The primary vision that guided the development of the CT BHP was to develop an integrated public behavioral health service system that offers enhanced access as well as increased coordination of a more complete and effective system of community-based recovery focused services and supports.

The CT BHP’s clinical philosophy emphasizes a care management system that offers easy and timely access to the most appropriate, high quality, recovery focused mental health and/or substance use services for members. The utilization management system supports providers in delivering clinically necessary and effective care with minimal administrative burden. Both Utilization Management (UM) and Care Management (CM) activities are conducted by independently licensed behavioral health clinicians. These care managers and intensive care managers operate under the supervision of board certified, Connecticut licensed psychiatrists. Together, UM and CM provide the foundation to support providers in the delivery of high quality treatment services and supports with minimal administrative barriers.

Utilization Management (UM) is designed to ensure that CT BHP members receive the most appropriate, integrated and effective treatment—and therefore the best clinical outcomes. This is accomplished through the prospective, retrospective and concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to an individual.

Care Management (CM) is designed to ensure that those services are coordinated with and on behalf of the child, family or adult, regardless of funding streams.

Both UM and CM encompass management of care from the point of engagement through discharge. Throughout this process, our approach embraces the principles of recovery and resiliency. The recovery philosophy was endorsed by the President's New Freedom Commission on Mental Health, for people who have serious mental illness. However, it is clear that the same principles are equally important and applicable to children, families and adults. Therefore, CT BHP’s approach to care management incorporates a substantial role for Peer Specialists and includes system-wide training in the recovery philosophy for individuals and families. Peer Specialists are available to members through community organizations and to all CMAP providers for training, technical assistance and support to those organizations or providers working to embrace a recovery driven system of care. More information on this topic can be found in the Recovery and Resiliency section of this Provider Manual.

**Utilization Management Criteria**

The goal of Utilization Management (UM) is to ensure that all services that are authorized meet the Departments’ definition of medical necessity.

**Medical Necessity**

Please Note: Any and all decisions to deny a service are based on the following medical necessity definition. For purposes of the administration of the medical assistance programs by the Department of Social Services, “medically necessary” and “medical necessity” mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are
defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

The Connecticut Behavioral Health Partnership (CT BHP) uses the ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders: Third Edition (ASAM PPC-3) Published by the American Society of Addiction Medicine, Inc.

**Level of Care Guidelines**
The above standards for medical necessity and medical appropriateness of care have been translated into Clinical Level of Care Guidelines. These guidelines are based on recommendations from Connecticut clinicians with expertise in the diagnosis and treatment of people who have mental illness and/or addictive disorders and members and parents of children with behavioral health service needs. The guidelines also reflect opinions of national experts, citations from standard clinical references and guidelines of professional behavioral health organizations. These guidelines are annually reviewed by the Beacon Health Options clinical staff. Any recommendations for changes are forwarded to the statutorily mandated Clinical Management Committee for review. Suggested changes are forwarded for review and approval to the Connecticut Behavioral Health Partnership Oversight Council Operations Sub-Committee. Any changes made to the criteria are reflected in the annual quality management program evaluation. Level of Care Guidelines can be accessed on the CT BHP website: [www.CTBHP.com](http://www.CTBHP.com). The substance use treatment guidelines that will inform medical necessity are guided by the American Society of Addiction Medicine (ASAM) criteria. The Level of Care Guidelines assists the clinicians at Beacon Health Options who are reviewing authorization requests from providers, but cannot be used to deny authorization. Denial of authorization for services is solely based on the Medical Necessity definition referenced above.

**Determining Appropriate Services**
The Care Manager reviews the member’s clinical condition and determines the most appropriate services based on medical necessity and the appropriate Level of Care Guidelines.

As part of that review process, the provider and the Beacon Health Options clinician:

- Review, discuss and evaluate physical and behavioral health information about the member that has been provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual’s clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals as appropriate;
- Consider the views and choices of the member or the member’s legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views and considers the services being provided concurrently by other service delivery systems; and
- Ensure that decisions regarding benefit coverage for children covered by CMAP are in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
In order to evaluate the appropriateness of a requested service, the Beacon Health Options Care Manager and the requesting provider review four parameters:

- Severity of condition;
- Intensity of service;
- Psychosocial, cultural, linguistic factors; and
- Least restrictive setting.

**Severity of Condition:**
The severity of current signs, symptoms, and functional impairments resulting from the presence of a psychiatric diagnosis are evaluated in determining what specified level is most appropriate at a given point in time. In addition, the presence of certain “high risk” clinical factors warrant consideration in evaluating an individual to determine his/her severity of condition. These factors include, but are not limited to:

- Repeated attempts at self-harm or aggressiveness to others, with documented suicidal or homicidal intent;
- Significant co-morbidities (e.g., psychiatric/medical; psychiatric/substance use, psychiatric/intellectual disability/developmental disability; substance use/medical);
- Coexisting pregnancy and substance use disorder;
- Medication non-adherence;
- Unstable DSM 5 or ICD-10 (*effective October 2015*) disorder;
- History of individual or family violence;
- Multiple family members requiring treatment;
- Decline in ability to maintain previous levels of functioning; or
- Significant impairment in one or more areas of functioning.

**Intensity of Service:**
The level of care authorized should match the individual’s condition, taking into consideration his or her strengths and limitations (e.g., physical, psychological, social, cognitive) and psychosocial needs. It is the expectation of the CT BHP that treatment planning throughout a course of treatment is individualized, specifically states what benefits the member can reasonably expect to receive, what actions the member is expected to take and includes discharge planning from admission. Family members of minors or of adult members, with consent, are to take an active role in all treatment and discharge planning activities.

**Psychosocial and Cultural and Linguistic Factors:**
These considerations represent factors that are either aggravating an individual’s clinical condition or need to be addressed to assure effective treatment. An inappropriate or more intensive level of care may result if the issues are not addressed.

Common stressors/barriers to progress may include:

- Primary language; Absence of services in primary language
- Psychosocial factors;
- Lack of culturally appropriate services;
- Inadequate housing or homelessness;
- Lack of effective family or social support;
- Gender-specific issues;
- Physical disability or illness;
- Recent or imminent stressors;
- Recent significant change in school or work performance;
- Inability for self-care;
- Active legal issues;
- Recent or imminent re-entry to the community; and
- Transportation access.

**Least Restrictive Setting:**
In general, people respond better to treatment and have better clinical outcomes when they can remain in their homes as an integral part of their families and community. Therefore, the Care Manager and requesting provider carefully consider whether the treatment and setting being requested is the least restrictive environment in which the most appropriate care and treatment can be safely provided.

**Working with Care Managers**

Care management is a set of activities designed to assure that services authorized by Beacon Health Options on behalf of members are integrated to certify the best clinical outcomes. CT BHP services should be coordinated with services provided through other funding streams to ensure consistency and continuity in the overall delivery of services to an individual, child and family.

All Beacon Health Options Care Managers assist with the determination of medical necessity of requested services and work with providers, members and families to coordinate services. Beacon Health Options has two different levels of Care Management: routine Care Management and Intensive Care Management. All clinicians serving in these roles are Master’s Degree trained, independently licensed behavioral health practitioners, or licensed Bachelor of Science in Nursing (BSNs) in the State of Connecticut.

**Care Management**
Care Management activities are generally web based through the secure ProviderConnect platform. Care Management is provided for recipients whose treatment needs may be acute, intermittent or chronic, but whose utilization is within expected parameters. This level of Care Management is performed as part of the process of authorizing services as the Care Manager works with the provider on treatment, discharge, aftercare and follow-up.

**Intensive Care Management**
Intensive Care Management activities include identifying children and adults who are encountering barriers to care and providing short term assistance and problem solving to eliminate those barriers. Each Intensive Care Manager (ICM) carries a caseload of 30-40 children and/or adults.

The Departments and Beacon Health Options in consultation with the Behavioral Health Partnership Oversight Council have established criteria for referral to an Intensive Care Manager (see below for examples). Beacon Health Options conducts analyses on an ongoing basis to identify members that meet the criteria and then refer these individuals to the ICM for follow-up.

If the referred individual does not have an established source for their behavioral health care needs, the ICM will help connect the member to care and will follow-up to see that they stay connected. If an individual is already receiving behavioral health (BH) services, the ICM will case conference with the member/parent.
and/or providers to determine and/or identify opportunities to improve the member’s care. If a child has complex service needs and would benefit from wraparound services, the ICM may refer the child to a Community Collaborative for care coordination or in the case of an adult member refer the member to a Local Mental Health Authority (LMHA) and/or other community resource. If a member already has a Care Coordinator, Enhanced Care Coordinator or is DCF involved and has a caseworker, the ICM would offer assistance to help stabilize the member. Finally, for those members with co-morbid medical conditions, the ICM will coordinate with Community Health Network of Connecticut (CHN CT) and/or provider.

**Sample ICM Referral Criteria**

- Delay of discharge from emergency department or hospital setting;
- Multiple emergency departments visits in short period of time;
- High risk hospital discharge (i.e., multiple risk factors, recent prior admissions);
- History of unsuccessful connections to care;
- Disruptions in placement due to behavior;
- Serious medical co-morbidities; and/or
- Transition risk - age 17 years and receiving multiple behavioral health services.

**Sample Plan/Interventions**

- Collaborate and coordinate with involved state agencies, hospitals and member specific team;
- Participate in care planning with member and/or family members;
- Identify alternative services that had not been considered by provider or family;
- Monitor success of connection to care and intervene if connection is disrupted;
- Facilitate access to and/or enrollment of provider with special qualifications (e.g., language specialty); and/or
- Assist with coordination of Wellness Recovery Care Plans (WRAP) with adult populations, Local Mental Health Authorities, and DHMAS.

**Peer Based Services**

Peers are an important part of the care continuum. Talking to a person who has had similar experiences has been found to be helpful for members in recovery. Peers are adult behavioral health consumers, who are in long term recovery, and who utilize their lived experience to provide education and outreach to members. They support engagement in treatment, assist in navigating the service system, and identify natural supports. They may also be parents of children who have experience with the children’s behavioral health system. Beacon Health Options implements an extensive training program in cooperation with advocacy agencies to build additional leadership and mentoring skills amongst the Peer staff.

**CRITICAL ELEMENTS IN TREATMENT AND RECOVERY PLANS**

The CT BHP expects all providers to develop a treatment and recovery plan with the member and the member’s family as appropriate. The content of the treatment plan may vary depending on the complexity of the member’s needs, the array of services being provided, and the duration of the episode of care. Nevertheless, Care Managers and Intensive Care Managers talk with providers about the member’s treatment and discharge plan as part of every review process.

The following list includes key elements that the CT BHP expects to be documented as part of client-centered treatment, recovery and/or discharge planning:
• Member strengths and resources;
• Primary therapist;
• Primary Care Physician;
• Date of most recent treatment plan update;
• Measurable goals;
• Behavioral objectives;
• Treatment modalities and frequency, including;
  o Individual therapy;
  o Family therapy;
  o Group therapy;
  o Partial hospitalization;
  o Medication management;
  o Case management;
  o Substance Use Services; and/or
  o Other.
• Medical conditions;
• Medications (type, dosage);
• Family and other natural supports, and involvement;
• Community resources involvement;
• Consultations;
• Substance use issues/treatment;
• Treatment obstacles and strategy for overcoming obstacles;
• Date of planned discharge; and
• Wellness Recovery Action Plan (WRAP).

**OTHER REVIEWS CONDUCTED BY CT BHP**

In addition to conducting prior authorization and concurrent reviews, Care Managers may also conduct record reviews. In some instances, those reviews are related to reimbursement of services. In others, the Care Managers, as an integral part of the overall Quality Management Program, are verifying the quality and appropriateness of services provided.

CT BHP providers are required to cooperate with all record reviews conducted by Beacon Health Options. Findings of the reviews will be shared with the provider. If findings are not favorable to the provider, the provider is offered an opportunity to provide additional information and/or implement an improvement or corrective action plan.

**Focused Chart Reviews**

Beacon Health Options may conduct focused chart reviews of a provider whenever concerns are raised about a particular member or about the services a provider is offering to multiple members. Such reviews may be conducted on site and without prior notice to the provider.

**Retrospective Reviews**

A retrospective review for medical necessity is a review conducted after services have been provided to the member. Retrospective reviews may also occur when a decision regarding the authorization of a service previously administratively denied is overturned on appeal. Under these circumstances, the service would be retrospectively reviewed for medical necessity.
Retrospective reviews for medical necessity typically involve the review of the medical record for the dates of service in question. Providers are encouraged to submit a copy or portion of the medical record that will best assist in determining medical necessity, along with their request for a retrospective review. When all the necessary clinical information accompanies the request, a decision will be rendered within 30 calendar days. However, if the request is made verbally, the provider will be notified by mail that additional information is needed and will be given 45 calendar days to respond to the request. If the information is not received within that time frame, the appropriate administrative or clinical denial is issued. In those instances when the information is received within the timeframe, the review of the record will be conducted and a decision made within 15 calendar days of the receipt of the necessary information.

Most retrospective reviews are the result of the member being granted back-dated eligibility and the provider subsequently asking for the authorization of services rendered during the now covered time period. When a member is granted eligibility and that eligibility is back-dated, providers who provided services to the member during the now covered period of time can request that those services be reviewed for medical necessity. These retroactive medical necessity reviews are a subset of retrospective reviews and follow the policy and procedures that govern retrospective reviews. For a retroactive review to be conducted, the effective date of eligibility must span the date(s) of service.

**Overview of Authorization and Registration of Services**

**Authorized Services** – are those for which the treating provider must request authorization for treatment and concurrent (continuing stay) reviews for an extension of the previous authorization. Prior authorizations and their concurrent reviews are clinical exchanges between the treating provider and a Care Manager employed by Beacon Health Options. Providers may initiate the authorization process via ProviderConnect or by calling 1-(877) 55-CT BHP [1-(877) 552-8247]. Categories of services that require authorization are:

- Psychiatric Hospitalization
- Inpatient Detoxification;
- Residential Detoxification;
- Crisis Stabilization Bed (CARES unit);
- Psychiatric Residential Treatment Facility (PRTF);
- Residential Treatment Center (RTC) for Children through DCF;
- Adult Group Homes through DMHAS;
- Child Group Homes through DCF;
- 1:1 for Children in Congregate Care for DCF;
- Partial Hospitalization (PHP);
- Intensive Outpatient Services (IOP);
- Electroconvulsive Therapy (ECT);
- Methadone Maintenance;
- Ambulatory Detoxification;
- Extended Day Treatment (EDT);
- Home-based Services for Ages 21 and under;
  - Intensive In Home Children and Adolescent Psychiatric Services (IICAPS)
  - Multidimensional Family Therapy (MDFT)
  - Multi-systemic Therapy (MST)
  - Functional Family Therapy (FFT)
- Outpatient Services;
- Case Management for < 19 years of age (after initial 3 hours);
• Autism Spectrum Disorder (ASD) Services
• Psychological Testing; and
• Home Health Services for Behavioral Health issues.

While some services requiring authorization are conducted via telephonic reviews, most are completed via the CT BHP web registration system (ProviderConnect). Registration is conducted at the time of the initiation of services when the member is accepted for treatment. For services that require registration, please visit the CT BHP website at www.CTBHP.com. See “Registering Services on the Web” below.

A complete listing of services that require registration can be found on the CT BHP website at: www.CTBHP.com. From the home page, go to For Providers, then go to Covered Services and then select the provider type of interest. An “R” in the column headed ‘Auth Req’d?’ is used to identify a procedure that requires registration.

THE PROCESS OF SERVICE REGISTRATION/AUTHORIZATION

In order to complete a review that is both efficient and comprehensive enough to establish the appropriate level of care and service necessary, an established set of questions are presented for the provider as they relate to the particular member’s need and service. These questions can be viewed in their entirety on the CT BHP website www.CTBHP.com under “For Providers”.

Registering Services on the Web

Beacon Health Options offers a web-enabled application for registering services (i.e. Inpatient, PHP, Outpatient, IOP, Ambulatory Detoxification, Methadone Maintenance, Psychological Testing, Home-Based and Home Health services.) Access to this application is located by going to: www.CTBHP.com under For Providers. The “For Providers” homepage provides access to the ProviderConnect security access form to obtain an ID and password, user manuals and training videos. The following steps outline the procedures for accessing and utilizing ProviderConnect:

Step 1: Before accessing the system, providers and/or system users must print, complete and submit an Online Services Account Request Form to obtain a User ID and Password. This ID and password will establish secure access to the system.

Step 2: Our comprehensive user’s manual and our training videos provide screen shot by screen shot reference guides to entering registrations for system users. Providers are strongly encouraged to print the user manual or watch our training videos before attempting to complete registrations and/or re-registrations/concurrent reviews.

ProviderConnect links directly to the Beacon Health Options’ management information system so authorization numbers are automatically generated and subsequent authorization letters are then available to print at the provider’s practice location.
Authorization of Services

For those services requiring a telephonic review, the Care Manager and provider will complete the review process and, in most cases, will come to an agreement about the services to be authorized and the authorization period (or number of units). For those services that are completed via the registration process, when the service units and date span are in keeping with established parameters, the services are authorized at the conclusion of the registration process in ProviderConnect. In both these situations, the provider is given an authorization number and a written notice of the authorization is available to that provider. In keeping with CMAP regulations, notices indicate that authorization does not confer a guarantee of payment. The basis for all decisions will be documented.

When a provider makes a request for a level of care that is not consistent with the Level of Care (LOC) Guidelines, the provider is informed and, where possible, the provider is made aware of the medical necessity criteria and appropriate LOC. The reviewer may also suggest medically appropriate alternatives to the requested LOC when these alternatives might better meet the providers stated goals and the members identified needs. In situations where there is agreement, the care will be authorized.

Please find copies of review templates at www.CTBHP.com under the Provider section.

A Care Manager can only authorize treatment. Any decision to deny, partially deny, reduce, suspend or terminate services must be made by a Peer Advisor. Peer Advisors must be a doctoral level psychologist, a psychiatrist, an ASAM-certified physician, or a certified addiction medicine specialist. Peer Advisors will be involved only in reviewing cases that fall within their area of clinical expertise.

Medical Director/Peer Advisor

If the Care Manager is unable to authorize the care requested by the provider, the Care Manager will refer the request to a Medical Director/Peer Advisor. Consultations may be conducted by the CT BHP Medical Directors or contracted psychiatrists or doctoral level psychologists.

Peer Advisors review those requests in which services do not appear to meet medical necessity guidelines and/or those in which the Care Manager may identify a potential quality of care issue.

The Peer Advisor reviews the available clinical information and attempts to contact the referring provider for a telephonic consultation. If the Peer Advisor can reach the referring provider, the case is reviewed with the provider. If the Peer Advisor is unable to reach the referring provider within one hour, the Peer Advisor will render the decision to authorize (or not) the requested services based on the available clinical information.

Whenever possible, the Peer Advisor or Care Manager will inform the provider telephonically of the decision. A written notification is also sent to the member and provider in accordance with requirements of the CT BHP. The written notification includes a description of the rights to appeal the decision and the process by which to file that appeal.
PARTICIPATING IN A CONCURRENT (CONTINUING STAY) REVIEW

After the initial authorization is given, the second and subsequent reviews focus on identifying progress in treatment and planning for discharge. It will be the responsibility of the provider to initiate the concurrent review process, specifically, to contact the Care Manager prior to the end date of the authorization to insure continued authorization and service provision as appropriate. In most instances, the provider and the Care Manager establish a mutually agreeable time for the next review.

A concurrent authorization review is held between the provider who is presenting the information and the Beacon Care Manager. Concurrent reviews focus on the member’s response to treatment, the continuing severity of symptoms, appropriateness and intensity of the treatment plan, and the provider’s progress in discharge planning and arranging aftercare. The Care Manager also checks the involvement of family members and/or other significant individuals in the treatment and discharge planning. Just as in the initial authorization process, the Care Manager documents all clinical information received and the basis for the services authorized.

For those services requiring a telephonic review, the Care Manager conducts the review with the provider and, in most cases, will come to an agreement about the services to be authorized as well as the authorization timeframe and/or number of units. For those services that are completed via the registration process, providing the service units and date span are in keeping with established parameters, the services are authorized at the conclusion of the registration process in ProviderConnect. Providers can access authorization schedules by visiting the CT BHP website and clicking on ‘For Providers’ then ‘Covered Services’. The provider should then click on the link that identifies the correct provider type under the ‘Authorization Schedule’ header. In both these situations, the provider is given an authorization number and a written notice of the authorization is made available to the provider either via ProviderConnect or by mail at the provider’s request. The authorization notice includes language that indicates that the authorization does not confer a guarantee of payment.

When a provider makes a request for a Level of Care (LOC) that does not meet medical necessity criteria for the individual, the provider is informed of this. The reviewer will work with the provider to make them aware of alternatives to the requested LOC in terms of type, frequency, timing, site, extent, duration and effectiveness for the member’s illness. In situations where there is agreement, the care will be authorized. In situations when there is continued disagreement, the Care Manager will inform the provider that the case needs to be referred to a Physician Peer Advisor for review.

If the Care Manager is unable to independently determine the appropriateness of the continued treatment, the case is referred to a Peer Advisor. If a denial, partial denial, reduction, suspension or termination occurs, the appropriate denial letter with appeal rights notice is generated on the day the determination is made.

Upon receiving all necessary clinical information required to make a level of care determination, a concurrent review decision is made and communicated by 5:00pm for any requests prior to 12:00pm and for any requests after 12:00pm the determination will be made by 12:00pm following day for services in psychiatric hospitals, general hospitals, inpatient detoxification, residential detoxification, psychiatric residential treatment facilities (PRTFs), Intermediate duration acute psychiatric units, partial hospitalization programs, and adult day treatment programs. All times will be measured from the time the Care Managers or Peer Advisors have received all requested information.
**DISCHARGE & AFTER CARE PLAN**

In order to ensure a high level connect to care rate, Care Managers will verify discharge information to establish that the treated member is ready to discharge from the treating level of care.

In order to determine that a member has engaged in treatment at the aftercare facility following discharge from a more acute level of care, Beacon Health Options staff will contact the Member and or aftercare service provider who has been identified during the acute care discharge review process.

**CT BHP Bypass Programs**

Bypass Programs are a Utilization Management strategy that provides administrative relief to identified providers by authorizing care at the initiation of care for longer periods of time, thus decreasing the number of concurrent reviews required for an episode of care. At present, there are Bypass Programs available to inpatient mental health units that treat adult and/or child/adolescent members as well as Intensive Outpatient providers and IICAPS services for our child/adolescent populations. These programs must meet criteria particular to the level of care such as average length of stay (ALOS), duration and/or intensity as well as quality standards. As an example, the following describes an abridged listing of criteria and methodology utilized to identify providers who are eligible to participate in the inpatient Bypass program for adults.

Eligibility for the Bypass Program for adult inpatient psychiatric services is based upon:

- Treatment of an annually determined minimum volume of members during the previous calendar year, and
- An ALOS that is no greater than the annually determined number of standard deviations from the statewide average;
- A 7 day readmission rate that remains below the annually established rate;
- Discharge information for all members entered via web at an annually determined rate; and
- Verification that the provider has no current corrective action plans related to quality of care involving the targeted Adult inpatient unit/s.