State of Connecticut
Department of Social Services
Medical Care Administration
25 Sigourney Street
Hartford, CT 06106-5033

PB 2007-45

Policy Transmittal 2007-09
June 2007

Contact: Ondria Lucky
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Michael P. Starkowski
Commissioner

June 1, 2007
Effective Date

TO: **General Hospitals and Managed Care Organizations**

SUBJECT: **Access Requirements and Fees for General Hospital Enhanced Care Clinics under the Connecticut Behavioral Health Partnership**

The purpose of this bulletin is to notify Enhanced Care Clinics of general requirements for continued designation as an Enhanced Care Clinic (ECC), of initial requirements regarding access to services and of ECC fees. ECCs must be able to demonstrate compliance with the requirements outlined in this transmittal no later than September 1, 2007.

ACCESS REQUIREMENTS

A. Centralized Point of Access, Screening and Triage Protocols

ECCs must establish and maintain a centralized point of access that covers all clinic sites. ECCs must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine.

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 clients 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. See Attachment, Charts 1-2.

An ECC is not required to accept referrals that are 1) outside of its scope of practice or 2) outside of its catchment area. The scope of practice for general hospital outpatient clinics that operate under DPH licensure of the hospital will depend on whether the clinic is staffed to provide adult or child services and psychiatric or substance abuse services.

An ECC must screen all referrals, whether telephonic or walk-in, according to the following levels of clinical need and triage clients to achieve the specified response times.

1. 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 lay person, 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 client 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 client could not be safely evaluated in an outpatient clinic setting.

If the above conditions do not exist and the client is able to get to a clinical setting, arrangements must be made to evaluate the client at the ECC. Clients 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 client who presents at the designated ECC with an emergent condition within two (2) hours of presenting to the ECC, whether or not the client has undergone a telephonic pre-screening (See Attachment, Chart 3). The face-to-face clinical evaluation must occur within the required timeframe for at least 95% of emergent cases that present at the ECC.

General hospital outpatient clinics must also provide same day access to a psychiatric medical professional (MD or APRN) for emergent care clients when a psychiatric medication evaluation is clinically indicated.

ECCs that operate DCF or 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 clients. 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.

CT BHP 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 state contract.

2. 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) days without imposing undue risk on the individual's well-being.

Clients 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. 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. Attachment, Chart 4 illustrates client flow for urgent referrals.

Within the first two (2) years of operations, the CT BHP will establish a requirement that a specific percentage of ECC clients who are determined by the ECC to be urgent attend an appointment within two (2) calendar days. DSS and DCF shall submit the proposed percentage to the CT BHP Oversight Council for review and comment prior to establishing the percentage as a performance requirement.

General hospital outpatient ECCs must also provide same day access to a psychiatric medical professional (MD or APRN) for urgent care clients when a psychiatric medication evaluation is clinically indicated.

3. 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.

Clients 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 14 calendar days of the screening. The offer must be within the required timeframe for at least 95% of routine referrals. Attachment, Chart 5 illustrates client flow for routine referrals.

Within the first two (2) years of operations, the CT BHP will establish a requirement that a specific percentage of ECC clients who are determined by an ECC to be routine attend an appointment within 14 days. The Departments will submit the proposed percentage to the CT BHP Oversight Council for review and comment prior to establishing the percentage as a performance requirement.

4. Emergent, Urgent or Routine Follow-Up Visit

Following an initial face-to-face clinical evaluation those clients 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 clients that require a more intensive service than outpatient, the clinic must facilitate linkage to the more appropriate service and such linkage must occur within the 14-day timeframe. If timely linkage is not possible, the clinic must provide follow-up care to the client until such linkage is possible and such outpatient 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. Attachment, Chart 6 illustrates client flow for these follow-up appointments.

Within the first two (2) years of operations, the CT BHP will establish a requirement that a specific percentage of ECC clients attend a follow-up appointment within 14 days. The Departments will submit the proposed percentage to the CT BHP Oversight Council for review and comment prior to establishing the percentage as a performance requirement.

5. Transportation

ECCs must coordinate with the client's HUSKY Managed Care Organization (MCO) or transportation broker, as necessary, to arrange for transportation. HUSKY MCOs waive the 48 hours advance notice requirement for clients that require emergent or urgent care. Clients should be advised to indicate that the visit is emergent or urgent at the time the client schedules the appointment with the transportation broker.

6. 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 Department's discretion.

7. No Shows – Missed Appointments

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

8. Documentation

ECCs 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 discontinuation.

B. 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 clients with scheduling constraints and those who are triaged as urgent following an initial screening. If the two (2)-calendar day requirement results in the need for a weekend appointment, then such an appointment should be scheduled. Secondary sites are exempt from the extended business hours requirement.

C. 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 shall apprise the caller of the ECC's timely access policy and shall instruct 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 client or a new client.

Clients whose needs are assessed by the clinician on call to be routine must be apprised of the ECC's timely access policy and shall be instructed to call back during normal business hours. The initial contact for such routine requests received after hours shall be the first contact that takes place with the member or parent during normal business hours.

Clients 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. Clients whose needs are assessed to be emergent should be handled according to the ECC's usual after hours emergency protocol.

D. Expansion in Service Volume

Timely access requirements may be suspended by the CT BHP for a particular ECC 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%. An initial analysis of volume will compare unduplicated users in SFY 2008 to unduplicated users in SFY 2007. Subsequent fiscal years will be compared to the immediately preceding fiscal year.

Providers can obtain further information regarding CT BHP covered services, fees, and authorization by going to the CT Behavioral Health Website: www.ctbhp.com. From this web page go to "For Providers," then to "Covered Services/Fees" or "Authorization Schedule."

Retroactive Payment

Payment for any services that have been affected by this rate increase will be adjusted accordingly during the next EDS mass adjustment cycle. The mass adjustment cycle will only adjust claims in which the billed amount is greater than or equal to the applicable updated fee.

Billing Questions

For questions about billing or if further assistance is needed to access the fee schedules on the EDS web site, contact 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 Farmington, CT area.....860-409-4500

Posting Instructions: Provider bulletins can be downloaded from the web site at www.ctmedicalprogram.com

Distribution: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by Electronic Data Systems.

Responsible Unit: DSS, Medical Care Administration, Medical Policy Section, Ondria Lucky, Policy Consultant, at 860-424-5195.

Date Issued: June 2007

Attachment

Chart 1: Screening and Triage - Telephone

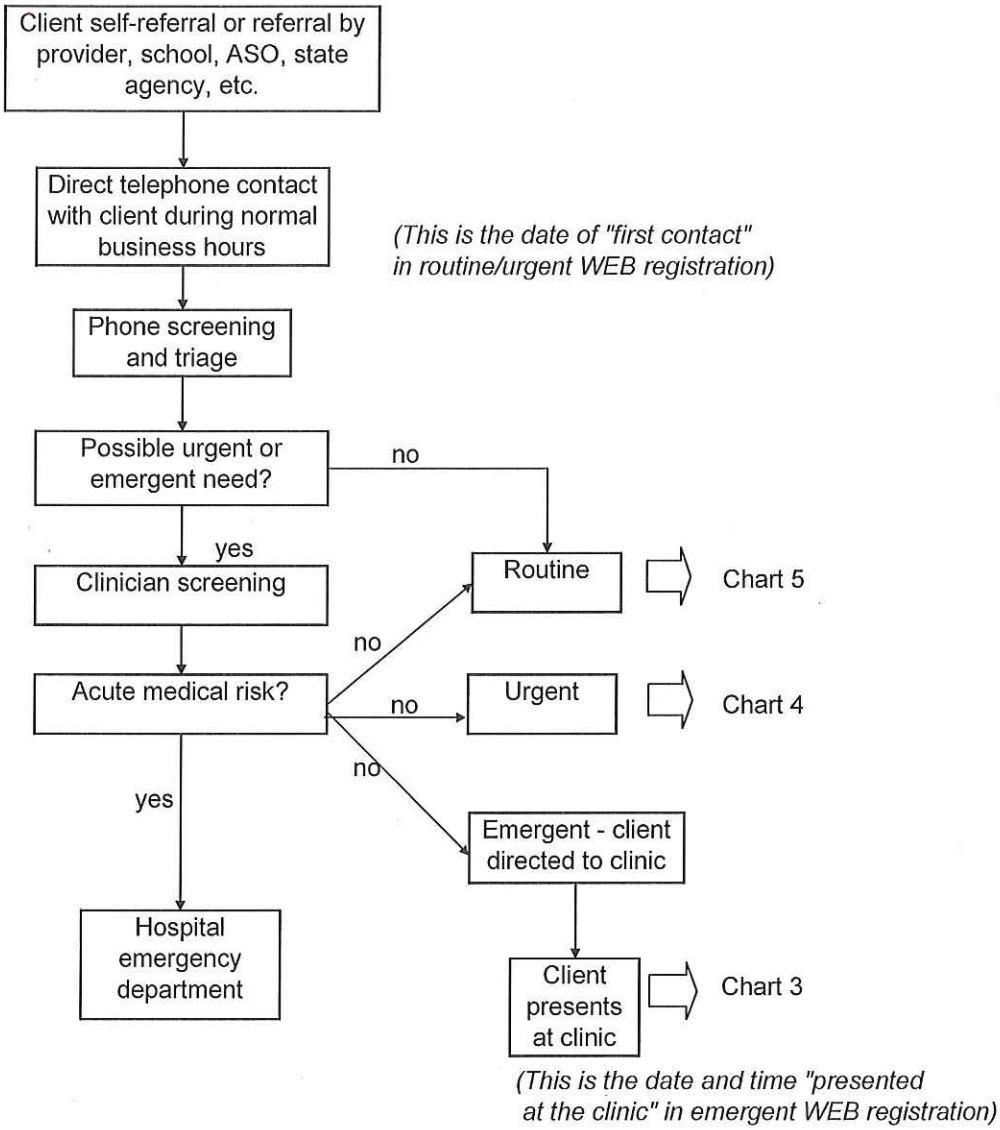


Chart 2: Screening and Triage - Walk-in

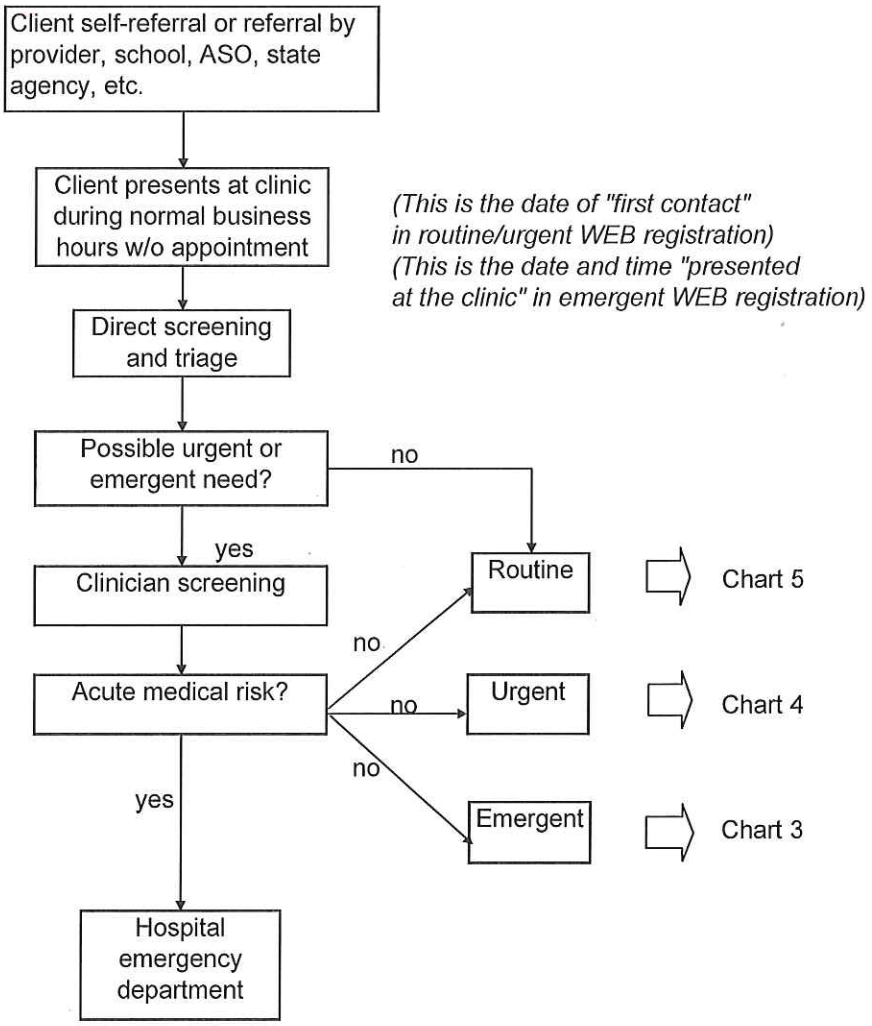
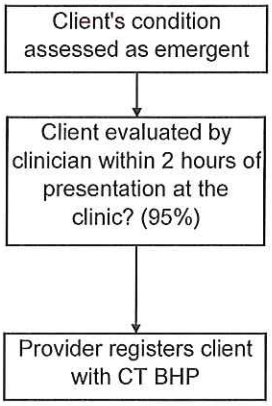
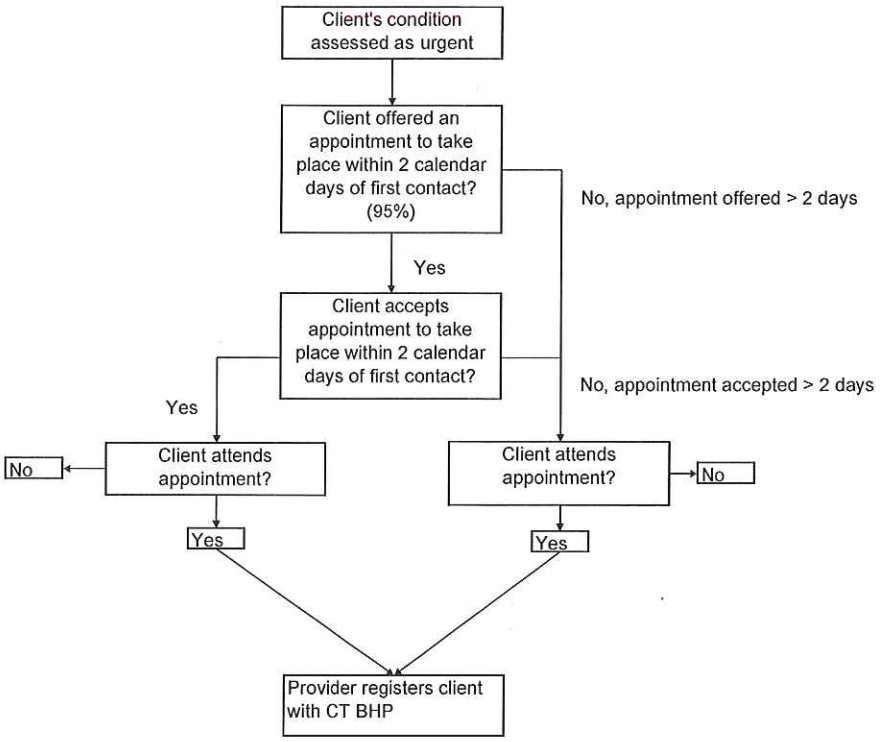


Chart 3: Emergent Condition Flow Diagram



Initial and final measure: Emergent clients seen within 2 hours/Emergent clients that presented at clinic = 95%

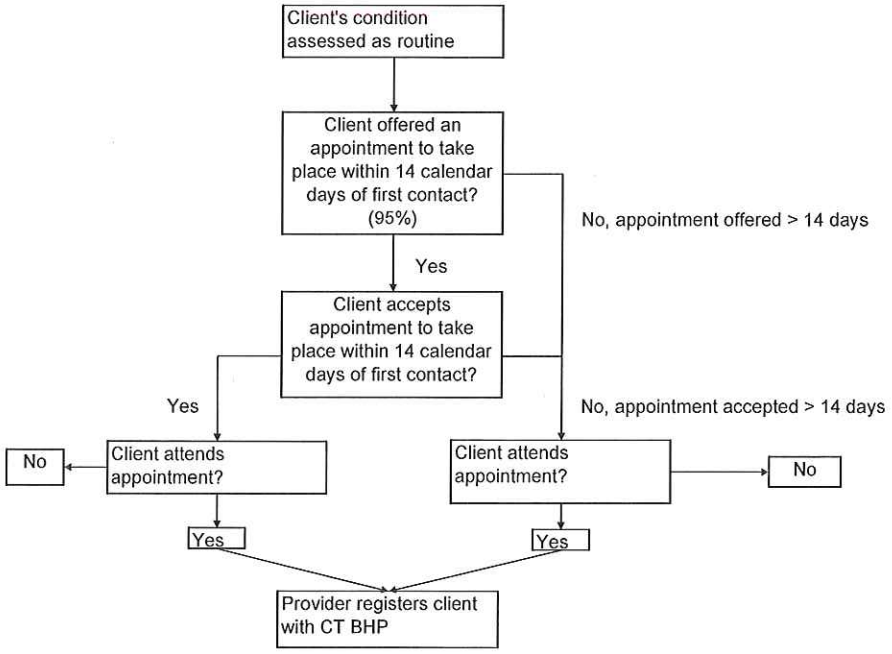
Chart 4: Urgent Condition Flow Diagram



Initial measure: clients offered appointment within 2 days of initial contact & screening/clients assessed as urgent = 95%

Final measure: client attends appointment within 2 days of initial contact & screening/urgent clients that attended appointment = TBD%

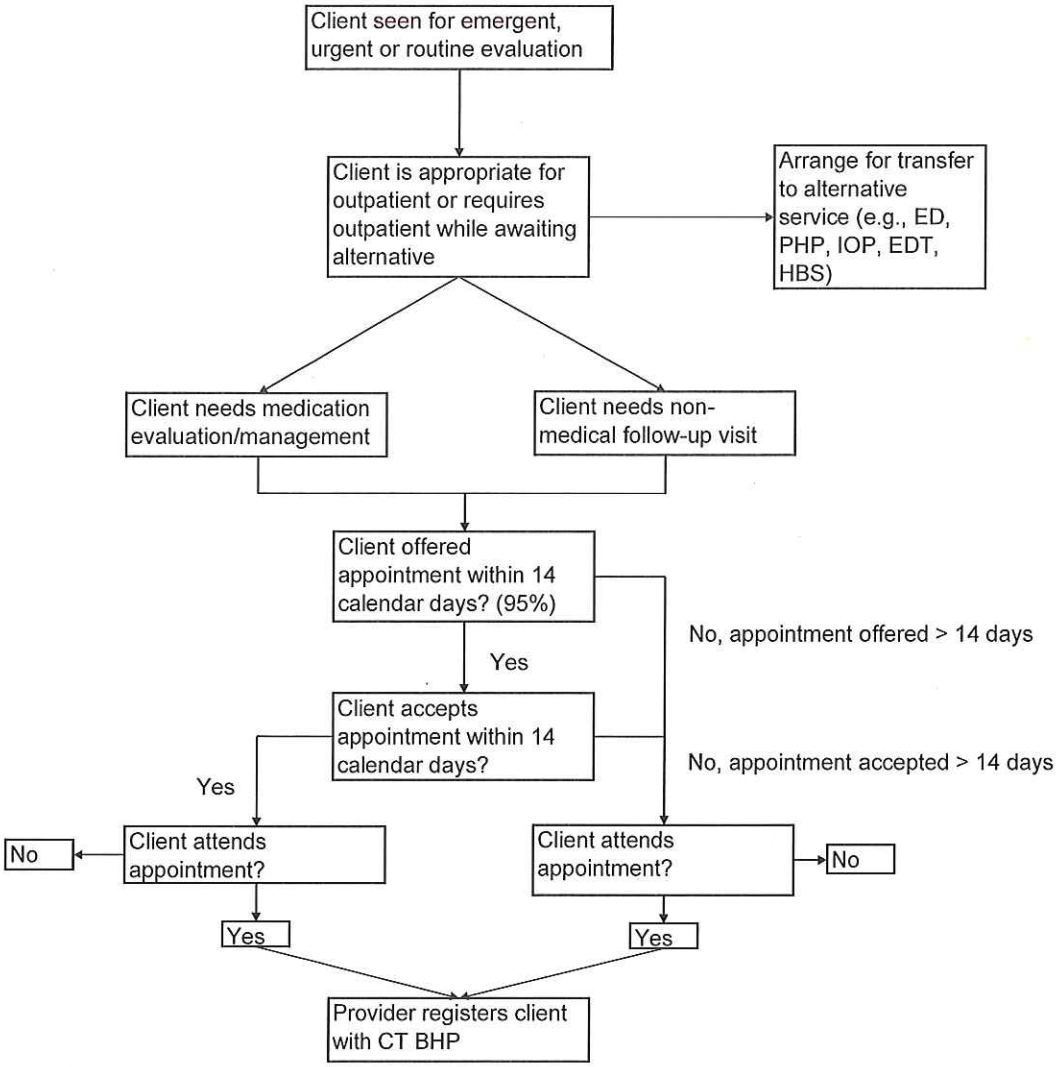
Chart 5: Routine Condition Flow Diagram



Initial measure: clients offered appointment within 14 days of initial contact & screening/clients assessed as routine = 95%

Final measure: client attends appointment within 14 days of initial contact & screening/routine clients that attended appointment = TBD%

Chart 6: Follow-up Appointment Flow Diagram



Initial measure: clients offered appointment within 14 days of initial evaluation/clients appropriate for OP f/u = 95%

Final measure: client attends appointment within 14 days of initial evaluation/clients that attend f/u visit = TBD%

Note: *Performance measures calculated separately for clients referred for medication evaluation/management f/u and those referred for routine non-medical f/u visit*