Connecticut BHP
Supporting Health and Recovery

PROVIDER NOTICE

Alert#: **PN-2012- 06A**

Issued: **May 7, 2012**

To: **CT BHP Detoxification Providers**

Subject: **Clarification: Detox Facilities (Hospital-based and Free Standing) and Use of Release of Information on Admission**

PN 2012-6A SUPERCEDES PN 2012-6

Dear Provider,

This notice is being sent to notify you of new procedures for obtaining pre-certification for opiate detoxification. These procedures are to be used every time the intention is to provide opiate detox. The purpose of the process is to ensure that adequate and appropriate treatment history is available to determine the appropriate level of care and the type of service that will meet the member's needs most effectively.

Steps to Follow for Opiate Detoxification Pre-Certification

1. When the member arrives at the provider facility, the provider performs the clinical evaluation to determine the recommended level of care, and to ensure that the member meets medical necessity for the requested services.

2. The provider then asks the member to sign necessary Release of Information (ROI) forms to facilitate authorization for service and appropriate level of care decision making. There are three (3) possible ROI's to complete depending on the HUSKY eligibility group:

    - For all HUSKY members: The ValueOptions/CT Behavioral Health Partnership ROI is completed to allow VO/CT BHP to disclose the member's treatment history to the admitting provider. (The ROI form can be found on the CT BHP website by clicking on the 'For Providers' button on the homepage and then clicking on the 'Forms' link along the left-hand navigation bar. Additionally, a copy of the ROI form has been attached to this Provider Notice. Copies of the form can be made and kept on hand by the provider.) The signed ROI will be maintained in the member's clinical record at the provider's facility.

    - For HUSKY D members ONLY: The provider asks the member to sign a separate copy of the ValueOptions/CT BHP ROI form that would allow ValueOptions to disclose the member's status and history to Advanced Behavioral Health (ABH). The provider would identify ABH as the organization to which information should be disclosed. The purpose for that disclosure is to facilitate a possible referral for Case Management and/or Residential Rehabilitation services as part of the discharge plan.

    - For HUSKY D members ONLY: The provider's own ROI form would be signed to allow the provider to disclose information to ABH as part of discharge planning and coordination of care. That disclosure would allow ABH to participate in discharge planning for possible Residential Rehabilitation services and Case Management.

3. The provider then calls CT BHP for pre-certification for the opiate detox services. Upon notifying the CT BHP clinician that the detox is for opiates, the CT BHP clinician will ask if the ROIs have been obtained. It will not be necessary to fax or send the ROIs to the CT BHP; the clinician will accept the provider's statement that the ROIs have been completed and are on file.

4. The CT BHP clinician will then review the member's treatment history, including the determination of whether the member meets criteria for admission to the Opiate Agonist Treatment Protocol (OATP).* The OATP is available to all HUSKY members. If the member meets OATP criteria, the provider will be informed of the eligibility and will be asked to present that option to the member.

5. If the member elects to participate in OATP, then the provider will either initiate the protocol (if the provider is an OATP participant) or will coordinate the referral to an OATP provider. CT BHP will assist in this referral process, if necessary.

6. CT BHP will authorize the detoxification services for the provider that ultimately provides the service. The authorization will be subject to the same requirements for medical necessity as are all requests for authorization.

7. As part of discharge planning for HUSKY D members, the provider collaborates with ABH regarding either Case Management services or a referral to Residential Rehabilitation services.

8. If the member does not sign the ROI, then the authorization request process still can continue. Previous treatment information will not be disclosed by CT BHP, however.

***Eligibility for OATP**

- 3 or more admissions to an acute care setting for the purpose of detoxification from opiates (either free-standing or hospital-based program) within a 90-day period

  Or

- 4 or more admissions for detoxification from opiates within 6 months

If you have any questions, please feel free to contact the CT BHP Call Center at 1-877-552-8247.

Provider Relations Department
Connecticut Behavioral Health Partnership

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Connecticut BHP Supporting Health and Recovery

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Rocky Hill, CT 06067

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL

Patient/Client (Last Name, First Name)	Date of Birth	MPI #	Last 4 digits of SS#

I, the undersigned, authorize ValueOptions, Inc. to DISCLOSE information to

Name of Organization ____________________ Address: ____________________

____________________ City ____________________

____________________ State ____________________ Zip Code ____________

I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified:
Limitations/Restrictions____________________

Purpose of Release: ___Evaluation and Treatment ___ Benefit Determination ___Other____________________

___Placement/Referral ___ Care Coordination

Information to be released/obtained: (*Check Appropriate Boxes*)

- ☐ Psychiatric Evaluation
- ☐ Psychosocial History/Assessment
- ☐ Psychological Evaluation
- ☐ Treatment Plans
- ☐ Medical History and Physical Exam
- ☐ Discharge/Transfer Summary
- ☐ Medication Records
- ☐ Opioid & Substance Abuse History/Treatment
- ☐ Diagnostic Reports (*specify*): ___________
- Other (*specify*):____________________

Dates of Treatment Covered by this Request:

- ☐ All prior episodes of care, through discharge from present episode of care
- ☐ Limited to the following Dates(s): ____________________

This authorization, if not cancelled, will expire:

____

Date (*not to exceed 12 months*), event or condition upon which this authorization expires. *If blank, authorization will expire 12 months from date of signature below.*

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke Medical, Psychiatric and Substance Abuse authorization at any time by signing the "**CANCELLATION/REVOCATION**" section below OR I may VERBALLY revoke Substance Abuse authorization, except to the extent that action already has been taken on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by ValueOptions, Inc. pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information, unless otherwise restricted above.

____________________ ____________
Signature of Patient/Client/Authorized (Legal) Representative* Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOCATION:____________________ ____________
Signature of Patient/Client/Authorized (Legal) Representative* Date

*If this form has been signed by the patient's/client's Authorized (Legal) Representative, a copy of the legal appointment must be attached. ☐ Conservator/Guardian ☐ Executor of Estate ☐ Other (*specify*): ____________________

☐ **File only - Ongoing verbal communication** ☐ Send attention to: __________________

****NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.**

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