Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2018-22**
www.ctdssmap.com **April 2018**

TO: Freestanding Behavioral Health Clinics and General Hospitals

RE: Access Requirements for Freestanding Behavioral Health Enhanced Care Clinics under the Connecticut Behavioral Health Partnership

This is notification of the general requirements for continued designation as an Enhanced Care Clinic (ECC), and of initial requirements regarding access to services.

This provider bulletin supersedes policy transmittal 2007-44, Access Requirements and Fees for General Hospitals Enhanced Care Clinics under the Connecticut Behavioral Health Partnership and policy transmittal 2007-45, Access Requirements and Fees for Freestanding Mental Health Enhanced Care Clinics under the Connecticut Behavioral Health Partnership.

ECCs must establish and maintain a centralized point of access that covers all clinic sites. ECCs must accept 100% telephonic and walk-in referrals that present during business hours and are within the clinic's scope of practice and catchment area. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. Triage must be done even if the clinic now uses the Open Access model.

Self-referrals (member or parent) during business hours must be screened on the same day that the referral is received. Referrals from individuals other than the member or parent must be screened when the clinic first has contact by telephone or face-to-face with the member or parent. The triage process must provide for diversion to a hospital-based emergency department for member that require medical management (e.g. overdose) or whose level of physical agitation would present a danger to self or others in a clinical setting. An ECC is not required to accept referrals that are 1) outside of its scope of practice or 2) outside of its catchment area.

An ECC must screen and triage all referrals, whether telephonic or walk-in, according to the following levels of clinical care:

Emergency Screening and Evaluation

Definition of Emergency Psychiatric Condition: A psychiatric or substance abuse condition manifesting itself by acute symptoms of sufficient severity (including severe distress) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate psychiatric attention may result in placing the health of the individual in serious jeopardy due to harm to self, harm to others, or grave disability.

Under circumstances in which a clinic determines as a result of a telephonic screening that a member is of sufficient risk as to require a call to 911 or an evaluation in a hospital emergency department, the provider must document why the member could not be safely evaluated in an outpatient clinic setting.

If the above conditions do not exist and the member is able to get to the ECC, arrangements must be made to evaluate the member at the ECC. Members that undergo telephonic screening and are determined by the ECC to be emergent should be directed to come to the ECC immediately. A clinician must evaluate a member who presents at the

designated ECC with an emergent condition within two (2) hours of presenting to the ECC, whether or not the member has undergone a telephonic pre-screening. Those members who are screened at primary locations during the latter part of the business day shall require an after-hour appointment in order to meet the emergent access requirement. The face-to-face clinical evaluation must occur within the required timeframe for at least 95% of emergent referrals.

ECCs that operate Department of Child and Family (DCF) or Department of Mental Health and Services (DMHAS) funded mobile crisis teams may use the infrastructure created by these contracts and may utilize these teams in the response to walk-in crisis members. However, the use of crisis teams must not interfere with the ECC's ability to meet DCF and DMHAS standards for timely response to requests for mobile crisis intervention. Services provided by crisis team staff in the clinic must be billed using routine, office-based outpatient clinic codes and are subject to the same registration requirements as routine outpatient clinic services.

Services provided by mobile crisis teams off-site are not subject to registration or to ECC timely access requirements and should be billed using codes S9484 (crisis intervention per hour) and S9485 (crisis intervention, per diem) found on the www.ctdssmap.com Web site under the Behavioral Health Clinic fee schedule.

Medicaid/HUSKY Health payments for clinic-based crisis services must be accepted as payment in full. ECCs may need to increase staffing over time to accommodate the walk-in volume while maintaining the response rate expected through the ECC contract.

Urgent Evaluation

Definition of Urgent Condition: A psychiatric or substance abuse condition of a less serious nature than those that constitute emergencies but for which treatment is required to prevent a serious deterioration in the individual's health and for which treatment cannot be delayed for more than two (2) calendar days without imposing undue risk on the individual's well-being.

Members that undergo telephonic or walk-in screening and are determined by the ECC to be urgent must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Those members who are screened at the primary site location at the end of the week (Thursday or Friday) may require a weekend appointment in order to meet the urgent access requirement. The offered appointment must be within the required timeframe for at least 95% of urgent referrals. The ECC must also make reasonable efforts to accommodate issues such as child care responsibilities or transportation limitations that might interfere with attending an urgent appointment.

Routine Evaluation

Definition of Routine Condition: A psychiatric or substance abuse condition of a less serious nature than those that constitute urgent conditions and for which a delay in treatment is unlikely to result in a serious deterioration in the individual's health and for

which treatment can be delayed for two (2) weeks without imposing undue risk on the individual's well-being.

Members that undergo telephonic or walk-in screening and are determined by the ECC to be routine must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within fourteen (14) calendar days of the screening. The offer must be within the required timeframe for at least 95% of routine referrals.

Emergent, Urgent or Routine Follow-Up Visit

Following an initial face-to-face clinical evaluation those members who are determined to be clinically appropriate to receive outpatient services must be offered a follow-up appointment within 14 calendar days of the initial evaluation. For members that require a more intensive service than outpatient, the clinic must facilitate linkage to the more appropriate service.

If timely linkage is not possible, the clinic must provide follow-up care to the member until such linkage is possible and such follow-up care shall be subject to the 14-day requirement. This 14-day requirement applies to follow-up for a medication evaluation when indicated as well as non-medical treatment services.

Transportation

When necessary, ECC's must coordinate transportation with the Medicaid Non-Emergency Medical Transportation Broker (NEMT) at 1-855-478-7350. The NEMT Broker will waive the 48 hour notice requirement for members that require emergent or urgent care.

Compliance Surveys

ECC performance related to the access requirement will be assessed by means of periodic compliance surveys. Survey methods include, but may not be limited to CT BHP web-based outpatient registration, mystery shopper calls, and claims payment data. All ECCs must use the web-based registration system. On-site reviews and other methods for monitoring performance may be used at the discretion of CTBHP.

No Shows – Missed Appointments

Members who miss the scheduled initial appointment and call back should be treated as new referrals and thus are excluded from the timeliness calculations. Members that miss the follow-up visit will be included in the timeliness calculations.

Documentation

ECC's must maintain documentation to support data submitted using the web-based outpatient registration system and documentation to support that care practices are consistent with policies and procedures related to enhanced care clinic requirements. ECCs must also maintain documentation of all referrals and the disposition of those referrals including but not limited to: date of first contact, dates of the appointments offered for the initial face-to-face clinical evaluation and the first follow-up visit, date of first face-to-face evaluation, date of psychiatric evaluation, if provided, date treatment began, service end date, and reason for discharge.

If the psychiatric evaluation is deferred, proper documentation for deferment must be noted in member chart.

Extended Hours of Operation

Each ECC primary site must be open for business for at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. ECCs may meet this requirement with early morning, weeknight or weekend hours. For clinics that do not maintain routine weekend business hours, weekend hours must be offered on an as needed basis to accommodate members with scheduling constraints. This includes members who are triaged as urgent following an initial screening. If the two (2) calendar day requirement results in the need for a weekend appointment, such an appointment shall be scheduled. Secondary sites are exempt from the extended business hour requirements.

After Hours Coverage

ECCs must have an answering service or a clinician on call to respond to calls outside of normal business hours.

If the call is received by the answering service and the caller is not in crisis, the answering service will direct the caller to call back during normal business hours. If the caller is in crisis, the answering service must provide the caller with telephonic access to a clinician on-call, whether the caller is an existing member or a new member.

Members whose needs are assessed by the clinician on call to be routine will be directed to call back during normal business hours. Members whose needs are assessed to be urgent must be offered an urgent access appointment to take place within the following two (2) calendar days. The clinician on-call must have access to a schedule of urgent visit appointment slots available during the following two (2) calendar days. Members whose needs are assessed to be emergent should be handled according to the ECC's extended hours of operation emergency protocol. A clinician must evaluate a member who presents with an emergent condition within two (2) hours of presenting to the on-call clinician, whether or not the member has undergone a telephonic pre-screening.

Expansion in Service Volume

An ECC's compliance with requirements pertaining to timely access may be suspended by the CT BHP during any year in which there is an increase in the ECC's service volume (based on unduplicated users) over the previous year's volume of more than 20%.

Fee Schedule

Providers can obtain further information regarding the CT BHP covered services, fees and authorizations by going to: www.ctbhp.com.

Responsible Unit: DSS, Division of Health Services, Integrated Care Section, Maureen Reault, (860) 424-5843

Date Issued: April 2018