but not life threatening.
- **Urgent Needs – must be seen within 48 hours.** These include cases in which the member’s ability to contract for the safety of himself or others may be time-limited, when the severity or nature of presenting symptoms is intolerable but not life threatening to the patient, or in response to a catastrophic life event.
- **Routine Office Visit – must be seen within 10 (5 for Aetna members) business days.** Routine calls concern members who present in no immediate distress and can wait to schedule an appointment without any adverse outcomes.

**In the event that a practitioner is contacted directly for an appointment by a member and the practitioner is unable to provide an appointment within the above time frames, the practitioner must call BHC so that BHC staff can assist the member in accessing a timely appointment.**

BHC will monitor the level of adherence to these established standards by site visits and phone calls from BHC to practitioner offices requesting an appointment for members.

Providers are expected to adhere to these standards. Repeated failure to adhere to access standards or, to notify BHC of their inability to do so, may result in sanctions on network participation.

### **5.3 Utilization Review Process**

**It is important to know that all services must be either registered or pre-authorized by following the procedures described below. Failure to follow these procedures may result in a delay, reduction or denial of payment.**

**Verifying the eligibility of the patient at the beginning of treatment is the responsibility of the provider.** Providers may call the Health Plan Member Service Department for benefit information. The Member Service Representative of the Health Plan will be able to notify you of the current eligibility status of the member and the applicable member cost shares.

Members may have an PPO, HMO Product or a Point-of-Service (POS) Product and as such all-participating facilities are required to be used for PPO, HMO or in network POS benefits. If a patient is admitted to an emergency department of a non-participating facility, he/she will be transported to an in-network facility, dependent upon availability, as soon as they are stable enough for transport.

### **Admission Review (Inpatient, Partial, IOP)**

**All admissions to inpatient, partial hospital, residential treatment, respite, intensive outpatient, and ambulatory crisis (detoxification, ECT) services must be prior authorized and are included in the continued stay review process.**

Emergent conditions requiring immediate hospitalization may be certified up to 24 hours following the admission/procedure and are subject to continued stay review on a concurrent basis. A behavioral health emergency is defined as a condition that manifests suddenly with severe symptoms, poses imminent or serious harm to oneself or others, and is recognized by a prudent layperson as a condition that requires immediate medical attention. If the member's situation is a life-threatening emergency, and the member is not already in an emergency room, he/she is referred to the nearest emergency room.

Admission reviews are conducted telephonically by care managers. All BHC care managers have a minimum of three years of clinical experience and are licensed Behavioral Health Professionals. Cases where clinical indications are unclear or where medical necessity is not met are referred to the Medical Director or designee. Providers and members are notified of review outcomes within established

timeframes, consistent with applicable state and federal statutes and regulations. Written confirmation letters of all admission determinations are mailed to providers.

### **Continued Stay Review (Inpatient, Partial, IOP)**

Care managers conduct continued stay reviews telephonically or by fax communications at regular intervals throughout the period of hospitalization. Determinations are based on medical necessity criteria, consideration of the severity and complexity of the patient's symptoms, and progress in meeting treatment goals. Cases where clinical indications are unclear or where medical necessity is not met are referred to the Medical Director or his/her designee. Each review is concluded prior to the expiration of the current certification, and the provider is informed of the review outcome at the conclusion of the review. Adverse determinations are confirmed in writing to the provider and the member within established timeframes.

### **Discharge Planning**

Discharge planning begins after the initial treatment assessment is performed.

Discharge planning focuses on establishing the next appropriate level of care that will enable the patient to return to his/her maximum level of functioning. The following areas are evaluated according to the patient's situation:

- Appropriateness of transition to a clinically appropriate, less intensive level of care
- Aftercare treatment plan, including record of first follow-up appointment
- Availability of social support network
- Availability of community-based resources which are adjunct to the social support network and aftercare treatment.

### **Outpatient Treatment Review**

**Outpatient Treatment** requires registration and/or authorization by BHC. Providers are expected to pre-register care and to verify eligibility prior to initiation of treatment. Registration is required prior to submission of the first claim. These

sessions are authorized per episode of care. A break in treatment of at least six-months designates the end of an episode of care. Care may be registered via telephone or fax through the use of our Patient Registration Form (**Attachment B**).

Submission of an outpatient treatment report (OTR) is required before the 8<sup>th</sup> visit (**Attachment C**). A care manager reviews the OTR for medical necessity and appropriateness of care according to clinical criteria. OTRs that are submitted with incomplete information will be returned to the provider for completion. If the care manager cannot authorize care, the case is referred to the Medical Director or designee. Determination letters are sent to the provider within established timeframes. Adverse determination letters are also sent to the member. Additional sessions require submission of an updated OTR.

**Psychological Testing** requires prior authorization, which can be obtained through the completion and submission of a Psychological Testing Form (**Attachment D**). The provider is required to fill out the form and send it to BHC **prior to testing**. A clinical psychologist will review the request and the requesting provider will be informed of the decision within the required timeframes.

## 5.4 Levels of Care

BHC manages the medical necessity and appropriateness for all settings and levels within the behavioral health continuum. Clinical criteria are developed for all levels of care and are utilized in all review determinations. Tailored treatment plans are developed through the use of alternative levels of care and treatment modalities as provided under the member's health benefit plan. Levels of care include:

### **Acute Inpatient**

The goal of acute inpatient mental health care is to stabilize individuals who display acute psychiatric conditions associated with a relatively sudden onset and a short severe course. Typically, the individual poses a significant danger to self or others, and or displays severe psychosocial dysfunction or mental instability. Acute inpatient care represents the most intensive level of psychiatric treatment. Treatment

encompasses multi-disciplinary assessments and multi-modal interventions. Twenty-four-hour skilled nursing care, daily medical care and a structured treatment milieu are required. Special treatment may include restraint, seclusion and a locked unit.

### **Observation/Holding Bed**

A 23-hour secure and protected, hospital level, medically staffed, psychiatrically supervised treatment environment, designed specifically for those patients who, as a result of a psychiatric disorder, are in acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and role functions, and require temporary evaluation and crisis stabilization in order to determine the most appropriate level of care and possibly avoid hospitalization.

### **Acute Residential**

Acute residential treatment is a level of care that provides diversion from inpatient hospitalization by means of a programmatic therapeutic 24-hour treatment living situation with moderate levels of supervision, structure, restrictiveness and intensity of service. Programs serve children and adolescents with sufficient intellectual potential to respond to active treatment and who need a protected and structured environment. The programs are planned for each individual's needs and are generally completed in 1 to 14 days. It is expected that realistic discharge goals will be set at admission and that family members, involved agencies and/or guardians will actively participate in the enrollee's treatment. Treatment is less restrictive than inpatient treatment and more restrictive than partial hospitalization or outpatient treatment. Residential treatment offers comprehensive services including a therapeutic milieu, along with multi-disciplinary, multi-modal therapies. It also features the use of community resources for planned, purposeful, and therapeutic activities and allows residents some degree of autonomy.

### **Psychiatric Partial Hospitalization**

Partial hospitalization is a nonresidential treatment program available up to 7 days per week that includes the major diagnostic services and psychosocial and prevocational

treatment modalities found in a comprehensive inpatient program, including therapeutic milieu, nursing, and psychiatric medication management. Psychiatric partial hospital treatment may be appropriate whenever a patient does not require the more restrictive and intensive environment of a 24-hour inpatient hospital, but does require more intensive and comprehensive services than can be provided at the outpatient level. The environment at this level of treatment is highly structured, and there should be a high staff-to-patient ratio in order to guarantee sufficient therapeutic services and professional monitoring, control, and protection. Partial psychiatric hospitalization may effectively serve acute and sub-acute patient populations. Partial hospitalization may be appropriate to provide stabilization of acute, severe mental illness; as a therapeutically-supported alternative to or step down from inpatient care; in the arrest of chronic illness that is deteriorating, and the restoration of patients to a level of functioning that allows them to be safely maintained in the community.

### **Psychiatric Intensive Outpatient**

Psychiatric Intensive Outpatient Program (IOP) represents a level of care in the continuum between partial hospital and traditional outpatient treatment. IOP services provide time limited comprehensive and coordinated multidisciplinary treatment plans that include multiple services and modalities delivered in an outpatient setting, typically 3 hours per day, 2 to 4 times per week. IOP may be used to intervene in a complex or refractory clinical situation, which would otherwise result in admission to a higher level of care. Clinical interventions available should include individual, couple and family psychotherapy, group therapies, medication management, and psycho-educational services. Adjunctive therapies such as life planning skills (assistance with vocational, educational, financial issues) and special issue or expressive therapies, which should be included in the per diem, may be provided but must be standardized in content or duration; that is, they must have a specific function within a given patient's treatment plan. All treatment plans must be individualized and should focus on stabilization and discharge to community outpatient treatment and support groups as needed. The IOP provides significantly more structure/treatment

than traditional outpatient therapy yet significantly less structure than traditional inpatient hospital program.

### **Outpatient Services**

Services that are provided in an ambulatory care setting such as mental health clinic, hospital outpatient department, community health center, group practice or provider's office (services may also be delivered in a home or school setting with specific authorization from BHC). Services focus on the enhancement and/or maintenance of the individual's level of functioning and alleviation of symptoms, which significantly interfere with functioning. The goal of outpatient therapy may be crisis resolution, therapeutic stabilization, improvement in adaptation, or recovery from addiction. The treatment modality, frequency and length of treatment will vary correspondingly.

## **Substance Abuse**

### **Medically Managed Detoxification**

Detoxification services provide a planned program of 24-hour medically managed evaluation, care and treatment to individuals who are experiencing a severe withdrawal syndrome and/or acute biomedical complications as a result of a substance abuse disorder. Medically managed detoxification services are typically rendered in a hospital facility that can provide life support in addition to 24-hour physician (daily physician/individual contact is necessary) and nursing care. It should also provide a multidisciplinary staff of clinicians who are trained in addiction treatment, and overall management of medical care. Although the treatment is specific to substance abuse disorders, the multidisciplinary team with the additional support services allows for the conjoint treatment of coexisting biomedical and emotional/behavioral conditions.

### **Medically Monitored Detoxification**

Medically monitored detoxification services provide a planned program of inpatient 24-hour medically monitored evaluation, care and treatment provided to individuals experiencing or at significant risk of developing an uncomplicated withdrawal

syndrome as a result of an alcohol and/or substance abuse disorder. These services are typically rendered in a licensed acute care setting (e.g., licensed freestanding or hospital based programs) with 24-hour physician consultation availability, 24-hour nursing care and observation, counseling staff that are trained in addiction treatment, and overall monitoring of medical care. Individuals receiving medically monitored detoxification do not require the medical and clinical intensity of a hospital based detoxification service, nor can they be effectively treated in a less intensive outpatient level of care. Services are typically provided under a defined set of physician-approved policies, procedures or clinical protocols.

### **Ambulatory Detoxification**

Ambulatory Detoxification services provide a planned outpatient program to individuals who require detoxification as a result of an alcohol and/or substance abuse disorder and are assessed to be not at risk for an acute and/or complicated withdrawal syndrome. Ambulatory detoxification services are typically rendered in an office setting, outpatient department of a hospital or addiction treatment facility by trained clinicians including but not limited to physicians and registered nurses who provide medically supervised evaluation detoxification, monitoring and referral services. Individuals receiving ambulatory detoxification do not require the medical and clinical intensity of services offered in a Medically Monitored Detoxification or Medically Managed Detoxification program. Services are typically provided under a defined set of physician-approved policies, procedures or clinical protocols.

### **Residential Substance Abuse Rehabilitation Program**

A Residential Substance Abuse Rehabilitation Program is a programmatic short-term therapeutic 24-hour living situation with moderate levels of supervision, structure, restrictiveness and intensity of treatment services which provide continuity of care after medically monitored or managed detoxification for individuals engaging in recovery. The program provides moderate intensity, and multidisciplinary treatment interventions. Though the emphasis is on group therapy and educational sessions, patients also receive individual, family, occupational, and other forms of therapy.

Linkage to aftercare, relapse components and self-help groups, such as AA are also included in the treatment and discharge plan.

### **Substance Abuse Partial Hospitalization Program**

Partial hospitalization is a nonresidential treatment program available up to 7 days per week that includes the major diagnostic services and psychosocial and prevocational treatment modalities found in a comprehensive inpatient program, including therapeutic milieu, nursing, and medication management. Partial hospital treatment may be appropriate whenever a patient does not require the more restrictive and intensive environment of a 24-hour inpatient hospital, but does require more intensive and comprehensive services than can be provided at the outpatient level. The environment at this level of treatment is highly structured, and treatment is provided by an interdisciplinary team of appropriately credentialed addiction professionals. Partial hospitalization may effectively serve acute and sub-acute patient populations. Partial hospitalization may be appropriate to provide stabilization of acute, severe substance abuse illness; as a therapeutically supported alternative to or step down from inpatient care; in the arrest of chronic illness that is deteriorating, and the restoration of patients to a level of functioning that allows them to be safely maintained in the community.

### **Substance Abuse Intensive Outpatient Program**

Substance Abuse Intensive Outpatient Program (SAIOP) is indicated for patients who require structured, time-limited, multi-modal treatment to achieve abstinence and sustain recovery. These services can be day and/or evening and enable patients to maintain residence in the community and continue their work, attend school, and be a part of family life. SAIOP, where available, should be recommended as a first treatment option to those individuals with support systems and absence of complications that may hinder the rehabilitation process. These multi-modal and multidisciplinary services can be provided in:

1. Freestanding facilities devoted to substance abuse rehabilitation.
2. Outpatient departments in acute-care hospitals.

3. Private offices of health care professionals.

**An effective multi-modal SAIOP should include the following types of treatment:**

- |                           |   |
|---------------------------|---|
| 1. Didactic presentations | 6. Regular urine and/or serum drug screening  |
| 2. Individual counseling  |   |
| 3. Group therapy          | 7. Strategies for relapse prevention to include community and social support systems in treatment |
| 4. Family counseling      |   |
| 5. Physician services     |   |

An ideal SAIOP has variable lengths of stay and reduces each participant's frequency of attendance as recovery becomes reliably established and the individual can resume more of his/her usual life obligations. It is expected that individualized treatment plans will address the patient's specific physical, psychological, and behavioral problems, and the ramifications of the patient's abuse of drugs. A SAIOP will typically range across a continuum from 3 times a week, 3 hours per day to the equivalent of partial hospitalization.

## **5.5 Medical Necessity**

BHC determines the medical necessity of services requested and/or provided during the review process. Medical necessity is defined as services, which are:

- (1) Intended to identify or treat a diagnosable disorder that causes pain or suffering, threatens life, or results in illness as defined in the DSM-IV, manifested by impairment in functioning.
- (2) Consistent with nationally acceptable standards of medical practice.
- (3) Individualized, specific and consistent with the individual's signs, symptoms, history and diagnosis.
- (4) Reasonably expected to help restore or maintain the individual's health or to improve or prevent deterioration in the individual's diagnosable disorder.
- (5) Not primarily for the convenience of the individual, provider or another party.

- (6) Provided in the least restrictive setting that balances safety, effectiveness, and efficiency.

Medically necessary services may be reduced or eliminated based on non-clinical factors such as benefit limits, exclusions and pre-certification requirements. BHC's determinations are based on need and benefit coverage. BHC does not offer any form of incentives to its employees to encourage denials. All BHC reviewers are compensated by salary or per case flat rate without reference to the case outcomes or overall company utilization rates.

## **5.6 Clinical Criteria**

BHC utilizes written clinical criteria to determine the appropriate levels of care and the services required for both psychiatric and chemical dependency cases. These criteria are used in the determination of all review decisions unless otherwise directed by the MCO. The criteria are reviewed and updated annually to comply with current and accepted standards of care. Final authority for the approval and adoption of the clinical criteria is the responsibility of the Management Committee. Review criteria are made available to providers upon request and also maintained on BHC's web site: <http://www.behavioralhealthct.com>.

## **5.7 Response Timeframes**

All reviews are conducted according to the timeliness standards established by BHC, and consistent with applicable state and federal statutes and regulations\*. The following are BHC's established timeframes.

**BHC’s Established Timeframes**

<b>A. Precertification/Prior authorization</b>	<b>BHC</b>
<b>1. <u>Non-Urgent Care (Inpatient Partial IOP)</u></b>	
a. From receipt of all information to making a decision	1 business day
b. From making the decision to notifying the practitioner	1 business day
<b>2. <u>Non-Urgent Care (Outpatient )</u></b>	
• From receipt of all information to making a decision and Notifying the practitioner	2 business days
<b>3. <u>Urgent Care</u></b>	
a. From review request to making a decision	1 calendar day
b. From review request to notifying the practitioner	1 calendar day
c. For <b>denials</b> , from review request to notifying the practitioner <b>and</b> member	1 calendar day
d. For <b>denials</b> , from making the decision to written or electronic confirmation of the decision to practitioner <b>and</b> member	2 business days
<b>4. Expedited Review</b>	3 Hours

\*BHC complies with states that require stricter timeframes.

**5.8 Complaints/Appeals**

Providers are welcome to express concerns or suggestions for improvement in services. All complaints and comments are recorded and reviewed by BHC’s clinical and management staff. Members and providers may also appeal a clinical determination or a claim denial made by BHC. The procedure for filing an appeal accompanies any adverse determination and is included with the Explanation of Benefits form for claim denials.

**5.9 Practice Guideline**

BHC has adopted Practice Guidelines for use by network providers in providing services. The guidelines are based on clinical literature and expert consensus. Guidelines are selected for high volume or high-risk diagnoses. BHC utilizes the

American Psychiatric Association clinical practice guidelines for Major Depressive Disorders and for Substance Use Disorders.

The guideline for Major Depressive Disorders has been modified based on input from participating providers on the Performance Improvement Utilization Management Committee to include a specific timeframe for medication evaluation. For patients with moderate to severe major depression, a medication evaluation should be in place by the fourth visit. For patients with mild or moderate depression, if there is no relief from symptoms within six sessions, a medication evaluation should take place.

BHC monitors the following guidelines by outpatient treatment record reviews and by outpatient treatment reports (OTRs).

### **Major Depressive Disorders**

1. Appropriate medication evaluation or referral for medication evaluation if patient has not shown improvement within the first six sessions of treatment for major depressive disorders.
2. Patients diagnosed with depression are screened for a comorbid substance abuse disorder.

### **Substance Abuse Disorders**

1. Patients with substance use disorders should be screened for continued use.
2. Patients with substance use disorders are screened for depression.
3. Patients with substance use disorders are assessed for possible withdrawal.

## **5.10 Coordination of Care**

BHC believes that linkage with primary care physicians (PCPs) promotes continuity of care, coordination of care, increased value from the services being delivered, and broader support of the clinical issues being addressed. PCPs play an integral role especially for members who have accompanying medical problems or concerns. However, before any information regarding a member is disclosed, providers must have the member sign the consent portion of the PCP Collaboration of Care Form (**Attachment E**).

Promoting an active linkage with primary care physicians ensures that continuity and coordination of care are maximized and informs physicians of the degree of involvement of behavioral health care providers with their patients. In addition, exchanging important information will minimize the potential for adverse drug interactions resulting from the medications prescribed by the PCP and the behavioral health care provider. The exchange of information with the PCP can be accomplished through the use of the PCP Collaboration of Care Form (**Attachment E**).

All providers registering care with BHC will receive a copy of the PCP Collaboration Form along with BHC Authorization Letter and a blank Outpatient Treatment Report (**Attachment C**). The PCP collaboration form is to be completed and reviewed with the member. The member's signature in the appropriate area indicates whether or not he/she consents to the information being sent to his/her PCP at the start of care, whenever medications are prescribed or changed, and at the time of termination from treatment. If consent is granted, the Collaboration of Care Form should be completed and sent to the PCP. A copy of the PCP Collaboration of Care Form must be retained in the behavioral health record for future auditing purposes, regardless of the member's decision regarding consent. Copies of the forms listed above are in the attachment section of this manual. In addition to coordinating care with PCPs, when members are receiving care from more than one behavioral health provider, it is important that the behavioral health providers communicate with each other and coordinate care. Again, a written release of information form is required before any information can be shared with another behavioral health provider.

## **5.11 Clinical Quality Improvement Activities**

In an effort to improve the quality of clinical care, clinical services and member services, BHC has implemented the following programs:

- **Follow-up After Discharge for a Psychiatric Diagnosis:** This program supports the HEDIS effectiveness of care measure for follow-up visits after hospitalization. Within seven days of being discharged, all patients should have a follow-up visit. BHC's Care Managers collaborate with facilities and

practitioners to see that each patient has a scheduled appointment prior to discharge.

- **Depression Education Program/Antidepressant Medication Management:**

This program supports the HEDIS effectiveness of care measure for antidepressant medication management. Patients that are newly diagnosed with a depressive disorder should stay on medication for the prescribed amount of time (typically 6 to 12 months). In addition, these patients should be seen at least three times during the acute treatment period (1<sup>st</sup> 12 weeks).

## **5.12 Treatment Record Reviews**

BHC has adopted the NCQA Treatment Record Review Guidelines and will be conducting treatment record reviews of high volume practitioners.

These guidelines are widely known and used in the healthcare community.

Results from these reviews will be shared with providers on an individual and on an aggregate basis.

## **5.13 Required Standards for Treatment Record Documentation:**

### **Chart Format/Treatment Record Structure**

- 1) All pages contain the patient's name and/or ID number.
- 2) The record includes the patient's address, employer or school, home, and work numbers, including emergency contacts, marital/legal status, appropriate consent forms, and guardianship information, if relevant.
- 3) All entries include the responsible clinician's name, professional degree, and relevant identification number, if applicable.
- 4) All entries are dated.
- 5) The record is legible to someone other than the writer.
- 6) Allergies and adverse reactions are clearly documented.

- 7) A lack of known allergies and sensitivities to pharmaceuticals and other substances is prominently noted.
- 8) Records for relevant former psychiatric/chemical dependency/medical care are in the patient chart.
- 9) Canceled appointments and no shows are documented.

### **Assessment And Evaluation**

- 1) Relevant medical conditions are listed, prominently identified and revised.
- 2) Presenting problems and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
- 3) Special status situations, such as imminent risk of harm, suicidal ideation or significantly compromised ability to perform ADLs are documented and revised in compliance with written protocols.
- 4) A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
- 5) For children and adolescents – Parental and perinatal events and a complete development history (physical, psychological, social, intellectual and academic) is documented.
- 6) For patients 12 and older – Documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
- 7) There is an evaluation summary by the current treating clinician which contains a formulation of the problem and premorbid functioning baseline, using standardized functioning rating scales and a generally accepted Mental Status Exam format.

- 8) A mental exam status exam documents the patient' affect, speech, mood, thought content, judgement, insight, attention/concentration, memory and impulse control.

### **Treatment Planning**

- 1) The treatment plan is in place by the third session and consistent with the diagnosis.
- 2) The plan includes a statement regarding intensity of service needed.
- 3) A DSM-IV diagnosis is documented, consistent with the presenting problems, history, Mental Status Exam, and/or other assessment data.
- 4) The treatment plans are consistent with diagnoses, and they have objectives, measurable goals and estimated time frames for goal attainment and problem resolution.
- 5) The focus of treatment is consistent with the treatment plan goals and objectives.
- 6) Progress notes describe the patient's strengths and limitations in achieving treatment plan goals and objectives.
- 7) Patients who become homicidal, suicidal, or unable to conduct ADLs are promptly referred to the appropriate level of care.
- 8) The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.
- 9) The medication record includes rationale for use/choice.
- 10) The record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescriptions and refills.
- 11) Informed consent for medication and the understanding of the treatment plan is documented.

### **Continuity and Coordination of Care**

- 1) The treatment record reflects continuity and coordination of care between the primary clinician, consultants, ancillary providers, the patient's PCP, with other Behavioral Health practitioners (if applicable) and healthcare institutions.
- 2) The treatment record documents preventive services as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources and referral for education courses.
- 3) There is a completed PCP Collaboration Form or equivalent documentation present in the treatment record.
- 4) Contacts with the PCP are noted.

### **During Treatment Record Reviews, BHC will also Monitor Site /Provider Accessibility, including the Following:**

- 1) There is 24-hour on call coverage that includes an answering service.
- 2) There is 24-hour on call coverage that includes a referral system for emergencies and a physician available by phone.
- 3) There are time slots blocked out each day for urgent visits and/or a referral system in place to accommodate such needs.
- 4) Routine care is available within 10 working days
- 5) The average office wait time is less than 20 minutes.

## **5.14 Provider Satisfaction Survey**

Provider satisfaction with BHC is measured on an annual basis and specifically measures various aspects of providers' satisfaction with the care management process. All results are reported to the PI/UM Committee and to providers and are used to incorporate changes into daily operations as well as more global programs and initiatives.

## **5.15 Program Evaluation**

The Utilization Management and Quality Management Plan is formally reviewed and evaluated annually by the PI/UM Committee. Recommendations for revisions are reviewed with the Management Committee for final approval. All other activities are evaluated as they occur by the PI/UM Committee for relevancy and effectiveness. Changes in UM procedures are made as necessary.

## **SECTION VI: CLAIMS PROCEDURES**

### **6.1 Claim Submission**

Claims for services provided to Hartford Hospital PPO members should be submitted directly to BHC at:

Behavioral Health Connecticut  
P.O. Box 775  
Middletown, CT 06457

Inquiries regarding the status of these claims should be made to:  
BHC at 1-800-741-4443.

Claims for outpatient services provided by non-facility-based clinicians must be submitted on the National Industry Standard Claim Form (HCFA 1500). The Uniform Billing Form (UB-92) must be used for acute and sub-acute institutional services, including inpatient, detoxification, residential, 23-hour observation, partial hospital and intensive outpatient services. Traditional outpatient services provided through a hospital clinic may be billed on either a HCFA 1500 or an UB-92 form. Detailed guidelines concerning completion of both the HCFA 1500 and the UB-92 form can be found in the following sections along with policies and procedures applicable to all commercial plan claims. In general, please note the following:

1. A separate claim form must be submitted for each patient containing all of the required elements.
2. Each line item can include no more than two dates of service for the same procedure code (does not apply to facility claims).
3. All claims must be submitted in a timely fashion, consistent with the Participating Provider Agreement. Claims that are not submitted within the contracted filing limits will not be considered for reimbursement.

## **6.2 Member Held Harmless**

BHC's Participating Provider Agreement lists your reimbursement rates for contracted services by CPT and/or Revenue Code. Providers are required to collect applicable co-insurance, co-payments and deductibles from the member at the time of service. BHC reimburses you at a rate equal to the contracted reimbursement rate, negotiated rate or your customary (billed) charge (whichever is less), less any applicable co-insurance, co-payment and/or deductible amount. Providers may not bill members for services paid for by BHC beyond the amounts referenced above or for any non-authorized services which are covered under a member's benefit plan when appropriate authorization is requested. This practice, known as "balance billing", is specifically prohibited under the Participating Provider Agreement and may result in Provider sanctions.

Members may contract with their Provider to self-pay for services not covered under their health benefit plan or for services not meeting medical necessity criteria. However, such agreements must be in writing between the member or his/her guardian and the Provider.

## **6.3 Member Eligibility**

Providers are responsible for and are strongly encouraged to verify a member's eligibility prior to providing an initial service and/or submitting a claim. It is recommended that you verify eligibility while you are registering outpatient treatment or obtaining an initial authorization for acute/sub-acute facility care. BHC's Customer Service Department (800-741-4443) can provide you with this information and/or facilitate obtaining verification. Claim payment is based upon the member's eligibility at the time the service is rendered. It should be noted that neither prior verification of eligibility nor authorization of care by BHC are guarantees of payment.

## **6.4 Claims Turnaround Time**

BHC will process and pay a clean claim (complete, error-free claim) within forty-five (45) days of receipt. All other claims will be adjudicated within thirty (30) days from the receipt date. Per Connecticut State law, interest at a rate of 15% per annum will be applied to claim payments exceeding these timeframes.

## **6.5 Claim Filing Limit**

Claims for outpatient care must be submitted within ninety (90) days of the date of service to be considered for reimbursement.

Claims for facility-based acute and sub-acute care must be submitted within ninety (90) days of the discharge date to be considered for reimbursement. Split billing is accepted. However, the split bill must be submitted within ninety (90) days of the last date of service on the claim.

Claims involving Coordination of Benefits (COB), in which the plan managed by BHC is secondary, must be submitted within ninety (90) days after the Provider receives an explanation of benefits from the primary payer (see Section 6.9).

Claim filing limits are specifically stated in the Participating Provider Agreement. The time limits referenced above are standard limits of the Agreement and may, at times, differ from those stated in your Participating Provider Agreement with BHC as a result of term negotiations. In such circumstances, the time limits stated in your contract will prevail.

## **6.6 Missed Appointment Policy**

An authorization for treatment issued by BHC does not authorize payment for missed appointments. Claims for missed appointments will be denied. Providers may bill members for missed appointments only if the member has agreed in writing at the start of treatment to pay out of pocket for missed appointments.

## **6.7 Diagnostic Interview Examination**

A diagnostic interview examination (CPT Code 90801 or 90802) will be reimbursed only when the evaluation is done during the first session with a new member.

## **6.8 Maximum Visits Per Day**

BHC-administered plans only provide benefits for one professional service per day except for the following:

1. Outpatient psychotherapy with a non-psychiatrist and medication management with a psychiatrist provided on the same day.
2. Outpatient psychotherapy and pre-authorized psychological testing provided on the same day.
3. Intensive outpatient services billed in an unbundled format.

## **6.9 Secondary Coverage/Coordination of Benefits**

BHC applies the National Association of Insurance Commissioners (NAIC) model for determining order of coverage (primary and secondary) when processing claims involving more than one insurance plan. In accordance with Connecticut Regulation 38A-480-1 through 554-6, BHC applies the standard COB (100% COB Allowance) when coordinating benefits with other group coverage. Under this provision, BHC will calculate the plan's normal benefits based upon the primary plan's fee arrangement.

The Provider must exhaust all avenues of other insurance coverage and payment prior to billing for covered services. 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 HCFA 1500 claims submission. An EOB is not required when billing on an UB-92, however, fields 50,54, 58b and 58c must denote the disposition of the claim from the other insurance carrier.

Claims involving COB will require medical review and authorization. In order to expedite payment, Providers are strongly encouraged to obtain clinical authorization for care from both the primary insurer and BHC at the time of treatment.

Claims involving COB in which a BHC-managed plan is the secondary coverage must be submitted to BHC within 90 days of the date of remittance from the primary payer.

## **6.10 Incomplete Claims**

Claims will be denied and returned due to invalid or incomplete required data elements. The provider will be notified via letter outlining the fields requiring completion or correction. The original claim will accompany the letter. The denied claims will also appear on the Provider's remittance advice.

The required data elements for both HCFA 1500 and UB 92 forms are listed in Section 6.15 and 6.16 below.

## **6.11 Resubmission of Claims Denied as Incomplete**

To receive reimbursement for claims denied as incomplete, the Provider must resubmit the claim with the identified fields corrected or completed. Claim filing limits will be met if:

1. The date of first submission is within 90 days of the date of service (date of discharge for facility care); and,
2. The date of resubmission is within 90 days of the date of first denial.

Providers must include the number of the initially denied claim on the resubmitted claim. This will document that its original submission met the filing limit and will apply the appropriate timeframe for payment. Submit the claim number in:

- ◆ Box 19 on the HCFA 1500 Form
- ◆ Box 37a on the UB 92 Form

## 6.12 Reconsideration of Paid Claims

A Provider may request reconsideration of a claim thought to be paid incorrectly by submitting a completed Claim Reconsideration Form within 90 days of the date the claim was paid. This does not apply to claims that have been denied (see Section 6.13). Incomplete Claim Reconsideration Forms will not be processed. Completed forms may be either mailed or faxed to BHC accompanied by a copy of the remittance advice page showing the original payment. Any adjustment in payment will be reflected in and applied to the next weekly payment cycle following processing.

## 6.13 Claim Inquiries and Complaints

A Provider with a claim inquiry (seeking information concerning the status of a submitted claim, an explanation of a paid claim or clarification of a claim denied for administrative reasons) should contact BHC through the toll free Provider Line at 800-741-4443. BHC's representatives will research the inquiry and provide a response/answer immediately, or refer the inquiry to the BHC Claims Department for further investigation. In the latter case, the Provider will receive a telephonic response within three business days.

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

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

Complaint letters must be accompanied by the corresponding denial letter or remittance and must be submitted to BHC within 90 days of the timely filing limit for the denied services. (Refer to Section 6.5 above for the timely filing limit.) BHC may

request additional information before rendering a decision. The Provider will be notified in writing of the final decision within 30 days from receipt of all required documentation.

## 6.14 Billing Codes

The following is a listing of the most commonly used CPT Codes and UB 92 Revenue Codes accepted by BHC. Please note that coding may vary by Provider and/or service level. Therefore, it is recommended that you refer to your Participating Provider Agreement for coding specific to you or your facility. Claims submitted with codes other than those listed on the rate schedule of your Agreement will be rejected. If you have questions concerning coding, it is recommended that you call BHC's Provider Relations Line at 800-741-4443 prior to submitting a claim.

### HCFA 1500 - Professional Ambulatory Codes

CPT Code	Description
90801	Diagnostic Interview <sup>1</sup>
90802	Diagnostic Interview – Interactive – Child <sup>2</sup>
90804	Individual Therapy - (20-30 min.)
90805	Individual Therapy w/ Med Management (20-30 min.)
90806	Individual Therapy (45-50 min.)
90807	Individual Therapy w/ Med Management (45-50 min.)
90811	Individual Therapy w/Med Management- Interactive - Child (20-30 Min.) <sup>2</sup>
90813	Individual Therapy w/Med Management- Interactive - Child (45-50 Min.) <sup>2</sup>
90846	Family Therapy without patient
90847	Family Therapy with patient
90849	Multi-family Therapy
90853	Group Therapy
90862	Psychopharmacology Management
96100	Psychological Testing
99222	Inpatient visit - 1st day <sup>4</sup>
99232	Inpatient visit – Subsequent days <sup>4</sup>
9925x	Hospital Consultation - Initial <sup>3</sup>
9926x	Hospital Consultation - Subsequent <sup>3</sup>
9930x	Nursing Home Evaluation
9931x	Nursing Home Subsequent

Notes:

<sup>1</sup> - Does not apply when Inpatient, PHP or IOP services are provided by the same facility within 10 days of the evaluation.

<sup>2</sup> - Applies to children through age 12.

<sup>3</sup> - Hospital consultations are defined as psychiatric evaluations and treatment of patients hospitalized on medical/surgical units who have co-morbid behavioral health symptoms.

<sup>4</sup> Does not apply to services provided in a facility with an all-inclusive contracted per diem rate.

### **UB-92 - Facility Codes**

#### Psychiatric Services

<b>Service</b>	<b>UB-92 Revenue Code</b>
23-hour Observation Bed	762
Inpatient Treatment	114, 124, 134, 154
Sub-Acute	100
Partial Hospital	912, 913
Structured Outpatient	905
Individual Therapy	914
Group Therapy	915
Family Therapy	916

#### Substance Abuse Services

<b>Service</b>	<b>UB-92 Revenue Code</b>
23-hour Observation Bed	769
Inpatient Detox (Level IV)	116, 126, 136, 156
Partial Hospital	911
Structured Outpatient	906
Group Therapy	915

#### Ambulatory Services

<b>Service</b>	<b>UB-92 Revenue Code</b>
Institutional Outpatient	513, HCPCS or CPT

## **6.15 HCFA 1500 Claim Form Instructions**

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

at [www.medicaretraining.com](http://www.medicaretraining.com). The following is a summary of the HCFA-1500 Claim Form required fields and descriptions:

- Box 1. NOT A REQUIRED FIELD Check the box that corresponds to the program name of the member. The box for “OTHER” would be most appropriate for BHC-managed accounts.
- Box 1a. Print the member’s identification number.
- Box 2. Print the patient’s full name – last name first, first name second, middle initial last.
- Box 3. Print the patient’s birth date, and check the box that corresponds to the patient’s gender.
- Box 4. Print the subscribing member’s full name – last name first, first name, then middle initial.
- Box 5. Print the patient’s address.
- Box 6. Check the box that corresponds to the patient’s relationship with the member.
- Box 7. Print the subscribing member’s address.
- Box 8. NOT A REQUIRED FIELD Check the boxes that correspond to the patient’s marital and employment status.
- Box 9. If the member is covered by another health insurance company, the name of that carrier should be indicated. If there is no other coverage, please indicate “none” or leave blank.
- Box 9a. Print the identification number corresponding to the health insurance company if you know it.
- Box 9b. Print the other insured’s date of birth and check the appropriate box for gender if you know it.

- Box 9c. Print the employer name or school name of the other insured (if known).
- Box 9d. Print the insurance plan name or program name of the other insured (if known).
- Box 10. Check the box that corresponds to the nature of the injury: -----  
a. employment, b. auto accident or c. other accident or check “no”
- Box 10d. NOT A REQUIRED FIELD Reserved for local use.
- Box 11. Print the insured’s group policy or FECA number.
- Box 11a. Print the insured’s date of birth and check the appropriate box for gender.
- Box 11b. Print the employer name or school name of the insured.
- Box 11c. Print the insurance plan name or program name of the member.
- Box 11d. Check the appropriate box; if the answer is yes, please complete boxes 9a – 9d.
- Boxes 12 and 13. Complete these boxes to accept assignment of reimbursement. The member’s signature is not required when the physician or health care provider rendering medical services is participating. To receive direct reimbursement for covered services rendered to members, the phrase “signature on file” must be placed in these boxes. The member’s actual signature must be obtained and kept in the physician/health care provider’s records
- Box 14. NOT A REQUIRED FIELD
- Box 15. NOT A REQUIRED FIELD
- Box 16. NOT A REQUIRED FIELD Unless the patient has been disabled and is unable to return to work for any period of time.
- Box 17. NOT A REQUIRED FIELD

- Box 17a. NOT A REQUIRED FIELD
- Box 18. Print the admission and discharge dates for services related to a hospitalization.
- Box 19. Required only for resubmission of claims initially denied as incomplete. Insert claim number associated with initial denial.
- Box 20. Check the appropriate box if an outside lab was utilized. Charges made to the physician by the lab should be indicated.
- Box 21. Print diagnosis (ICD-9) codes which relate to box 24, line items 1 through 6. A maximum of 4 diagnosis codes can be indicated. A description of the ICD-9 codes is not necessary.
- Box 22. NOT A REQUIRED FIELD Not used.
- Box 23. NOT A REQUIRED FIELD Print the prior authorization number.
- Box 24a. To indicate date(s) of service, follow these guidelines:  
Individual dates must be listed separately within the body of the claim form. The date of service requires six positions, listed in the following order: month, day and year. Multiple services provided on the same date must be listed on the same claim form.
- Box 24b. Print the appropriate place-of-service code.
- Box 24c. Print the appropriate type-of-service code.
- Box 24d. Print the appropriate CPT or HCPC codes and modifiers, as applicable. Refer to the CPT coding manual. If a description of service is necessary, please attach it to the red HCFA-1500 claim form upon submission.
- Box 24e. Print the appropriate diagnosis code, using ICD-9 diagnostic codes. You may also print 1, 2, 3 or 4 or any combination to cross reference a

code indicated in box 21. The numbers must be separated by a comma.

- Box 24f. Print your actual charge for the services being rendered. Do not print the fee schedule amounts.
- Box 24g. Print the number of days or units for which the service was provided.
- Boxes 24h, 24i & 24j. NOT REQUIRED FIELDS.
- Box 25. Print the number under which you report your earnings, and check the appropriate box that identifies whether it is a federal tax identification number or your social security number.
- Box 26. NOT A REQUIRED FIELD Use of this box is for the medical office's use only.
- Box 27. Please check the appropriate box for assignment.
- Box 28. Print the exact amount of total charges for all services listed on the claim form. Procedures for which there is no charge should not be indicated on the claim form.
- Box 29. NOT A REQUIRED FIELD Print the exact amount paid by the patient.
- Box 30. NOT A REQUIRED FIELD Print the exact amount of any balance due to the physician or health care provider.
- Box 31. The personal signature of the person who has provided medical care is always required. This applies for both participating and non-participating physicians and health care providers.
- Box 32. If services were rendered in a location other than the patient's home or the physician or health care provider's office, print the name and address of the facility (otherwise leave blank).

- Box 33. Print the physician or health care professional's name, address and 13-digit provider identification number.
- ◆ The name and corresponding information for the specific physician or health care provider who rendered the service should be listed.
  - ◆ If a group of physicians or a corporation is involved, the physician or health care provider's name should be printed on the first line, and the name of the group on the second line.
  - ◆ If the provider of service(s) practices in multiple office locations, the appropriate office address where services were rendered should be listed.

## 6.16 UB-92/HCFA 1450 Claim Form Instructions

Claims for facility-based services and programs must be filed on a properly and accurately submitted paper UB-92 claim form with the entries completed that are deemed to be mandatory by the National Uniform Billing Committee. A downloadable training program on how to complete the form can be obtained through the HCFA Web site at [www.hcfa.gov](http://www.hcfa.gov) or at [www.medicaretraining.com](http://www.medicaretraining.com). The following is a summary of the UB-92/HCFA-1450 Claim Form required fields and descriptions.

- Box 1. Enter the name of the facility submitting the bill and the complete billing address and telephone number.
- Box 2. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 3. NOT A REQUIRED FIELD Enter the unique number assigned by the Facility for the Patient.
- Box 4. Enter a valid 3-digit Type of Bill code, which provides specific information about the services rendered.

- Box 5. Enter the nine-digit Employer Identification Number (EIN) for the Provider indicated in box 1 assigned by the Internal revenue Service (IRS).
- Box 6. 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.
- Box 7. NOT A REQUIRED FIELD Enter the number of inpatient days covered for the billing period noted in Field 6.
- Box 8. NOT A REQUIRED FIELD Enter the number of inpatient days not covered by the primary payer.
- Box 9. NOT A REQUIRED FIELD Enter the number of the inpatient Medicare days occurring after the 60<sup>th</sup> day and before the 91<sup>st</sup> day in a single episode.
- Box 10. NOT A REQUIRED FIELD Enter the number of lifetime reserve days used during the billing period noted on the claim.
- Box 11. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 12. Enter the Patient Name (Last, First Name, and Middle Initial).
- Box 13. Enter the complete mailing address of the Patient. Include the street number and name, post office box or rural route number and apartment number if applicable, city, state and zip code.
- Box 14. Enter the Patient's Date of Birth in MMDDYY format.
- Box 15. Enter the sex of the Patient.
- Box 16. Enter the marital status of the Patient on the date of the admission.
- Box 17. Enter the original date the Patient was admitted for care in MMDDYY format.

- Box 18. Enter the admission hour in Military Standard Time (e.g., 00:00 to 24:00), if applicable.
- Box 19. NOT A REQUIRED FIELD Enter the admission type if applicable.
- Box 20. NOT A REQUIRED FIELD Enter the appropriate Admission Source Code.
- Box 21. NOT A REQUIRED FIELD Enter the hour at which the Patient was discharged from inpatient care if applicable.
- Box 22. Enter the appropriate code indicating the Patient's disposition as of the ending date of service for the period of care.
- Box 23. NOT A REQUIRED FIELD Enter the number assigned by the Provider to the Patient's medical or health record.
- Box 24-30. NOT A REQUIRED FIELD Enter a valid Condition Code, if applicable.
- Box 31. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 32a,b,- NOT A REQUIRED FIELD Enter a valid Occurrence Code  
35 a,b. and date if applicable. Enter the date in MMDDYY format.
- Box 36a,b. NOT A REQUIRED FIELD Only required if an Occurrence Span Code is entered. Enter the date in MMDDYY format.
- Box 37a Required only for resubmission of claims initially denied as incomplete. Insert claim number associated with initial denial.
- Box 37 b,c. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 38. Enter the name and address of the party responsible for payment of the bill.
- Box 39a, NOT A REQUIRED FIELD Enter a valid Value Code and  
Box 41 a,b, 39b,c,d –amount if applicable.

c,d.

- Box 42. Enter the applicable revenue codes for the services rendered. There are 23 lines available and should include the total line for revenue code 0001.
- Box 43. NOT A REQUIRED FIELD Enter the corresponding description of the revenue code indicated in Field 43 lines 1-23.
- Box 44. Enter a valid HCPC or CPT procedure code for the ancillary services for outpatient or the accommodation rate for inpatient claims.
- Box 45. Enter the date the service was rendered in MMDDYY format.
- Box 46. Enter the service units for each service billed.
- Box 47. Enter the amount equal to the per unit charge to the related revenue codes billed for the statement from and through dates. This amount includes both the covered and non-covered charges.
- Box 48. Enter the total non-covered charges for the Primary Payer if applicable for each service billed.
- Box 49. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 50a,b,c. Enter the name(s) of the Primary, Secondary and Tertiary Payers as applicable. Provider should list multiple Payers in priority sequence according to the priority the provider expects to receive payment from these Payers.
- Box 51a,b,c. NOT A REQUIRED FIELD Enter your plan assigned provider number if known.
- Box 52a,b,c. Enter the appropriate code denoting whether the Provider has on file a signed statement from the beneficiary to release information. Refer to attachment for valid codes.

- Box 53a,b,c. Enter the applicable code to indicate whether the Provider has a signed form authorizing the third party insurer to pay the Provider directly for the services rendered.
- Box 54a,b,c. 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.
- Box 55a,b,c. NOT A REQUIRED FIELD Enter the estimated amount due from the Payer indicated in Field 50 lines a,b,c.
- Box 56. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 57. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 58a,b,c. Enter the Insured's Name (Last, First Name, Middle Initial).
- Box 59a,b,c. Enter the applicable code that indicates the relationship of the patient to the insured noted in Field 58.
- Box 60a,b,c. Enter the Insured's Identification number assigned by the Payer organization. Enter the Social Security Number (SSN) and the Medicaid Number if applicable.
- Box 61a,b,c. Enter the group or plan name of the Primary, Secondary and Tertiary Payer through which the coverage is provided to the insured.
- Box 62a,b,c. Enter the plan or group number for the Primary, Secondary and Tertiary Payer.
- Box 63a,b,c. NOT A REQUIRED FIELD Enter the authorization number assigned by BHC.
- Box 64a,b,c. NOT A REQUIRED FIELD Enter the applicable code, which defines the employment status code of the insured indicated in Field 50.
- Box 65a,b,c. NOT A REQUIRED FIELD Enter the name of the Primary Employer that provides the coverage for the insured indicated in Field 58.

- Box 66a,b,c. NOT A REQUIRED FIELD Enter the specific location of the Primary Insured individual identified in Field 58.
- Box 67. 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.
- Box 68-75. 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.
- Box 76. 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.
- Box 77. NOT A REQUIRED FIELD Enter a valid ICD-9 diagnosis code (including the fourth and fifth digits if applicable) for the external cause of injury, poisoning or adverse effect.
- Box 78. NOT A REQUIRED FIELD Unlabeled at this time.
- Box 79. NOT A REQUIRED FIELD Enter the corresponding code which denotes the medical coding system used to complete the claim form.
- Box 80-. NOT A REQUIRED FIELD Enter a valid ICD-9 code and date for the principal procedure performed during the period covered by the bill.
- Box 81. NOT A REQUIRED FIELD Enter additional ICD-9 codes and dates to identify and significant procedures performed during the statement from and through dates.
- Box 82. Enter the name and/or the assigned number of the licensed Physician who has primary responsibility for the Patient's care.

- Box 83. NOT A REQUIRED FIELD Enter the name and/or number of the licensed Physician other than the attending Physician who treated the Patient.
- Box 84. Enter “IOP” if billing for Intensive Outpatient Programs. Enter any additional information pertaining to the third party Payer.
- Box 85. Enter the signature of an authorized representative noting the Physician’s certification is in effect. A stamp or facsimile of the Provider’s representative signature is acceptable.
- Box 86. Enter the date the bill is submitted to the Payer organization in MMDDYY format.

**SECTION VII:**

**ATTACHMENTS**

- A            CHANGE OF ADDRESS FORM**
- B            PATIENT REGISTRATION FORM**
- C            OUTPATIENT TREATMENT FORM (OTR)**
- D            PSYCHOLOGICAL TESTING FORM**
- E            PCP COLLABORATION OF CARE FORM**



**Behavioral Health Connecticut, LLC**

**CHANGE OF INFORMATION NOTIFICATION**

<b>DATE:</b>	
<b>PROVIDER NAME:</b>	
<b>GROUP NAME:</b> (If Applicable)	
<b>ADDRESS:</b>	
<b>OFFICE PHONE NUMBER:</b>	
<b>BILLING/MAILING ADDRESS:</b> (If Different)	
<b>BILLING PHONE NUMBER:</b>	
<b>FAX NUMBER:</b>	
<b>TAX ID NUMBER:</b> (For this location) Circle One: SS# or EIN	

\*Circle One

**Replacement location?      Yes                  No      Start Date: \_\_\_\_\_**

**Add this location?          Yes                  No      Start Date: \_\_\_\_\_**

Please complete this form for each additional location and indicate whether this new information will replace or add to your present locations. For claims payment purposes, a W-9 form is required to accompany this form.

**Fax changes to: Provider Relations Department (860) 704-6212 or mail to:**

**Behavioral Health Connecticut ▪ P.O. Box 775, Middletown, CT 06457**

\*\*\*Please call Provider Relations at 800-741-4443 for additional assistance\*\*\*

Behavioral Health Connecticut  
**Patient Registration Form**

Aetna PPO Hartford Hospital Employees

**Patient Information**

Patient's ID/SS Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Group Number: \_\_\_\_\_

**Provider Information:**

Provider Name & Credentials: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider's Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_

Provider Tax ID Number: \_\_\_\_\_

Diagnosis Code (5 digit DSMIV code): \_\_\_\_\_

Medication Management Only (90801 + 90862):  Yes

Outpatient Office Visits (excluding 90862):  Yes

First Date of Visit Under This Insurance: \_\_\_\_\_

**Please note:** Psychological Testing, Intensive Outpatient, Partial Hospital and all other inpatient/facility bases services will require prior authorization. Please call for confirmation.



	Mild Severe	Moderate	<b>Modality Used:</b> Please Check	
	1 2 3 4 5 6 7 8 9 10		Cognitive <input type="checkbox"/>	<input type="checkbox"/> Interpersonal
	1 2 3 4 5 6 7 8 9 10		Behavioral <input type="checkbox"/>	<input type="checkbox"/>
	1 2 3 4 5 6 7 8 9 10		<b>Frequency (# visits per week or month)</b>	<b>Duration</b>
	1 2 3 4 5 6 7 8 9 10		*Medication Management (90862) _____	# Visits Requested with this OTR: _____
	1 2 3 4 5 6 7 8 9 10		Psychotherapy 20-30 min (90804) _____	Start Date This Auth: _____
	1 2 3 4 5 6 7 8 9 10		_____ with meds (90805) _____	Stop Date This Auth: _____
	1 2 3 4 5 6 7 8 9 10		Psychotherapy 45-50 min (90806) _____	Projected Discharge Date: _____
	1 2 3 4 5 6 7 8 9 10		_____ with meds (90807) _____	
			Family Therapy 45-50 min (90847) _____	
			Group Therapy 60-90 min (90853) _____	
			Other _____	
			*If only 90862 requested, no OTR needed. Contact BHC to register	

Provider's Signature \_\_\_\_\_ My signature confirms that I am providing the above requested services  
 Providers Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_ Revised: 01/01/02

### Guidelines for Completing the Outpatient Treatment Report [OTR]

An Outpatient treatment report (OTR) is required PRIOR to the 8<sup>th</sup> visit. An OTR is also required if additional sessions are needed beyond what has been previously authorized.

In order to be processed all areas of the OTR must be completed. Incomplete forms will be returned to the provider.

An OTR does not need to be completed for medication management visits (90862). If this is the only service being rendered, an annual registration is all that is required.

**DEMOGRAPHICS:** This information is needed to ensure that authorization is accurately provided for the specific member, provider and service location.

**Communication with PCP:** It is important that behavioral health practitioners exchange information, upon consent of the patient, with the primary care providers. We ask that you speak with your patient about the importance of all care being coordinated. If [s]he refuses to have the PCP notified, please indicate this on the OTR. We include the PCP Collaboration Form with the OTR that is mailed to you upon initial registration.

**CLINICAL STATUS:** This includes information provided in the sections titled: Assessments, Current Symptoms, Severity of Symptoms, DSM IV Diagnosis and Medication (including dosage and compliance). Updating these areas on each OTR documents ongoing treatment. This information is necessary to evaluate medical necessity.

**TREATMENT:** In order to evaluate medical necessity, requests must specify the frequency and duration of treatment. Your request must also include a specific number of sessions to be used within a specific time span. For this reason we ask you to tell us when you will begin to use the additional sessions you are requesting [Start date this authorization] and when you project completing these sessions [Stop date this authorization]. If you project that care will be needed beyond the stop date we ask you to provide the projected date of discharge.

**A new authorization should start (start date) only after the date that previously authorized visits will be used. Please note that the start date of this authorization will supercede all previous authorizations including any unused sessions.**

Example: An OTR is submitted to BHC on 1/7/02. Seven visits had been previously authorized. The 7<sup>th</sup> visit will be used on 1/14/02. The start date requested on the OTR submitted on 1/7/02 should be 1/15/02.

## Request for Psychological Testing

Please complete all fields legibly. If incomplete or illegible, the form will be returned to you.

1. Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

2. Referring Provider: \_\_\_\_\_ Tel #: \_\_\_\_\_

Provider to conduct testing: \_\_\_\_\_ Tel #: \_\_\_\_\_

3. Referral Question: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Current Diagnosis:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

5. Has an initial interview by the testing psychologist taken place? Please document findings of initial interview.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. List current symptomatology and length of time symptoms have been present.

\_\_\_\_\_  
\_\_\_\_\_

7. Has the patient been evaluated for medication? Please document results of that evaluation. If an evaluation has not occurred, indicate reason.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**8. Current Medications**

<u>Name</u>	<u>Dosage</u>	<u>Start Date</u>
_____		
_____		
_____		
_____		

**9. Previous Med Trials**

<u>Name</u>	<u>Dosage</u>	<u>Start Date</u>
_____		
_____		
_____		

**10. Current Treatment**

- Individual Therapy Provider: \_\_\_\_\_ Start Date: \_\_\_\_\_
- Medication Mgmt Provider: \_\_\_\_\_ Start Date: \_\_\_\_\_
- Group Therapy Provider: \_\_\_\_\_ Start Date: \_\_\_\_\_
- PHP/IOP Provider/Facility: \_\_\_\_\_ Start Date: \_\_\_\_\_
- Other: Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**11. Past Treatment History**

- Individual Therapy Provider: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- Medication Mgmt Provider: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- Group Therapy Provider: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- PHP/IOP Provider/Facility: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- Inpatient Facility: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_

**12. Previous Testing done:**

Provider: \_\_\_\_\_ Date of Testing: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If previous testing has not been reviewed, indicate why not: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**13. Current Testing:**

Test Name: \_\_\_\_\_ Time Requested: \_\_\_\_\_

Total # of hours requested: \_\_\_\_\_

**14. Signature** \_\_\_\_\_ **of** \_\_\_\_\_ **Requesting** \_\_\_\_\_ **Psychologist:**

**Date:** \_\_\_\_\_

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**For BHC use only:**

⊖ # of hours authorized \_\_\_\_\_

⊖ Denied. Specific reason for denial: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Denial letter to follow within one day of this notification)

**Name of MD/PhD reviewer:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Behavioral Health Connecticut, LLC  
PCP Collaboration Form**

**To be completed and sent to PCP. Copy should be retained in member's medical record for future auditing purposes.**

Patient Name: \_\_\_\_\_ PCP Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Phone: \_\_\_\_\_

Group #: \_\_\_\_\_

Date of First Visit: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Medications Prescribed by Psychiatrist/APRN: \_\_\_\_\_

Treatment Plan:

\_\_\_\_\_ Medication Management  
\_\_\_\_\_ Psychotherapy  
\_\_\_\_\_ No further treatment indicated

If you wish to call and discuss this further, please contact me at: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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**I hereby authorize** \_\_\_\_\_ to release a copy of this form to \_\_\_\_\_  
(Behavioral Health Provider) (name)

and speak over the phone about my treatment for the purpose of continuity and coordination of care. This consent will be in effect during the course of my treatment. I understand that I may revoke this authorization at any time by submitting written notification.

\_\_\_\_\_  
Patient Signature (or signature of parent/guardian) \_\_\_\_\_ date

\_\_\_\_\_  
Behavioral Health Provider \_\_\_\_\_ date

[Patient to deliver]

[Mailed]

[Faxed]

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**I do not** wish my primary care physician to be contacted regarding my treatment.

\_\_\_\_\_  
Patient Signature (or signature of parent/guardian) \_\_\_\_\_ date

\_\_\_\_\_  
Behavioral Health Provider \_\_\_\_\_ date

## **SECTION VIII:**

### **GLOSSARY OF TERMS**

**Access Line** – is BHC’s toll free number: **800-741-4443**.

**Clinical Care Manager** – is a qualified psychiatric and licensed social worker, psychiatric nurse or other clinically licensed professional who is employed by BHC to perform Case Management & Utilization functions.

**Clinical Denial** – a determination made by a BHC physician (or psychologist in the case of psychological testing) not to certify a requested mental health or substance abuse service. Denial is based on Medical Necessity.

**Complaint** – a written or telephonic statement of dissatisfaction by a Member, Member’s representative or Provider.

**Concurrent Review** – a review of Medical Necessity of current treatment at the present level of care.

**Covered Services** – are Mental Health and Substance Abuse Services that are Medically Necessary and covered as benefits under the member’s Health Plan.

**Credentialing** – is one component of the initial contracting process. Credentialing Specialists review the applications, resume and other supporting document submitted by the Provider.

**Discharge Planning** – the evaluation of a Member’s mental health or substance abuse service needs, or both. The evaluation determines the next appropriate level of care after discharge from one level of care.

**Member** – is a Covered Individual.

**NCQA** – National Committee for Quality Assurance.

**Participating Provider** – a provider who has met BHC’s credentialing and recredentialing standards and entered into a Provider Contract with BHC.

**Precertification** – a clinical decision that establishes the Medical Necessity and appropriateness of treatment with BHC’s clinical criteria prior to the beginning of mental health or substance abuse care. This process begins immediately following the provider’s evaluation and is authorized based on Medical Necessity of the requested level of care.

**Provider** – any hospital, institution, group, individual practitioner or other health care professional providing Mental Health and Substance Abuse Services.

**Utilization Review** – monitoring and evaluating Mental Health and Substance Abuse Services to determine whether such services are medically necessary.