



**Connecticut Department of Social Services
Medical Assistance Program
Provider Bulletin**

PB 2006-15

March 2006

TO: Hospitals, State Institutions and Psychiatric Residential Treatment Facilities

**SUBJECT: Connecticut Behavioral Health Partnership Transition Plan for
Authorization of Services**

This bulletin outlines the processes and serves as advance notification to hospitals and Psychiatric Residential Treatment Facilities (PRTFs) of the schedule for implementing authorizations under the Connecticut Behavioral Health Partnership (CTBHP). The CTBHP will implement authorizations for inpatient services at PRTFs and for inpatient psychiatric, substance abuse and observation bed services at hospitals **effective April 1, 2006**.

Detailed information about the new Connecticut Behavioral Health Partnership (CTBHP) was disseminated in PB-2005-76, which is available on the www.ctmedicalprogram.com website. Of particular note was the announcement that no authorization or registration would be required for any CTBHP covered services during a transitional courtesy period beginning January 1, 2006.

Providers will receive a letter for authorized services, but will not receive an authorization number at this time. **An authorization number will not be required for claim submission or payment at this time.** Additionally, the provider authorization lookup function on the EDS website www.ctmedicalprogram.com will not show these authorizations. The lookup function will be available for CTBHP inpatient authorizations once authorization numbers are issued. At a future date, providers will be notified when authorization numbers will be issued and required for claim submission. Changes or adjustments to the above will be communicated in a timely manner via Provider Bulletin.

All inpatient care at acute care hospitals and psychiatric hospitals (including observation bed services) and Psychiatric Residential Treatment Facilities (PRTFs) for HUSKY A and HUSKY B clients will be subject to the following:

New admissions:

- All new admissions on or after April 1, 2006 must be preauthorized for service. Hospitals and PRTFs will be required to call CTBHP at 1- 877-552-8247 for authorization.
- Continued stay reviews will be required for clients admitted on or after April 1, 2006.

Members admitted prior to April 1, 2006:

- For members who were admitted prior to April 1, 2006 and continue to be inpatient for dates of service on or after April 1, 2006 an authorization will be necessary for payment for dates of service on or after April 1, 2006. Providers must submit a modified review form (attached) for each member still in care on April 1, 2006. This modified review form can be faxed to CTBHP at 1-866-584-4194 between April 1, 2006 and April 15,

2006. This form will serve to provide CTBHP with initial clinical and demographic information and will document the member's continued inpatient treatment as of April 1, 2006.

- In order to receive an authorization for reimbursement, providers must call 1-877-552-8247 **on the day of discharge or by April 15, 2006**, whichever is sooner.
- Continued stay reviews will be required for stays beyond April 15, 2006.

Random Audits:

- In order to ensure compliance with the new authorization procedures, random audits of claim submissions may be conducted for the purpose of ensuring that providers are obtaining authorizations for services. Claims paid for services without authorization may be subject to recoupment.

All other CTBHP services will continue in the courtesy period, as described in PB-2005-76, until further notice.

The schedule outlined above is also posted at www.ctbhp.com. Questions about the phase in of authorizations can be directed to CTBHP at 1-877-552-8247 or www.ctbhp@valueoptions.com.

This bulletin and other program information can be found on at www.ctmedicalprogram.com. Questions regarding this bulletin may be directed to the EDS Provider Assistance Center - Monday through Friday from 8:30 a.m. to 5:00 p.m. at:

In-state toll free **800-842-8440** or
Out-of-state or in the
Local New Britain, CT area **860-832-9259**

EDS
PO Box 2991
Hartford, CT 06104





REQUEST FOR CONTINUED CARE AUTHORIZATION FOR MEMBERS ADMITTED PRIOR TO APRIL 1ST, 2006

STEP 1: PLEASE COMPLETE AND FAX TO: 1-(866)-584-4194 (Effective April 1st)

Name of clinician who filled out this form: _____

Degree and Credentials _____ Title: _____

Contact number: _____ Ext: _____

Facility: _____ Telephone Number: _____

Member Name:	
DOB:	SSN:
Medicaid/Consumer ID#:	
Actual date of Admission:	Level of Care: <i>(i.e. Inpatient, 23 Observation, PRTF)</i>

DSM IV DIAGNOSIS CODE:

AXIS I _____ AXIS II _____ AXIS III _____ AXIS IV _____ AXIS V _____

CLINICAL REVIEW: Please complete the following based on member's current clinical status:	
Mood Disturbance	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Psychosis/Hallucinations/Delusions	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Thinking, Cognition, Memory, Concentration problems	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Impulsive, reckless, aggressive behavior.	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Job, school performance problems.	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Social Functioning, relationships, marital, family problems	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Weight Loss associated with an eating disorder	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
ADL's	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Legal	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A
Substance Abuse/Dependence	<input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> N/A

None = No evidence of impairment; **Mild** = Occasional impairment or difficulties, but no interference with normal daily activities; **Moderate** = Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks; **Severe** = Currently experiencing severe symptoms, potential risk for harm to self/others, severe distress and/r disruption in daily activities; **N/A**= Impairment was not assessed – Please note use of NA may result in additional questions to ascertain this information.

Are there barriers to discharge/placement which are resulting in the need for continued inpatient care?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If so, please describe: _____	

STEP 2: Providers must call 1-877-552-8247 (1-877-55 CTBHP) on the day of discharge or by April 14th (whichever occurs first) in order to receive an authorization number for reimbursement of services.