

# **Legislative Regulation Review Committee**

2009-042

Department of Mental Health and Addiction Services

**GENERAL ASSISTANCE REGULATIONS**

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REGULATION  
OF

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Concerning

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Subject Matter of Regulation

DMHAS General Assistance Behavioral Health Program

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**Statement of Purpose:**

To adopt regulations for the operation of the behavioral health managed care program established pursuant to section 17a-453a of the Connecticut General Statutes.

**Sec. 17a-453a-1, Scope**, defines the statutory authority and purpose of the regulations.

**Sec. 17a-453a-2, Definitions**, defines certain terms used in the regulations.

**Sec. 17a-453a-3, Eligibility**, describes the eligibility requirements for covered services under the Department of Mental Health and Addiction Services (DMHAS) General Assistance Behavioral Health Program (GABHP).

**Sec. 17a-453a-4, Covered behavioral health services**, identifies those behavioral health services that are covered services within the DMHAS GABHP.

**Sec. 17a-453a-5, Service limitations, exclusions, and non-reimbursable services**, identifies the limitations and exclusions that apply to covered services of the GABHP.

**Sec. 17a-453a-6, Prior authorization review**, describes the process a provider must follow to request admission of an individual to a covered service under the DMHAS GABHP.

**Sec. 17a-453a-7, Continued stay authorization review**, describes the process a provider must follow to request continuation of an individual's treatment in a previously authorized covered service.

**Sec. 17a-453a-8, Alternative authorization review**, describes the alternative authorization process that must be utilized for specific covered services.

**Sec. 17a-453a-9, Recovery and discharge planning**, describes the requirements for completion of an individual's treatment or recovery plan and the requirements for the individual's discharge plan intended to assist in the maintenance of a substance-free lifestyle.

**Sec. 17a-453a-10, Quality management**, describes the quality management activities that will be monitored by DMHAS.

**Sec. 17a-453a-11, Provider participation**, describes the application process for providers interested in becoming a GABHP service provider.

**Sec. 17a-453a-12, Provider credentials**, describes the credentialing requirements for providers of GABHP covered services.

**Sec. 17a-453a-13, Provider contract**, describes the process and requirements for providers to enter into a contract to provide services within the DMHAS GABHP.

**Sec. 17a-453a-14, Claims Administration**, describes the process for submitting claims for reimbursement for services rendered to GABHP recipients.

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**Statement of Purpose (cont'd.)**

**Sec. 17a-453a-15, Provider grievance process,** describes the process available to a provider that seeks to file a claim grievance.

**Sec. 17a-453a-16, Audit,** describes the methodology utilized by DMHAS in conducting audits of contracted providers.

**Sec. 17a-453a-17, Fair hearing to appeal audit recovery or progressive sanctions,** describes the fair hearing process available to providers that seek to appeal audit report findings or progressive sanctions.

**Sec. 17a-453a-18, Recipient appeals and fair hearing,** describes the process available to GABHP recipients who seek to file an appeal regarding a service decision made by the department's designated agent.

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Subject Matter of Regulation

DMHAS General Assistance Behavioral Health Program

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**Section 17a-453**

The Regulations of Connecticut State Agencies are amended by adding sections 17a-453a-1 to 17a-453a-18, inclusive, as follows:

**(NEW) Section 17a-453a-1. Scope**

These regulations are issued pursuant to subsection (b) of section 17a-453a of the Connecticut General Statutes and govern the operation of the behavioral health managed care program for recipients of medical services under the state-administered general assistance (SAGA) program.

**(NEW) Sec.17a-453a-2. Definitions**

(a) As used in sections 17a-453a-3 to 17a-453a-18, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acute care services" means short-term inpatient treatment for a mental health, disorder, substance use disorder or co-occurring disorder and includes the following covered services: acute psychiatric hospitalization, medically managed inpatient detoxification, and medically monitored residential detoxification;

(2) "Alternative review" means a method specified in section 17a-453a-8 of the Regulations of Connecticut State Agencies by which a contracted provider can obtain authorization to provide certain covered services without contacting the designated agent directly by telephone or facsimile;

(3) "Ambulatory detoxification" means a non-residential, medically necessary service provided in a state-operated facility or in a facility licensed by the Department of Public Health (DPH) to offer ambulatory chemical detoxification and treatment for the purpose of withdrawal from a specific substance in a safe and effective manner in an outpatient setting;

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(4) "ASAM PPC-2R" means the American Society of Addictions Medicine Patient Placement Criteria, Second Revision;

(5) "Authorized representative" means a person designated by the general assistance behavioral health program (GABHP) recipient or a person authorized by law to act on behalf of the recipient for the purpose of filing an appeal pursuant to section 17a-453a-18 of the Regulations of Connecticut State Agencies;

(6) "Behavioral health services" means services designed for the treatment of psychiatric disorders, substance use disorders or co-occurring disorders;

(7) "CARF" means the Commission on Accreditation of Rehabilitation Facilities;

(8) "CFR" means the Code of Federal Regulations;

(9) "Chemical maintenance treatment" means a non-residential, medically necessary service provided in a state-operated facility or in a facility licensed by DPH to offer chemical maintenance treatment for the purpose of supporting a recipient's abstinence from an addictive substance;

(10) "Claim" means a bill or invoice from a contracted provider that contains all information necessary to match the bill or invoice with covered services and, if applicable, service authorization data;

(11) "Claims adjudication" means to verify a submitted claim and, if applicable, to utilize a fee schedule to determine the amount that will be paid to a contracted provider;

(12) "Clinical contact" means communication with direct observation of the recipient in order to establish a therapeutic relationship and assist with the amelioration of identified problems;

(13) "Clinical risk" means the potential for injury or harm to self or others, or property damage that could result in injury or harm to self or others;

(14) "Clinical supervision" means an ongoing process in which experienced and qualified professionals provide oversight and guidance to other professional employees or paraprofessional employees in order to ensure, maintain, improve, or develop the requisite clinical competence or skills;

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(15) "Commissioner" means the commissioner of the Department of Mental Health and Addiction Services (DMHAS);

(16) "Continued stay review" means the process by which the designated agent determines the ongoing necessity for services that are being delivered to a recipient;

(17) "Contracted provider" means a provider that is credentialed to provide a covered service and has a contract with DMHAS to provide that service;

(18) "Co-occurring disorders" means concurrent substance use and mental health disorders;

(19) "Covered services" means medically necessary services and procedures available through the general assistance behavioral health program established pursuant to section 17a-453a of the Connecticut General Statutes;

(20) "COA" means Council on Accreditation;

(21) "CPT" means current procedural terminology codes published by the American Medical Association;

(22) "Critical incident" means any event that has or may have serious or potentially serious effects on a recipient or others;

(23) "Denial of service" means any formal or informal rejection, in whole or in part, of a request for covered services;

(24) "Designated agent" means an organization under contract with DMHAS to provide utilization management, claims processing, or other support services necessary for the operation of the GABHP established pursuant to section 17a-453a of the Connecticut General Statutes;

(25) "Detoxification" means an inpatient, medically necessary service provided in a state-operated facility or in a facility licensed by DPH to offer "residential detoxification and evaluation" for the purpose of withdrawal from a specific psychoactive substance in a safe and effective manner;

(26) "Discharge plan" means the written evaluation of a recipient's behavioral health services needs, developed in order to arrange for appropriate care after discharge or upon transfer from one level of care to another;

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(27) "Discharge review" means the process for evaluating a recipient's discharge plan prior to discharge or prior to transfer from one level of care to another;

(28) "DMHAS" or "department" means the Department of Mental Health and Addiction Services;

(29) "DSM-IV" means the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition;

(30) "Eligibility management system identification (EMS-ID) number" means the unique identifier assigned to each individual applying for or receiving general assistance under Department of Social Services' (DSS) programs;

(31) "Eligible" means determined by DSS to meet the eligibility criteria for medical services pursuant to section 17b-192 of the Connecticut General Statutes and determined by DMHAS to need behavioral health services available through the behavioral health program established pursuant to section 17a-453a of the Connecticut General Statutes;

(32) "Emergency" means either: (A) a substance-induced condition where a recipient is incapacitated by alcohol or other drugs, is dangerous to self or others, and needs medical treatment for detoxification for potentially life-threatening symptoms of withdrawal from alcohol or other drugs or (B) a psychiatric condition where a recipient is dangerous to self or others or is gravely disabled and in need of immediate care and treatment in a hospital;

(33) "Emergency medical services" means services provided to recipients who are accident victims and recipients suffering from severe acute illness and psychiatric emergencies. Services include the detection and reporting of medical emergencies, initial care, transportation and care for recipients en route to health care facilities, medical treatment for the acutely ill and severely injured within emergency departments, and the provision of linkages to continued care or rehabilitation services;

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(34) "Emergency psychiatric service" means an immediately available service provided to recipients suffering from severe acute mental health disorders to meet their emergent psychiatric needs;

(35) "Facility" means the physical structure, building or portions thereof in which mental health or substance use treatment services, or both, are delivered;

(36) "Fee for Service" means a payment mechanism by which a contracted provider is paid for each covered service rendered to a recipient;

(37) "Formulary" means a listing of medications by national drug codes that are covered by a specific payor of medical services;

(38) "General assistance behavioral health program" hereinafter referred to as GABHP means the behavioral health program established pursuant to section 17a-453a of the Connecticut General Statutes;

(39) "General hospital" means a facility licensed as a general hospital by DPH pursuant to sections 19a-490 to 19a-503, inclusive, and 19a-507a(3) of the Connecticut General Statutes;

(40) "Individualized treatment" means treatment designed to meet a particular recipient's needs, guided by a recovery plan that is directly related to a specific, unique patient assessment;

(41) "Initial intake evaluation" means the first evaluation of a recipient conducted by a provider of behavioral health services;

(42) "JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations and the Joint Commission;

(43) "Level of care" means a discrete set of behavioral health services as specified in the ASAM PPC-2R or other DMHAS-authorized level of care placement criteria;

(44) "Licensed alcohol and drug counselor" (LADC) means a person who is licensed by DPH in accordance with Chapter 376b of the Connecticut General Statutes;

(45) "Licensed clinical social worker" (LCSW) means a person who is licensed by DPH in accordance with Chapter 383b of the Connecticut General Statutes;

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(46) "Licensed marriage and family therapist" (LMFT) means a person who is licensed by DPH in accordance with Chapter 383a of the Connecticut General Statutes;

(47) "Licensed professional counselor" (LPC) means a person who is licensed by DPH in accordance with Chapter 383c of the Connecticut General Statutes;

(48) "Matrix intensive outpatient program" or "Matrix IOP" means a comprehensive, evidence-based, sixteen (16) week program designed to give recipients with substance use disorders knowledge, structure and support, enabling them to achieve abstinence from substances and initiate long-term recovery;

(49) "Medical coverage" means a plan or program that pays for medically necessary behavioral health services;

(50) "Medical triage" means a service to which a recipient may be referred for the provision of immediate assessment of symptoms of substance use or mental health disorders, the immediate care and treatment of these symptoms as necessary, a determination of the need for treatment, and assistance in obtaining appropriate continued treatment;

(51) "Medically managed treatment" means inpatient services that involve daily medical care, where diagnostic and treatment services are directly provided or managed by an appropriately trained and licensed physician;

(52) "Medically monitored treatment" means inpatient services that are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, and other health care professionals and technical personnel under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct patient contact, review of records, team meetings, 24-hour coverage by a physician, and quality assurance programs;

(53) "Medically necessary" means appropriate and necessary for the symptoms, diagnosis, or treatment of a psychiatric or substance use condition, or both, as defined under DSM-IV or its successor, ASAM PPC-2R or its successor, or other DMHAS authorized level-of-care placement criteria;

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(54) "Mental health disorder services" means services provided for the care and treatment of recipients with mental health disorders and includes medical, psychiatric and psychosocial assessments; individual, group and family counseling; peer counseling; vocational counseling; and education groups;

(55) "Outpatient treatment" means a non-residential service to which an recipient may be admitted for a variety of counseling and other structured activities designed to arrest, ameliorate or reverse a mental health or substance use-related disorder;

(56) "Outpatient treatment review" or "OTR" means an alternative review method that a contracted provider can use to obtain authorization to provide those covered services designated by DMHAS by submitting reports in accordance with the format and procedures specified by the designated agent;

(57) "Panel or profile test" means certain multiple tests performed on a single specimen;

(58) "Partial hospitalization" means a non-residential, medically necessary service that is an alternative to inpatient care and is provided in a state-operated facility or a facility licensed by DPH to offer day or evening treatment for the purpose of systematic reduction of the use of a substance or of psychiatric symptoms;

(59) "Prior authorization" means the process of obtaining prior approval from the designated agent to provide a covered service;

(60) "Private freestanding mental health day treatment facility" means a facility licensed as a private freestanding mental health day treatment facility by DPH;

(61) "Private freestanding psychiatric hospital" means a facility licensed as a private freestanding psychiatric hospital by DPH;

(62) "Provider" means a person or entity that provides behavioral health services;

(63) "Psychiatrist" means an individual licensed by DPH in accordance with Chapter 370 of the Connecticut General Statutes;

(64) "Psychologist" means an individual licensed by DPH in accordance with Chapter 383 of the Connecticut General Statutes;

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(65) "Recipient" means an individual whom DSS determined meets the eligibility criteria for medical services pursuant to section 17b-192 of the Connecticut General Statutes and whom DMHAS determined needs behavioral health services available through the behavioral health program established pursuant to section 17a-453a of the Connecticut General Statutes;

(66) "Recovery" means a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by, that condition;

(67) "Recovery plan" means a written plan that directly relates to a recipient's bio-psychosocial assessment and that is developed with the involvement of the recipient or his or her authorized representative as specified in section 17a-453a-9 of these regulations; also may be referred to as treatment plan;

(68) "Registration process" means a systematic action of recording the recipient's demographic and personal health information for the purposes of payment of claims;

(69) "Rehabilitation" means the restoration of an optimum state of health by medical, psychological and social means, including peer group support for a recipient with a substance use disorder, a family member or a significant other for the specific purpose of reducing the use of substances or mitigating the effects of substance use disorders;

(70) "Relapse" means a recurrence of psychoactive substance use by a recipient who has previously achieved and maintained abstinence for a significant period of time beyond withdrawal;

(71) "Service" means a clinical or recovery support activity that is delivered in the framework of a treatment program for the specific purpose of reducing the use of substances or mitigating the effects of substance use disorders or mental health disorders, or both;

(72) "Service necessity" means a determination by DMHAS, or its designated agent, that a recipient requires a specified level of care based on criteria contained in the ASAM PPC-2R, or other DMHAS-authorized, level-of-care placement criteria;

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(73) "Service System" means a person-centered and outcome-oriented system of care that includes the use of strategy, planning, resource allocation, and ongoing evaluation to ensure customer satisfaction;

(74) "SAGA" means state-administered general assistance;

(75) "SAMHSA" means the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services;

(76) "State-operated facility" means a hospital or other facility that provides treatment for recipients with psychiatric or substance use disorders, or both, that is operated in whole or in part by the state of Connecticut;

(77) "Substance use disorders services" means services provided for the care and treatment of recipients with substance use disorders that include medical, psychiatric and psychosocial assessments; individual, group and family counseling; peer counseling; vocational counseling; and education groups;

(78) "Triage" means decision-making at the conclusion of an initial assessment process to determine the specific assignment of the recipient to a service or level of care;

(79) "Twenty-three (23) hour observation bed" means admission for no more than twenty-three (23) hours for assessment and stabilization to determine the need for inpatient versus outpatient care. A twenty-three (23) hour observation bed may be located in a hospital facility, a hospital emergency department or a residential detox facility;

(80) "Unexpected discharge" means any discharge of a recipient from a service or level of care where such discharge was not planned or scheduled as outlined in the recipient's recovery plan; and

(81) "Web-based registration" means an alternative review method that utilizes a web-based application to register recipients.

**Sec. 17a-453a-3. Eligibility**

(a) In order to be eligible for covered services under the DMHAS GABHP, the individual shall:

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(1) Be determined eligible by DSS for medical services pursuant to sections 17b-1 and 17b-192 of the Connecticut General Statutes;

(2) Be determined by DMHAS staff or the designated agent to need behavioral health services available through the GABHP established pursuant to section 17a-453a of the Connecticut General Statutes. Such determination shall be based upon an evaluation of service necessity that includes, but is not limited to, evaluation of:

- (A) The individual's mental status;
- (B) Problems identified by the individual;
- (C) The individual's history of behavioral health services; and

(3) Meet the criteria for a DSM-IV diagnosis for one or more behavioral health disorders included in the following range of DSM-IV diagnostic codes:

- (A) 291.1 to 292.9 inclusive; or
- (B) 295.0 to 315.9, inclusive, except for diagnosis 307.89, Pain Disorder Associated with a Medical Condition.

(b) An individual who, at the time he or she receives a covered service, does not satisfy the requirements of subsection (a)(1) of this section may be eligible to have such service paid for by the GABHP established pursuant to section 17a-453a of the Connecticut General Statutes, provided that:

- (1) The individual is subsequently determined by DSS to be retroactively eligible for medical services to a date that includes the date on which the covered service was delivered;
- (2) A contracted provider requests prior authorization from the designated agent before providing the covered service; and
- (3) All other requirements of this section are met.

**(NEW) Sec. 17a-453a-4. Covered Behavioral Health Services**

(a) The following behavioral health services shall be covered services within the DMHAS GABHP:

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(1) Acute psychiatric hospitalization: An inpatient, medically necessary service provided in a private freestanding psychiatric hospital or general hospital licensed by DPH, or state-operated facility that involves treatment of a psychiatric or co-occurring disorder, where a recipient's admission is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. Acute psychiatric hospitalization is used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. The acute psychiatric hospitalization service may be provided to recipients committed under a Physician's Emergency Certificate (PEC), as used in section 17a-502 of the Connecticut General Statutes, and may occur on a locked psychiatric unit;

(2) Ambulatory detoxification: A non-residential, medically necessary service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer ambulatory chemical detoxification or state-operated facility. This service uses prescribed medication to alleviate physical or psychological effects experienced by a recipient as a result of withdrawal from a specific substance and shall be provided only after an evaluation has been conducted and a determination has been made that the recipient is medically able to tolerate an outpatient detoxification. This service shall involve an assessment of needs, including those related to recovery supports and motivation of the recipient regarding his or her continuing participation in the treatment process. Recipients shall receive a minimum of one (1) hour per week of substance use disorders services.

(3) Ambulatory detoxification with on-site monitoring: A non-residential, medically necessary service in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer ambulatory chemical detoxification or a state-operated facility. Ambulatory detoxification with on-site monitoring shall provide psychiatric and other clinical services that address the recipient's problems as identified through a comprehensive bio-psychosocial assessment. This service uses prescribed medication to alleviate physical or psychological effects experienced by a recipient as a result of withdrawal from a specific substance and shall be provided only after an evaluation has been conducted and a determination has been made that the

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recipient is medically able to tolerate an outpatient detoxification.. This service shall involve an assessment of individual needs, including those related to recovery supports and motivation of the recipient regarding his or her continuing participation in the treatment process. Recipients shall receive a minimum of one (1) hour of substance use disorders services per week;

(4) Chemical maintenance treatment: A non-residential, medically necessary service provided in a state-operated facility or in a facility licensed by DPH to offer chemical maintenance treatment. Chemical maintenance treatment involves regularly scheduled administration of SAMHSA-approved medication, prescribed at individual dosages, and shall include a minimum of one (1) clinical contact per month. More frequent clinical contacts shall be provided if indicated in the recipient's recovery plan.

(5) Intensive outpatient-mental health: A non-residential, medically necessary service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer psychiatric outpatient services for adults or a state-operated facility. Each recipient shall receive three (3) to four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of nine (9) hours per week) of individualized treatment that includes at least one (1) individual or group therapy session per day. Treatment shall focus on reducing symptoms, improving functioning, maintaining the recipient in the community, preventing relapse and reducing the likelihood that care may be required in a more restrictive setting;

(6) Intensive outpatient-substance use: A non-residential, medically necessary service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer intensive outpatient services or state-operated facility. Each recipient shall receive three (3) to four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of nine (9) hours per week) of individualized treatment that includes at least one (1) individual or group therapy session per day. Treatment shall focus on relapse prevention and the recipient's ability to manage his or her recovery;

(7) Intensive residential treatment: A medically necessary, residential service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer

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intensive residential treatment or a state-operated facility. These services shall be provided in a 24-hour setting to treat recipients with substance use disorders who require an intensive rehabilitation program. Services in these settings are provided within a 15- to 30-day period and include a minimum of thirty (30) hours of substance use disorder services per week;

(8) Intermediate or long-term treatment or care: A medically necessary, residential service provided in a facility licensed by DPH to offer intermediate or long-term treatment or care and rehabilitation. Each recipient shall receive substance use disorder services to address significant problems with their behavior and functioning in major life areas due to a substance use disorder and to reintegrate them into the community. These services shall be provided in a structured recovery environment and shall comply with the following applicable requirements:

(A) If the facility is licensed for and provides intermediate or long-term residential treatment, a minimum of twenty (20) hours per week of substance use disorder services shall be provided to each recipient;

(B) If the facility is licensed for care and rehabilitation and provides long-term care, a minimum of twenty (20) hours per week of substance use disorder services shall be provided to each recipient per week; and

(C) If the facility is licensed for intermediate or long-term residential treatment and provides transitional or halfway-house services, a minimum of four (4) hours per week of substance use disorders services shall be provided to each recipient.

(9) Laboratory services: Specimen testing and analysis services used to establish diagnosis and treatment of behavioral health disorders and provided by a facility that is:

(A) Certified pursuant to the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), Title 42, Part 493 of the Code of Federal Regulations; and

(B) Licensed by DPH as a clinical laboratory in accordance with sections 19a-36-D20 to 19a-36-D38 of the Regulations of Connecticut State Agencies.

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(10) Matrix intensive outpatient: A non-residential comprehensive, evidence-based, sixteen-week individualized program that is provided in a facility licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer outpatient treatment. Matrix intensive outpatient is designed to give recipients with substance use disorders the knowledge, structure, and support to enable them to achieve abstinence from substances and initiate a long-term program of recovery;

(11) Medically managed inpatient detoxification: A medically necessary, inpatient service provided in a private freestanding psychiatric hospital or general hospital licensed by DPH, or state-operated facility that involves treatment of substance use disorders, where the recipient's admission is the result of a serious or dangerous condition that requires rapid treatment for a substance use disorder. Medically managed inpatient detoxification is used when on-site 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. This service shall provide evaluation for substance use disorders and withdrawal management. For recipients who have co-occurring disorders, psychiatric assessment and management shall be available. Medically managed inpatient detoxification may be provided to patients committed under a Physician's Emergency Certificate (PEC), as used in section 17a-684 of the Connecticut General Statutes;

(12) Medically monitored residential detoxification: A medically necessary, inpatient service provided in a state-operated facility or in a facility licensed by DPH to offer residential detoxification and evaluation that involves treatment of a substance use disorder. Medically monitored residential detoxification shall be used when 24-hour medical and nursing supervision are required. This service shall provide 24-hour substance use or dependence evaluation and withdrawal management;

(13) Observation bed-mental health: An inpatient, medically necessary service provided in a private freestanding psychiatric hospital or general hospital licensed by DPH, or state-operated facility that involves supervised stabilization, clinical monitoring and, when necessary, laboratory testing, to facilitate the formulation of an appropriate diagnosis and suitable treatment

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of a recipient who is in urgent need of care and treatment for mental health disorders.

Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required;

(14) Observation bed-substance use: An inpatient, medically necessary service provided in a private freestanding psychiatric hospital, general hospital or residential detoxification facility licensed by DPH, or state-operated facility that involves supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable treatment program for a recipient who is in urgent need of care and treatment for a substance use disorder. Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required;

(15) Outpatient-mental health: A non-residential, medically necessary service provided in a general hospital, psychiatric outpatient clinic for adults, private freestanding psychiatric hospital, facility licensed by DPH as an outpatient clinic pursuant to section 19a-495-550 of the Regulations of Connecticut State Agencies or state-operated facility that involves the evaluation, diagnosis and treatment of recipients;

(16) Outpatient-substance use: A non-residential, medically necessary service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer outpatient treatment or state-operated facility that includes, but is not limited to, professionally directed evaluation, treatment and recovery support services that shall be provided in regularly scheduled sessions, usually weekly, but no less frequently than every thirty (30) days;

(17) Partial hospitalization-mental health: A non-residential, medically necessary service provided in a general hospital, private freestanding psychiatric hospital, freestanding mental health day treatment facility licensed by DPH or state-operated facility that involves ambulatory, intensive psychiatric treatment services. Partial hospitalization-mental health services shall provide each recipient with a minimum of four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of twelve (12) hours per week), of individualized treatment based on a recovery plan that includes at least one (1) individual or group session per day. Partial

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hospitalization-mental health services may be provided on a day, evening, night or weekend schedule. Partial hospitalization-mental health services are designed to serve recipients with significant impairments resulting from psychiatric, emotional or behavioral disorders to avert hospitalization, thereby increasing a recipient's level of independent functioning.

(18) Partial hospitalization-substance use: A non-residential, medically necessary service provided in a general hospital, private freestanding psychiatric hospital, facility licensed by DPH to offer day or evening treatment or a state-operated facility that includes, but is not limited to, access to psychiatric, medical, and laboratory services for adults recently discharged from an inpatient facility or whose admission to inpatient care might be averted by treatment in a day or evening program. This service shall provide each recipient with a minimum of four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of twelve (12) hours per week), of substance use disorder services, based on an individualized recovery plan that includes at least one individual or group therapy session per day.

**(NEW) Sec. 17a-453a-5. Service Limitations, Exclusions, and Non-Reimbursable Services**

(a) Limitations: The following limitations shall apply to covered services:

(1) DMHAS payment for outpatient therapy shall be limited to one (1) session per provider, per day, for each recipient for each of the following therapies, unless additional service is authorized in advance by DMHAS's designated agent:

- (A) Individual therapy;
- (B) Group therapy; or
- (C) Family therapy.

(2) Unless authorized in advance by DMHAS's designated agent, medication management services performed by the same practitioner, on the same day, for the same recipient and for the principal purpose of medication monitoring or management shall not be reimbursed separately from individual or group therapy;

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(3) Group therapy sessions shall be limited to a maximum of twelve (12) participants per group session, excluding the supervising clinician(s); education groups shall be limited to a maximum of twenty-four (24) participants per group session, excluding the supervising professional(s);

(4) DMHAS payment for the following services shall be limited to one (1) such service for each recipient during a twelve (12) month period, if authorized in advance by the designated agent:

(A) Neuropsychological testing; or

(B) Psychological testing.

(5) Providers of chemical maintenance treatment shall furnish services at their licensed facility location, except as authorized in advance by DMHAS;

(6) DMHAS payment for laboratory services shall be limited to one (1) unit per allowable service per recipient per day, unless authorized by DMHAS's designated agent;

(7) DMHAS payment for initial intake evaluations shall not be considered unless:

(A) The recipient is eligible for SAGA medical benefits at the time of the evaluation or is found to be retroactively eligible for such benefits on the date on which the evaluation occurred;

(B) The recipient does not begin treatment in a level of care other than standard outpatient services with the same provider organization within ten (10) calendar days of the date of his or her initial evaluation;

(C) The provider registers the procedures within fifteen (15) calendar days after the evaluation was conducted;

(D) The provider's organization has not received reimbursement for an initial intake evaluation (Procedure Code 90801) for the same recipient within the previous six (6) months; and

(E) The provider organization has neither sought nor received payment for emergency room services on the same day as the initial intake evaluation. In order to obtain authorization for

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an initial intake evaluation, the provider shall submit a written request to the designated agent not more than fifteen (15) calendar days following the initial evaluation, and only if the recipient does not begin treatment with the provider within the ten (10) calendar days' time frame.

(b) Excluded services: The following behavioral health services shall be excluded under the DMHAS GABHP:

(1) Any services to a recipient with a primary DSM-IV diagnosis which is outside the range of diagnostic codes of 291.1 to 292.9, 295 to 307.88 or 307.90 to 315.9;

(2) Services that DMHAS determines to be "experimental" in nature (i.e., if utilized in the absence of clinical evidence);

(3) Services that the designated agent determines do not meet "service necessity" criteria, as defined in the ASAM PPC-2R or other DMHAS-authorized level-of-care placement criteria;

(4) Concurrent services which the designated agent determines to be similar or identical that are provided to the same recipient;

(5) Services, consultation or information provided over the telephone;

(6) Services that DMHAS determines are primarily for vocational or educational guidance, or services that are related solely to a specific employment opportunity, job skill, work setting or development of an academic skill;

(7) Therapies, treatments or procedures related to transsexual or gender-change medical or surgical procedures; and

(8) Services, treatment or items furnished to a recipient for which the provider does not usually charge non-recipients.

(c) DMHAS shall not reimburse a provider of inpatient or residential services for the following:

(1) The day of discharge or transfer, unless the recipient is discharged or transferred on the same day as he or she is admitted;

(2) A leave of absence or pass from an inpatient or residential facility that occurs without staff permission or against staff advice;

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(3) A leave of absence or pass from an inpatient or residential facility with staff permission, if the absence is longer than 24 hours, unless authorized in advance by the designated agent; and

(4) Emergency room services provided on the same day as a behavioral health-related inpatient admission to the same facility.

(d) DMHAS shall not reimburse a provider for the following:

(1) Electroconvulsive therapy, unless performed by a licensed psychiatrist and pre-authorized by DMHAS's designated agent;

(2) Hypnosis, unless performed by a licensed psychiatrist or psychologist and pre-authorized by the designated agent;

(3) Psychological or intelligence testing, unless performed by a licensed psychologist and pre-authorized by the designated agent;

(4) Neuropsychological testing, unless performed by a licensed psychologist and pre-authorized by the designated agent.

(5) Services performed by a staff member who is not a licensed physician, psychologist, registered nurse, social worker, other licensed behavioral health professional or a Connecticut certified alcohol and drug counselor, unless the following conditions are met:

(A) The individual is employed by, or under contract with, a licensed health facility whose medical director or clinical supervisor has determined that the staff member is qualified to render services to recipients;

(B) The individual, for mental health services only, is actively pursuing behavioral health licensure and is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional or a Connecticut certified clinical supervisor with at least two (2) years of experience in the provision of behavioral health treatment services; and

(C) The supervising clinician has signed the recipient's recovery plan.

(6) Services performed by staff of a licensed facility at a location other than that which is specified on the facility's license.

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(7) Any services performed by a laboratory that is not in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), Title 42 Part 493 of the Code of Federal Regulations;

(8) Individual laboratory tests, where it is determined by DMHAS that a panel or profile test should be conducted instead;

(e) DMHAS shall not reimburse an out-of-network provider for covered services except for a maximum of four (4) acute care services provided to recipients in a calendar year.

**Sec. 17a-453a-6. Prior authorization review**

(a) Providers shall obtain prior authorization from DMHAS's designated agent by contacting the designated agent by telephone before admitting an eligible or potentially eligible recipient to a covered service. Providers shall obtain prior authorization for designated outpatient services pursuant to section 17a-453a-8 of the Regulations of Connecticut State Agencies. The prior authorization review shall be designed to determine whether services are medically necessary, the service necessity and the proper treatment setting.

(b) The decision regarding prior authorization shall be rendered by DMHAS's designated agent, not more than three (3) hours after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision, or within five (5) business days for services authorized through alternative review and registration methods. Upon completion of the review, DMHAS's designated agent, shall:

(1) Authorize the requested covered service, for a specific number of days or sessions of treatment over a specified time period;

(2) Authorize a different covered service than requested; or

(3) Deny authorization, when the information received by DMHAS's designated agent does not demonstrate that the requested service is medically necessary.

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(c) The provider shall furnish DMHAS's designated agent with the following information for the purpose of prior authorization review of covered services requested for a potentially eligible or eligible recipient:

- (1) Recipient identifying information;
- (2) DSM-IV provisional or admitting diagnosis or diagnoses;
- (3) Level of care requested;
- (4) Clinical presentation of the recipient and justification for the requested service, including such factors as the recipient's mental status, natural supports and strengths;
- (5) Recovery plan objectives;
- (6) Prior history of mental illness or substance use, or both, if known, and history of treatment, if any;
- (7) Clinical risk assessment and relapse potential;
- (8) Medication(s) used;
- (9) Substance(s) used;
- (10) Whether the recipient is voluntarily agreeing to treatment;
- (11) Legal status of the recipient, if known;
- (12) Recipient's preference for service type and provider;
- (13) Treatment location;
- (14) Provisional discharge or aftercare plan, or both;
- (15) Projected date of discharge;
- (16) Name of the recipient's primary care physician, if any; and
- (17) All other information that the designated agent may require.

(d) DMHAS's designated agent may require that information necessary for prior authorization of inpatient covered services be collected by a DMHAS-designated mobile crisis team or another organization identified by DMHAS, following a face-to-face evaluation of the eligible or potentially eligible recipient.

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**(NEW) Sec. 17a-453a-7. Continued stay authorization review**

(a) Continued stay authorization review: The continued stay authorization review determines whether previously authorized covered services continue to be medically necessary. If a provider determines that additional care may be needed beyond that which has been authorized for an eligible or potentially eligible recipient, the provider shall contact DMHAS's designated agent by telephone not less than four (4) hours prior to the expiration of the existing authorization for acute care services and not more than 48 hours prior to the expiration of the existing authorization for other services in order to obtain a continued stay authorization, unless the service falls under the alternative authorization provisions described in section 17a-453a-8 of the Regulations of Connecticut State Agencies.

(b) The decision regarding continued stay authorization shall be rendered by DMHAS's designated agent not more than three (3) hours after the receipt of all information that DMHAS's designated agent determines is necessary and sufficient to render a decision or within five (5) business days for services authorized through alternative review and registration methods. Upon completion of the review, DMHAS's designated agent, shall:

(1) Authorize the requested covered service, for a specific number of days or sessions of treatment over a specified time period;

(2) Authorize a different covered service than requested; or

(3) Deny authorization, when the information received by DMHAS's designated agent does not demonstrate that the requested service is medically necessary.

(c) The provider shall furnish DMHAS's designated agent with such information as may be requested by the designated agent for the purpose of continued stay authorization review of covered services requested for a potentially eligible or eligible recipient, including, but not limited to, the following:

(1) Recipient identifying information;

(2) DSM-IV current diagnosis or diagnoses;

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- (3) Level of care requested;
- (4) Clinical presentation of the recipient and justification for the requested service, including such factors as the recipient's mental status, natural supports and strengths;
- (5) Recovery plan objectives;
- (6) Current symptoms of mental illness or substance use disorders, or both;
- (7) Clinical risk assessment and relapse potential;
- (8) Medication(s) used;
- (9) Substance(s) used;
- (10) Whether the recipient is voluntarily agreeing to treatment;
- (11) Legal status of the recipient, if known;
- (12) Recipient's preference for service type and provider;
- (13) Treatment location;
- (14) Provisional discharge or aftercare plan, or both;
- (15) Projected date of discharge;
- (16) Name of the recipient's primary care physician, if any; and
- (17) All other information that the designated agent may require.

**(NEW) Sec. 17a-453a-8. Alternative authorization review**

Web-based registration or outpatient treatment review (OTR) submission shall be the alternative methods of prior authorization review and continued stay review for the following covered services:

- (a) Outpatient Substance Abuse;
- (b) Outpatient Mental Health; and
- (c) Chemical Maintenance Treatment

DMHAS's designated agent may utilize telephonic review when additional information is required to ensure an appropriate prior authorization or continued stay decision for covered services identified in section 17a-453a-8 of the Regulations of Connecticut State Agencies.

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**Section 17a-453a****(NEW) Sec. 17a-453a-9. Recovery and Discharge Planning**

Except for those providing laboratory services, all providers shall meet the following requirements:

(a) Recovery planning: The provider shall develop a recovery plan with each recipient:

(1) The recovery plan shall be developed with participation from the recipient or, if the recipient does not participate in its development, shall contain a written explanation as to why the recipient did not participate;

(2) The recovery plan shall reflect:

(A) the recipient's preferences, interests, strengths and areas of health;

(B) specific outcomes that the recipient desires related to (i) above;

(C) activities, supports and services that may assist with the achievement of the recipient's desired outcomes;

(D) regularly scheduled review and, if necessary, revision of the plan; and

(E) review by, and signatures of the recipient, counselor or clinician responsible for the development of the plan with the recipient, and his or her supervisor (if the counselor or clinician is not licensed or certified).

(b) Discharge planning: The provider shall develop a discharge plan with each recipient:

(1) The discharge plan shall be developed with participation from the recipient or, if the recipient does not participate in its development, shall contain a written explanation as to why the recipient did not participate.

(2) Discharge plan review for residential and inpatient services: Providers are required to participate in a discharge plan review for all recipients admitted into the following services:

(A) acute psychiatric hospitalization;

(B) medically managed inpatient detoxification;

(C) medically monitored residential detoxification;

(D) intensive residential treatment;

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(E) intermediate or long-term treatment or care;

(c) Except when the recipient leaves the program unexpectedly, the provider shall contact the designated agent to request a discharge review not more than two (2) days, and not less than four (4) hours, before the recipient's scheduled departure;

(1) Reviews of unexpected discharges shall be conducted not later than one (1) business day following the date of the recipient's discharge. If a recipient leaves a program but is expected to return, the provider may delay the discharge review until either the recipient returns or a decision is made to discharge the recipient. The provider shall conform with generally accepted standards of professional practice regarding the duration of time it shall delay a discharge decision for a recipient who left the program unexpectedly and has not returned; and

(2) The discharge plan review for a recipient shall include the following:

(A) the recipient's identifying information;

(B) his or her DSM-IV discharge diagnosis;

(C) progress made toward the accomplishment of treatment objectives;

(D) clinical presentation of the recipient at the time of discharge, including such items as his or her mental status and response to treatment;

(E) clinical risk and relapse potential;

(F) medication(s) used during the present treatment episode;

(G) circumstances of discharge, including whether the recipient left upon completion of treatment or under some other discharge status, and the details of that status;

(H) recipient's involvement in recovery and discharge planning;

(I) details of the discharge or aftercare plan, or both, for the recipient, including the level of care recommended by the discharging provider and details of arrangements made to secure that care;

(J) living arrangement(s) and address upon discharge for the recipient; and

(K) arrangements for any medication(s) that may be needed by the recipient following discharge.

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**(NEW) Sec. 17a-453a-10. Quality management**

(a) Compliance with confidentiality requirements: The contracted provider shall comply with all state and federal requirements pertaining to the communication, storage, dissemination, and retention of confidential information regarding recipients with mental health or substance use disorders, or both, including the Health Insurance Portability and Accountability Act (HIPAA); 45 C.F.R. Part 164, 42 C.F.R. Part 2; section 17a- 688 (c) and Chapter 899 of the Connecticut General Statutes; and other such laws and regulations as may apply. In addition, the contracted provider shall assume responsibility for obtaining any release of information that may be necessary to meet contractual data transmittal and service coordination requirements specified in these regulations;

(b) Critical incident reporting. Except for providers of laboratory services, a contracted provider shall report every critical incident to the DMHAS Office of the Commissioner in the form and manner specified by the department.

(c) Other reporting requirements: The contracted provider shall submit to DMHAS or its designated agent timely and accurate information in a format specified by DMHAS or its designated agent. This information includes, but is not limited to, the following:

- (1) Demographic data regarding the recipients served;
- (2) Descriptions of the services provided;
- (3) Descriptions of the contracted provider's staff, sufficient for DMHAS to assess the agency's cultural competency;
- (4) Outcomes of treatment;
- (5) Results of risk assessment screening; and
- (6) A critical incident review summary, including recommendations, in the format and manner prescribed by the department.

(d) Out-of-network providers shall comply with all requirements set forth in section 17a-453-10 of the Regulations of Connecticut State Agencies.

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**(NEW) Sec. 17a-453a-11. Provider application**

(a) In order to be considered for participation in the DMHAS GABHP, a provider shall request, in writing, an application packet from DMHAS's designated agent. The application packet shall be completed by the provider and shall include all information required by DMHAS;

(b) DMHAS shall require, at a minimum, the following information from a provider:

- (1) Provider's name, address, telephone number, and contact person;
- (2) Program capacity;
- (3) Age groups and genders treated by the provider;
- (4) Staff licenses, competencies, and language(s) spoken by the provider's staff;
- (5) Problems and disorders treated by the provider;
- (6) Level(s) of care offered by the provider;
- (7) Provider's treatment specialties; and
- (8) A copy of the provider's state-required facility license(s).

(c) The provider shall complete the application and return it to DMHAS's designated agent not more than thirty (30) calendar days after the date of receipt. If a provider does not submit a completed application within the required time frame, DMHAS, at its sole discretion, may decide not to accept the provider's application.

(d) An out-of-network provider that delivers five (5) or more acute care services to recipients in a calendar year shall apply for participation in the DMHAS GABHP.

**(NEW) Sec. 17a-453a -12. Provider credentials**

(a) Credentialing process.

(1) The purpose of the credentialing process is for DMHAS to determine if a provider applying for participation in the general assistance behavioral health program has the requisite qualifications to participate in the DMHAS GABHP.

(2) If DMHAS determines that a provider has not met the required qualifications specified in section 17a-453a-12 of the Regulations of Connecticut State Agencies, DMHAS will not

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contract with the provider under the GABHP. The credentialing process shall include the assessment and validation of qualifications for providers, including hospitals, independent laboratories, mental health treatment facilities and substance use treatment facilities to determine if the provider is qualified to offer specific levels of care and meets the credentialing requirements for those levels of care;

(3) DMHAS's designated agent shall collect and review documentation that includes, but is not limited to:

(A) Status of facility or professional licensure, certification, or accreditation;

(B) Experience in providing services to recipients;

(C) Evidence of adequate malpractice insurance coverage; and

(D) Descriptions detailing programmatic and staffing information for each service and level of care proposed for credentialing.

(4) The designated agent shall review the credentials of each provider for each service or level of care that the provider proposes to deliver and shall make a recommendation to DMHAS. DMHAS shall decide whether the provider meets the credentialing qualifications necessary to offer the proposed service(s) or level(s) of care;

(5) The provider shall be required to submit to the designated agent additional information or clarification if any discrepancies or questions are identified;

(6) The provider shall be required to meet all credentialing criteria as specified in section 17a-453a-12 of the Regulations of Connecticut State Agencies. If any of the credentialing criteria are not met, the provider shall be denied participation in the DMHAS GABHP;

(7) Any provider that has been sanctioned by DSS for violations while participating in the Medicaid program shall not be credentialed for the DMHAS GABHP;

(8) DMHAS shall notify the provider in writing of the outcome of the credentialing process. If DMHAS determines that the provider meets the requisite credentialing qualifications as specified in section 17a-453a-12 of the Regulations of Connecticut State Agencies, then

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DMHAS may initiate the contracting process, as specified in section 17a-453a-13 of the Regulations of Connecticut State Agencies.

## (b) Denial.

(1) A provider that is denied participation in the DMHAS GABHP may request reconsideration of such denial. Such request shall be submitted in writing to the commissioner of DMHAS not more than ten (10) calendar days following receipt of the denial notice.

## (c) Credentialing criteria for covered services operated in Connecticut.

(1) Acute psychiatric hospitalization service as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

## (A) Acute psychiatric hospitalization services shall be delivered in a facility that:

- (i) is state-operated, a private freestanding psychiatric hospital or a general hospital;
- (ii) except as provided by state law, maintains professional liability insurance coverage of at least three million dollars (\$3,000,000) per occurrence and ten million dollars (\$10,000,000) in aggregate, or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and
- (iii) is JCAHO-accredited.

(B) If the service is located in a general hospital, the hospital shall provide the service on a psychiatric unit that is separate and distinct from a medical unit;

(C) The acute psychiatric hospitalization service shall include the following staff, licensed by the state of Connecticut and employed by or under contract with the facility in which the service operates:

- (i) a medical director;
- (ii) a board-certified or board-eligible psychiatrist;
- (iii) a psychologist;
- (iv) social workers;
- (v) a physician on site 24 hours per day, seven (7) days per week; and
- (vi) registered nurses on site 24 hours per day, seven (7) days per week;

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(D) Acute psychiatric hospitalization service components shall include:

- (i) the ability to conduct an admission 24 hours per day, seven (7) days per week;
- (ii) diagnostic evaluation, including screening for co-occurring substance use issues, a bio-psychological assessment and a risk assessment;
- (iii) a medical history and physical examination conducted upon admission;
- (iv) medication evaluation and monitoring;
- (v) medical management and monitoring of coexisting medical problems, except that life support systems or a full array of medical acute care services are not required;
- (vi) appropriate observation and precautions for suicidal patients;
- (vii) development of a recovery plan for each recipient;
- (viii) individual and group therapy and, when indicated, family therapy;
- (ix) rehabilitative social and recreational therapies, when indicated;
- (x) laboratory services, when indicated; and
- (xi) discharge planning that helps ensure the continuation of appropriate treatment.

(2) Ambulatory detoxification as described in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) The ambulatory detoxification service shall be delivered in a facility that:

- (i) Is a general hospital, a private freestanding psychiatric hospital or a facility licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer ambulatory chemical detoxification, or is state-operated;
- (ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and
- (iii) Is JCAHO or CARF-accredited or has a licensed physician with experience in providing services for substance use disorders, who is responsible for supervising all medical

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services and is credentialed by DMHAS in accordance with credentialing criteria contained in this section.

(B) The service shall include a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the State of Connecticut or certified as appropriate in his or her respective discipline and be employed by or under contract with the facility in which the service is operated;

(C) The organization operating the ambulatory detoxification service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling immediate access for its recipients, when needed, to facilities that offer such care; and

(D) Ambulatory detoxification service components shall include:

- (i) initial evaluation, including screening for co-occurring mental health issues;
- (ii) a physical examination by a physician, physician's assistant, or nurse practitioner as part of the initial assessment;
- (iii) individual assessment and medication or non-medication methods of detoxification;
- (iv) medical supervision and management of substance withdrawal as indicated by a licensed physician and inclusive of laboratory assessments;
- (v) one (1) hour of substance use disorder services per week;
- (vi) family or "significant other" involvement in the detoxification process, when appropriate;
- (vii) development of a recovery plan for each recipient;
- (viii) laboratory services, when indicated;
- (ix) the ability to provide or assist in accessing transportation services for recipients who are unable to drive safely for legal or medical reasons, or who otherwise lack transportation;

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(x) discharge planning that helps ensure the continuation of appropriate treatment and movement through the recovery continuum;

(xi) referral to self-help programs; and

(xii) adequate testing or analysis for drugs of abuse in a manner consistent with applicable state and federal statutes and regulations.

(E) Substance use disorder services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional, or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the program;

(ii) the medical or clinical supervisor has determined that the staff member is qualified to render clinical services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(3) Ambulatory detoxification with on-site monitoring as described in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Ambulatory detoxification with on-site monitoring service shall be delivered in a facility that:

(i) Is a general hospital, a private freestanding psychiatric hospital or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer ambulatory chemical detoxification, or is state-operated;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000)

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in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) Is JCAHO or CARF-accredited, or has a licensed physician with experience in providing services for substance use disorders, who is responsible for supervising all medical services provided by the program and is credentialed by DMHAS in accordance with credentialing criteria contained in this section.

(B) The service shall include a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a health services-related field, at least three (3) years of full-time work experience in substance use disorder treatment, be licensed by the State of Connecticut or certified as appropriate in his or her respective discipline, and be employed by or under contract with the facility in which the program is operated;

(C) The organization operating the ambulatory detoxification with on-site monitoring shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling immediate access for its recipients, when needed, to facilities that offer such care;

(D) Ambulatory detoxification with on-site monitoring service components shall include:

(i) initial evaluation, including screening for co-occurring mental health issues;

(ii) a physical examination by a physician, physician's assistant or nurse practitioner as part of the initial assessment;

(iii) individual assessment, medication or non-medication methods of detoxification;

(iv) medical supervision and management of substance withdrawal as indicated by a licensed physician and inclusive of laboratory assessments;

(v) a minimum of one (1) hour of substance use disorder services per week;

(vi) family or "significant other" involvement in the withdrawal process when appropriate;

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- (vii) development of a recovery plan for each recipient;
- (viii) laboratory services, when indicated;
- (ix) the ability to provide or assist in accessing transportation services for recipients who are unable to drive safely for legal or medical reasons, or who otherwise lack transportation;
- (x) discharge planning that helps ensure the continuation of appropriate treatment and movement through the recovery continuum;
- (xi) referral to self-help programs; and
- (xii) adequate testing or analysis for drugs of abuse in a manner consistent with applicable state and federal statutes and regulations.

(E) Ambulatory detoxification with on-site monitoring shall have a licensed nurse on site during all hours of operation; and

(F) Ambulatory detoxification with on-site monitoring shall have available psychiatric and other clinical services for problems identified through a comprehensive biopsychosocial assessment.

(G) Substance use disorder services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional, or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the program;

(ii) the medical or clinical supervisor has determined that the staff member is qualified to render clinical services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

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(4) Chemical maintenance treatment service as described in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Chemical maintenance treatment shall be provided in a facility that:

(i) is state-operated or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer chemical maintenance treatment;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) meets conditions for the use of methadone, or other SAMHSA-approved medications, in chemical maintenance treatment of opiate dependence, as used in 21 CFR, Part 291 and other applicable federal regulations; and

(iv) is JCAHO, CARF or COA-accredited, or has a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services-related field and at least three (3) years of full-time work experience in substance use disorders, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline, and be employed by or under contract with the facility in which the service is operated.

(B) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(C) Service components shall include:

(i) assessment to determine the appropriateness of chemical maintenance;

(ii) a medical history and physical examination conducted by the program's physician or other appropriate medical personnel;

(iii) laboratory services;

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- (iv) a minimum of one (1) clinical contact per recipient per month;
  - (v) medication evaluation and management;
  - (vi) a complete biopsychosocial assessment, including screening for co-occurring mental health issues;
  - (vii) development of a recovery plan for each recipient;
  - (viii) daily administration of methadone at least six (6) days per week, or administration as appropriate of another SAMHSA-approved medication; ability to dispense doses for off-premises consumption as appropriate;
  - (ix) psycho-educational programming;
  - (x) discharge planning that helps ensure the continuation of appropriate treatment;
  - (xi) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations;
  - (xii) vocational or pre-vocational planning; and
  - (xiii) referral to self-help programs.
- (E) Chemical maintenance programs shall have the ability to gradually increase to or maintain medication at a therapeutic and stable level in order to block the effects of opiates for recipients receiving such care;
- (F) The facility shall have a written medication diversion plan in place that assists in the identification and management of inappropriate diversion of take-home medications; and
- (G) Substance use disorder services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional, or a Connecticut certified alcohol and drug counselor shall meet the following conditions:
- (i) the staff member is employed by or under contract with the facility operating the program;
  - (ii) the medical or clinical supervisor has determined that the staff member is qualified to render clinical services; and

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(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(5) Intensive outpatient-mental health.

(A) The service shall be in a facility that:

(i) is state-operated, operated by a provider that is a licensed non-profit mental health facility, a licensed private freestanding psychiatric hospital or a general hospital;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;

(iii) is JCAHO or CARF-accredited, or has a board-certified or board eligible psychiatrist who is responsible for supervising all medical services. If the service is operated by a non-profit mental health agency, the psychiatrist shall be credentialed by DMHAS in accordance with credentialing criteria contained in section 17a-453a-12 of the Regulations of Connecticut State Agencies; and

(iv) includes a clinical supervisor with authority over all clinical services who is licensed in a behavioral health services-related field and has at least three (3) years of full-time work experience in mental health treatment.

(B) The service shall include the following licensed professionals from at least three of the following disciplines: psychiatry, nursing, psychology, social work, or other behavioral health professionals licensed by the state of Connecticut;

(C) The organization operating the service shall provide emergency medical services or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

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(D) Service components shall include:

- (i) diagnostic evaluation and risk assessment;
  - (ii) individual and group therapy, and when indicated, family therapy;
  - (iii) a complete biopsychosocial assessment, including screening for co-occurring substance use issues;
  - (iv) development of a recovery plan for each recipient;
  - (v) psycho-educational programming;
  - (vi) psychological testing, when indicated;
  - (vii) medication evaluation and management;
  - (viii) discharge planning that helps ensure the continuation of appropriate treatment;
- and
- (ix) referral to self-help programs.

(E) The program shall provide each recipient three (3) to four (4) hours per day, three (3) to five (5) days per week, of programming that includes not less than one (1) individual or group therapy session per day; and

(F) Any services, other than psycho-educational programming, performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse or other licensed behavioral health professional shall meet the following conditions:

- (i) the staff member is employed by or under contract with the facility operating the service;
- (ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and
- (iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional who has at least two (2) years of experience in the provision of behavioral health treatment services and is actively pursuing a DPH license in a behavioral health discipline;

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(6) Intensive outpatient-substance use.

(A) The service shall be in a facility that:

(i) is state-operated, a general hospital, a private freestanding psychiatric hospital or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer outpatient treatment;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited, or has a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a health services-related field, at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline, and be employed by or under contract with the facility in which the service is operated.

(B) The service shall include drug and alcohol abuse counselors or other staff in related fields with experience in treatment of substance use disorders;

(C) The organization operating the service shall provide emergency psychiatric and emergency medical services or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(D) Services components shall include:

(i) a biopsychosocial assessment, including screening for co-occurring substance use issues;

(ii) development of a recovery plan for each recipient;

(iii) orientation and referral to a self-help program;

(iv) psycho-educational programming;

(v) individual, group, and when indicated, family counseling;

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(vi) discharge planning that helps ensure the continuation of appropriate treatment;  
and

(vii) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations.

(E) The program shall provide each recipient three (3) to four (4) hours per day, three (3) to five (5) days per week, of substance use disorders services based on an individualized recovery plan inclusive of at least one (1) individual or group therapy session per day; and

(F) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the program;

(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavior health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(7) Intensive residential treatment.

(A) The service shall be in a facility that:

(i) is state-operated or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer intensive residential treatment;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

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(iii) is JCAHO or CARF-accredited, or has a clinical supervisor with authority over all clinical services.

(B) The service shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility in which the service is operated:

(i) a clinical supervisor with authority over all clinical services, who shall have a minimum of a master's degree in health services-related field and at least three (3) years of full-time work experience in substance use disorder treatment and be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline;

(ii) a sufficient number of staff to meet the needs of service recipients.

(C) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, or other behavioral health professional, or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the service;

(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor;

(D) The organization operating the service shall provide emergency psychiatric and emergency medical services or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care; and

(E) Service components shall include:

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- (i) a complete biopsychosocial assessment, including screening for co-occurring mental health issues;
  - (ii) development of a recovery plan for each recipient;
  - (iii) the program shall provide each recipient a minimum of thirty (30) hours per week of substance use disorder services;
  - (iv) orientation and referral to a self-help program;
  - (v) discharge planning that helps ensure the continuation of appropriate treatment;
  - (vi) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations; and
  - (vii) vocational and pre-vocational planning;
- (8) Intermediate or long-term treatment or care.
- (A) This service shall be in a facility that:
- (i) is licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer intermediate and long-term treatment and rehabilitation or care and rehabilitation;
  - (ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and
  - (iii) is JCAHO or CARF-accredited, or has a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work experience in substance use disorder treatment, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline, and be employed by or under contract with the facility in which the service is operated.

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(B) The organization operating the service shall provide emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for its clients, when needed, to facilities that offer such care.

(C) Service components shall include:

(i) a biopsychosocial assessment, including screening for co-occurring mental health issues;

(ii) development of a recovery plan for each recipient;

(iii) orientation and referral to a self-help program;

(iv) discharge planning that helps ensure the continuation of appropriate treatment;

(v) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations;

(vi) vocational and pre-vocational planning; and one of the following:

(I) a minimum of twenty (20) hours per week of substance use disorders services shall be provided to each recipient by facilities licensed for intermediate and long-term treatment and identified as providing intermediate and long-term residential treatment; or

(II) a minimum of twenty (20) hours per week of substance use disorders services shall be provided to each recipient by facilities licensed for care and rehabilitation and identified as providing long-term care, or

(III) a minimum of four (4) hours per week of substance use disorder services shall be provided to each recipient by facilities licensed for intermediate and long-term treatment and identified as providing transitional or halfway house services.

(D) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the program;

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(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(9) Laboratory services.

Specimen testing and analysis services used to establish diagnosis and treatment of behavioral health disorders shall be provided by a facility that is:

(A) Certified pursuant to the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), Title 42 Part 493 of the Code of Federal Regulations; and

(B) Licensed as a clinical laboratory in accordance with sections 19a-36-D20 to 19a-36-D38 of the Regulations of Connecticut State Agencies.

(10) Matrix intensive outpatient.

(A) The service shall be in a facility that:

(i) is licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer outpatient treatment;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited, or has a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the state of Connecticut or certified, as appropriate, in his or her respective discipline, and be employed by or under contract with the facility in which the service is operated.

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(B) The service shall include alcohol and drug abuse counselors or other staff in related fields with experience in treatment of substance use disorders, who are licensed by the state of Connecticut or certified as appropriate in their respective disciplines and are employed by or under contract with the facility in which the service is operated;

(C) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling immediate access for its recipients, when needed to facilities that offer such care;

(D) Components of matrix intensive outpatient services shall include:

(i) a biopsychosocial assessment, including screening for co-occurring mental health issues;

(ii) development of a recovery plan for each recipient;

(iii) individual sessions that are scheduled weekly and consist of eight (8), one-hour meetings for the first two months, followed by one each month for the next two months;

(iv) early recovery skills groups that meet twice weekly and consist of eight, one-hour group sessions during the first month of treatment;

(v) a recovery group that meets once weekly and consists of twelve, ninety-minute group sessions for the first three months;

(vi) a family education group that meets once weekly and consist of twelve, ninety-minute group sessions for the first three months;

(vii) a social support group that meets weekly and consists of ninety-minute group sessions, beginning at week thirteen;

(viii) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations;

(ix) referral to a self-help program,

(x) discharge planning that helps ensure the continuation of appropriate treatment;

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(xi) determination that the recipient has had a physical examination in the past twelve (12) months and referral for examination, if needed.

(E) Any substance use disorder services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional, or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the service;

(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render clinical services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(11) Medically managed inpatient detoxification.

(A) The service shall be in a facility that:

(i) is state-operated or a private freestanding psychiatric hospital or general hospital;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least three million dollars (\$3,000,000) per occurrence and ten million dollars (\$10,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited.

(B) The organization operating the service shall provide emergency psychiatric services or maintain written agreements enabling immediate access for its clients, when needed, to facilities that offer such care;

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(C) Service components shall include:

- (i) the ability to conduct an admission 24 hours per day, seven (7) days per week;
- (ii) a medical history and physical examination conducted upon admission, inclusive of laboratory testing;
- (iii) diagnostic evaluation and risk assessment;
- (iv) medical management and monitoring of substance withdrawal;
- (v) individual, group and, when indicated, family therapy;
- (vi) a biopsychosocial assessment, including screening for co-occurring mental health issues;
- (vii) development of a recovery plan for each recipient;
- (viii) appropriate observation and precautions for suicidal patients;
- (ix) referral to a self-help program;
- (x) medical management and monitoring of co-existing medical problems, except that life support systems or a full array of medical acute care services are not required; and
- (xi) discharge planning that helps ensure the continuation of appropriate treatment.

(D) The service shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines:

- (i) a medical director;
- (ii) a social worker or counselor experienced in the treatment of substance use disorders;
- (iii) a physician on site 24 hours per day, seven (7) days per week;
- (iv) a registered nurse on site 24 hours per day, seven (7) days per week; and
- (v) a pharmacist.

(12) Medically monitored residential detoxification.

(A) The service shall be in a facility that:

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(i) is state-operated or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer intensive residential detoxification and evaluation;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited, or has a physician with experience in providing substance use disorder services, who is responsible for supervising all medical services. The physician shall be credentialed by DMHAS in accordance with credentialing criteria contained in this section.

(B) The service shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines, and who are employed by or under contract with the facility in which the program is operated:

(i) a clinical supervisor with authority over all services, who has a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work experience in substance use disorders treatment, and is licensed by the state of Connecticut or certified as appropriate in his or her respective discipline and employed by or under contract with the facility in which the service is operated;

(ii) a registered nurse on site 24 hours per day, seven (7) days per week;

(iii) a physician who is on-call during those hours when a physician is not physically present;

(iv) a physician eligible to be certified by the American Board of Psychiatry or Neurology or a licensed clinical psychologist;

(v) a pharmacist; and

(vi) a social worker or counselor experienced in the treatment of substance use disorders.

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(C) The organization operating the service shall provide emergency psychiatric and emergency medical services or maintain written credentialing agreements enabling immediate access for its recipients, when needed, to facilities that offer such care;

(D) Service components shall include:

- (i) screening and initial evaluation by a registered nurse;
  - (ii) medical supervision and management of withdrawal from a substance, as indicated by a licensed physician and inclusive of laboratory assessments;
  - (iii) individual, group and, when indicated, family therapy;
  - (iv) a biopsychosocial assessment, including screening for co-occurring mental health issues;
  - (v) development of a recovery plan for each recipient;
  - (vi) referral to a self-help program;
  - (vii) psycho-educational programming;
  - (viii) treatment delivery reflecting cultural competency and gender appropriateness in a recovery model, inclusive of evidence-based best practices; and
  - (ix) discharge planning that helps ensure the continuation of appropriate treatment;
- and

(E) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, or other behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

- (i) the staff member is employed by or under contract with the facility operating the program;
- (ii) the medical or clinical supervisor has determined that the staff member is qualified to render clinical services; and
- (iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional with

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at least two (2) years of experience in the provision of behavioral health treatment services, or Connecticut certified clinical supervisor.

(13) Observation bed-mental health.

(A) The service shall be in a facility that:

(i) is state-operated, a private freestanding psychiatric hospital or general hospital, or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least three million dollars (\$3,000,000) per occurrence and ten million dollars (\$10,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO-accredited.

(B) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(C) The service shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines:

(i) a board-certified or board-eligible psychiatrist, who is responsible for supervising all medical services provided by the program; and

(ii) a registered nurse and other licensed or certified behavioral health professionals.

(D) The service shall provide each recipient up to twenty-three (23) hours of supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable disposition for recipients in urgent need of care; and

(E) Services components shall include:

(i) the ability to conduct an admission 24 hours per day, seven (7) days per week;

(ii) crisis intervention, as required;

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(iii) diagnostic evaluation and risk assessment, including co-occurring substance use history;

(iv) a medical history and physical examination conducted upon admission;

(v) medication evaluation and management;

(vi) appropriate observation and precautions for suicidal patients;

(vii) laboratory services, when indicated; and

(viii) discharge planning that helps ensure the continuation of appropriate treatment.

(14) Observation bed-substance use.

(A) Observation bed services-substance use shall be in a facility that:

(i) is state-operated, a freestanding psychiatric hospital, a general hospital or a facility for medically monitored residential detoxification or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer medical triage;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited or has a physician with experience in providing substance use disorders services, who is responsible for supervising all medical services. The physician shall be credentialed by DMHAS in accordance with credentialing criteria contained in this section.

(B) The service shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines, and employed by or under contract with the facility in which the program is operated:

(i) a registered nurse;

(ii) An alcohol and drug counselor; and

(iii) A clinical supervisor with authority over all services, who has a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work

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experience in substance use disorders treatment, and is licensed by the state of Connecticut or certified as appropriate in his or her respective discipline and employed by or under contract with the facility in which the service is operated.

(C) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling immediate access for its recipients, when needed, to facilities that offer such care;

(D) The service shall provide each recipient up to twenty-three (23) hours of supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable disposition for recipients in urgent need of care;

(E) Service components shall include:

- (i) crisis intervention, as required;
- (ii) diagnostic evaluation and risk assessment, including screening for co-occurring mental health issues;
- (iii) medication evaluation and management;
- (iv) discharge planning that helps ensure the continuation of appropriate treatment;
- (v) laboratory services, when indicated; and
- (vi) a physical examination and medical history conducted upon admission; and

(F) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional, or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

- (i) the staff member is employed by or under contract with the facility operating the program;
- (ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and
- (iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional

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with at least two (2) years of experience in the provision of behavioral health treatment services, or a Connecticut certified clinical supervisor.

(15) Outpatient-mental health.

(A) The service shall be in a facility that:

(i) is state-operated, a general hospital, a private freestanding psychiatric hospital or is a licensed psychiatric outpatient clinic for adults;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited, or has a board-certified or board-eligible psychiatrist who is responsible for supervising all medical services. If the service is operated by a nonprofit mental health facility, the psychiatrist shall be credentialed by DMHAS in accordance with credentialing criteria contained in this section of the GABHP regulations.

(B) The service shall include a clinical supervisor with authority over all clinical services, who is licensed by the state of Connecticut in a behavioral health services-related field and has at least three (3) years of full-time work experience in mental health treatment.

(C) The facility operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(D) Service components shall include:

(i) diagnostic evaluation and risk assessment;

(ii) individual and group therapy and, if indicated, family therapy;

(iii) a complete biopsychosocial assessment, including screening for co-occurring substance use;

(iv) development of a recovery plan for each recipient;

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- (v) psychological testing, when indicated;
- (vi) medication evaluation and management;
- (vii) discharge planning that helps ensure the continuation of appropriate treatment;

and

- (viii) referral to self-help programs.

(E) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional shall meet the following conditions:

- (i) the staff member is employed by or under contract with the facility operating the service;

- (ii) the medical director or clinical supervisor has determined that the staff member is qualified to render clinical services; and

- (iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services and is actively pursuing a DPH license in a behavioral health discipline.

(16) Outpatient-substance use.

(A) The service shall be in a facility that:

- (i) is state-operated, a general hospital, a private freestanding psychiatric hospital or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer outpatient treatment;

- (ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

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(iii) is JCAHO or CARF-accredited, or has a clinical supervisor with authority over all clinical services. The clinical supervisor shall have a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work experience in substance use disorders treatment, and be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline, and be employed by or under contract with the facility in which the service is operated.

(B) The service shall include Connecticut certified alcohol and drug abuse counselors or other staff in related fields with experience in treatment of substance use disorders, licensed by the state of Connecticut or certified as appropriate in their respective disciplines, and be employed by or under contract with the facility in which the service is operated;

(C) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(D) Service components shall include:

- (i) a biopsychosocial assessment, including screening for co-occurring mental health issues;
- (ii) development of a recovery plan for each recipient;
- (iii) individual and group therapy and, when indicated, family therapy;
- (iv) referral to a self-help program;
- (v) discharge planning that helps ensure the continuation of appropriate treatment; and
- (vi) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations.

(E) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse or other licensed behavioral health professional, or a Connecticut certified alcohol and drug counselor, shall meet the following conditions:

- (i) the staff member is employed by or under contract with the facility operating the program;

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(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and

(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(17) Partial hospitalization-mental health.

(A) The service shall be in a facility that:

(i) is state-operated, a private freestanding psychiatric hospital, general hospital or a licensed freestanding mental health day treatment facility;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited, or has a board-certified or board-eligible psychiatrist who is responsible for supervising all psychiatric services provided by the program. The psychiatrist shall be credentialed by DMHAS in accordance with credentialing criteria contained in the GABHP regulations.

(B) The service shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines, and employed by or under contract with the facility in which the service is operated:

(i) a clinical supervisor who is licensed by the state of Connecticut in a behavioral health services-related field and has at least three (3) years of full-time work experience in mental health treatment;

(ii) a registered nurse or other licensed behavioral health professionals;

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(iii) staff from the disciplines of nursing, psychology, social work, and occupational therapy;

(iv) other behavioral health professionals available on a full-time, part-time or consultative basis, as may be appropriate to recipient needs, from such disciplines as psychiatry, nursing, psychology and social work.

(C) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(D) Service components shall include:

- (i) diagnostic evaluation and risk assessment;
- (ii) a biopsychosocial assessment, including screening for co-occurring substance use;
- (iii) individual and group therapy and, when indicated, family therapy;
- (iv) rehabilitative social and recreational therapies;
- (v) development of a recovery plan for each recipient;
- (vi) laboratory services, when indicated;
- (vii) pre-vocational and vocational planning;
- (viii) medication evaluation and management;
- (ix) psycho-educational and self-help programming; and
- (x) discharge planning that helps ensure the continuation of appropriate treatment.

(E) Any services, other than psycho-education and self-help programming, performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse or other licensed behavioral health professional shall meet the following conditions:

(i) the staff member shall be employed by or under contract with the facility operating the program;

(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and

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(iii) the staff member is actively pursuing behavioral health licensure and is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse, or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services; and

(F) The service shall provide each recipient a minimum of four (4) hours per day, three (3) to five (5) days per week, of programming based on an individualized recovery plan that includes not less than one (1) individual or a minimum of one (1) group therapy session per day.

(18) Partial hospitalization (day or evening treatment)-substance use.

(A) The service shall be in a facility that:

(i) is state-operated, a private freestanding psychiatric hospital, general hospital or licensed in accordance with section 19a-495-570 of the Regulations of Connecticut State Agencies to offer day or evening treatment;

(ii) except as provided by state law, maintains professional liability insurance coverage of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate; or if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability; and

(iii) is JCAHO or CARF-accredited, or has a licensed physician with experience in providing services for substance use disorders who is responsible for supervising all medical services and is credentialed by DMHAS in accordance with credentialing criteria contained in this section.

(B) The service shall include a clinical supervisor with authority over all clinical services, who has a minimum of a master's degree in a health services-related field and at least three (3) years of full-time work experience in substance use disorders treatment, is licensed by the state of Connecticut or certified as appropriate in his or her respective disciplines and employed by or under contract with the facility in which the service is operated;

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(C) The organization operating the service shall provide emergency psychiatric and emergency medical services, or maintain written agreements enabling access for its recipients, when needed, to facilities that offer such care;

(D) The service shall provide each recipient a minimum of four (4) hours per day, three (3) to five (5) days per week, of programming, inclusive of at least one (1) individual or group therapy session per day;

(E) Service components shall include:

(i) a biopsychosocial assessment, including screening for co-occurring mental health issues;

(ii) development of a recovery plan for each recipient;

(iii) individual and group therapy and, when indicated, family therapy;

(iv) psycho-educational programming;

(v) vocational or pre-vocational planning;

(vi) orientation and referral to a self-help program,

(vii) discharge planning that helps ensure the continuation of appropriate treatment;

and

(viii) adequate testing or analysis for drugs of abuse in a manner consistent with applicable federal and state statutes and regulations.

(F) Any services performed by a staff member who is not a licensed physician, psychologist, social worker, registered nurse, other licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) the staff member is employed by or under contract with the facility operating the service;

(ii) the medical director or clinical supervisor has determined that the staff member is qualified to render services; and

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(iii) the staff member is under the direct supervision of a licensed physician, psychologist, social worker, registered nurse or other licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(d) Credentialing criteria for practitioners with medical responsibility.

(1) A physician who would be providing medical supervision within a level of care for which a provider is applying for credentials shall apply for separate credentials.

(A) The physician applicant shall:

(i) hold a current, valid and unrestricted license to practice medicine in the state of Connecticut;

(ii) be certified by the American Society of Addiction Medicine (ASAM) or have at least two (2) years of experience in the treatment of substance use disorders (for substance use disorder treatment services only);

(iii) maintain professional liability insurance coverage of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate;

(iv) possess a current Drug Enforcement Administration (DEA) certificate;

(v) not be subject to any current Medicaid or Medicare sanctions.

(B) As part of the credentialing process, DMHAS shall consider the following factors when determining the physician applicant's suitability to participate in the DMHAS GABHP:

(i) any malpractice claim(s) made against the applicant that have been settled, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim(s);

(ii) any lawsuit, other than a malpractice lawsuit, that is related to the physician applicant's competency to practice, or to the physician applicant's conduct in the course of his or her practice, filed against the physician applicant or settled, adjudicated or otherwise resolved;

(iii) insofar as permitted by law, any record of criminal convictions;

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(iv) any discipline imposed on the physician applicant for violation of the rules, bylaws or standards of practice of any governmental authority, health care facility, group practice or professional association or society;

(v) applicant's privilege to possess, dispense or prescribe a controlled substance has been surrendered, suspended, revoked, denied or restricted by any state or federal agency;

(vi) applicant withdrew a medical license application or was denied a medical license for any reason;

(vii) professional liability insurance carrier terminated, restricted, limited, imposed a surcharge or co-payment, or placed any condition(s) on the applicant's professional liability insurance related to the applicant's professional conduct or competency, or whether the applicant ever voluntarily terminated, restricted or limited his or her insurance coverage related to an inquiry from the liability insurance carrier;

(viii) applicant has been diagnosed with a medical condition that limits or impairs his or her ability to practice medicine;

(ix) applicant engaged in the use of chemical substance(s) in a way that interferes with his or her ability to practice medicine; and

(x) applicant participated in continuing education related to his or her area of practice.

(e) Credentialing of out-of-network providers.

(1) An out-of-network provider shall only be credentialed to provide acute care services.

(2) An out-of-network provider who delivers five (5) or more acute care services to eligible or potentially eligible recipients in a calendar year shall comply with the credentialing requirements for levels of care as described in section 17a-453a-12 of the Regulations of Connecticut State Agencies, except as provided in section 17a-453a-12 (d)(2);

(3) An out-of-network provider of acute care services who delivers such services to eligible or potentially eligible recipients shall be licensed in the state where the service is rendered; and

(4) An out-of-network provider who delivers five (5) or more acute care services to

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eligible or potentially eligible recipients without being credentialed shall not be paid under the DMHAS GABHP.

(f) Re-credentialing.

(1) DMHAS shall re-credential contracted providers every two (2) years. The re-credentialing process shall include updates of information collected in the original credentialing process and review of additional data that includes, but is not limited to:

(A) Consumer complaints;

(B) Results of quality reviews and provider profiles;

(C) Results of utilization management activities;

(D) Results of recipient satisfactory surveys;

(E) Re-verification of hospital privileges;

(F) Re-verification of current licensure or certification, or both;

(G) Re-verification of current malpractice and liability insurance, or self-funding resources; and

(H) Update on insurance claims, if any.

(2) Any contracted provider who has been sanctioned for violations while participating in the Medicaid program shall not be re-credentialed for the DMHAS GABHP.

**(NEW) Section 17a-453a-13. Provider contract**

(a) DMHAS, in its sole discretion, may extend an offer to contract with a provider who has been credentialed for covered services under the DMHAS GABHP.

(1) A provider who has been credentialed for a covered service may not participate in the DMHAS GABHP unless the provider has executed a contract with DMHAS for the provision of the covered service. The contract shall specify the terms and conditions that will govern the provider and to which the provider must adhere in order to participate in the DMHAS GABHP.

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Except as specified in subsection (b) of section 17a-453a-11 of the Regulations of Connecticut State Agencies, only contracted providers shall provide covered services to recipients

(2) DMHAS shall bear no financial responsibility for services that are rendered to recipients in the absence of a fully executed contract with DMHAS, except if services were rendered by an out-of-network provider, as described in subsection (b) of section 17a-453a-11 of the Regulations of Connecticut State Agencies.

(b) Data collection: Providers participating in the DMHAS GABHP shall be required to comply with all DMHAS requirements pertaining to the collection of data related to the behavioral health services provided in the state of Connecticut under this program. Such data shall be submitted in the format established by DMHAS.

(c) Termination of a provider's contract with DMHAS. DMHAS may terminate a contract with a provider after giving the provider a thirty (30) day written notification or as otherwise required by law and regulation. DMHAS Commissioner in his sole discretion may terminate the provider's contract for reasons that include but are not limited to the following:

(1) Loss, revocation, suspension, surrender or non-renewal of any credential required by section 17a-453a-11 of the Regulations of Connecticut State Agencies, such as the provider's facility license, or any other credential required as a condition of eligibility;

(2) The provider has a diminished ability to provide covered services legally, including disciplinary action by a governmental agency or licensing board that impairs the provider's ability to practice; and

(3) Loss of Drug Enforcement Administration (DEA) certification;

(4) Failure to comply with DMHAS credentialing and re-credentialing requirements and criteria as specified in section 17a-453a-12 of the Regulations of Connecticut State Agencies;

(5) Failure to notify DMHAS of any material event that would affect or modify the information contained in the provider's application for participation in the DMHAS GABHP;

(6) Disciplinary action by any other state, governmental agency or licensing board;

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(7) Termination of, or failure to maintain, adequate malpractice insurance coverage.

(d) Termination reconsideration process:

(1) A provider terminated from participation in the DMHAS GABHP may request reconsideration of such termination. Such request shall be submitted in writing to the commissioner not more than ten (10) calendar days after the date of receipt of such termination notice;

(2) The commissioner, in his sole discretion, shall determine whether to reinstate a provider;

(3) Following a decision to reinstate a provider, the commissioner may reinstate a provider's participation in the GABHP. Such participation may be subject to conditions and limitations as determined by DMHAS.

(4) Public notice of termination. Following a decision to terminate a provider's participation or the expiration of the ten (10) day period for the provider to request reconsideration of termination, the commissioner shall publish a notice of termination in the Connecticut Law Journal. The commissioner may take any steps necessary to inform the public of the provider's termination from the DMHAS GABHP.

(e) The DMHAS Commissioner may seek to terminate a provider's contract after giving the provider thirty (30) days written notice, based upon any of the following circumstances:

(1) Fraud, such as, the provider:

(A) presents a false claim for payment;

(B) accepts payment for goods or services performed that exceeds the amount due for the goods or services rendered to recipients;

(C) solicits to perform or performs services for any recipient, knowing that such recipient is not in need of such services;

(D) accepts from any person or source other than the DMHAS GABHP any additional compensation in excess of the amount authorized pursuant to section 17a-453a-14 of the Regulations of Connecticut State Agencies; or

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(E) presents a claim for payment to DMHAS or its designated agent for services that were not provided to a recipient.

(2) Failure to comply with the terms and conditions established in the contract;

(3) Failure to comply with the DMHAS quality management and utilization review program, as specified in section 17a-453a-10 of the Regulations of Connecticut State Agencies;

(4) Failure to render services to recipients in an ethical manner;

(5) Neglect of, or failure to perform, provider duties specified in the contract with DMHAS;

(6) Failure to implement corrective action required by DMHAS as the result of an audit as specified in section 17a-453a-16;

(7) Any other breach of the provider's GABHP contract that is not corrected by the provider not later than thirty (30) days after receipt of notice from DMHAS, or its designated agent.

(f) If the DMHAS Commissioner seeks to terminate a provider's contract for any reason specified in 17a-453a-13(e), the contracted provider may request a hearing pursuant to section 17a-453a-17 of the Regulations of Connecticut State Agencies.

(g) Non-renewal of contract. The contract is effective through the dates specified in the contract and, if not renewed, is considered expired without prejudice to the provider.

**(NEW) Sec. 17a-453a-14. Claims Administration**

(a) The contracted provider shall verify that DSS determined the individual eligible for medical services pursuant to section 17b-192 of the Connecticut General Statutes;

(b) Each claim shall contain evidence that the contracted provider complied with all prior authorization and continued stay requirements, as set forth in sections 17a-453a-6 to 17a-453a-8, inclusive, of the Regulations of Connecticut State Agencies;

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(c) Claims shall only be considered for payment for covered services delivered during dates of service on which an individual has been determined eligible by DSS pursuant to section 17b-192 of the Connecticut General Statutes. A claim may be considered for payment if a contracted provider is unable to confirm an individual's eligibility with DSS, provided that DSS determines that the individual was eligible for medical services pursuant to section 17b-192 of the Connecticut General Statutes either on or before the date that services were provided and the provider complied with the prior authorization requirement found in section 17a-453a-6 of the Regulations of State Agencies.

(d) Time Line to File Claims. The contracted provider shall file claims not later than 180 days after the date on which the covered service was provided or not later than 180 days after the date the designated agent received notification of the recipient's eligibility, unless such delay was due to the need for coordination of benefits or DMHAS finds that other good cause has been demonstrated. If such delay is due to a delay in determination by DSS of eligibility for medical coverage pursuant to section 17b-192 of the Connecticut General Statutes, the provider shall file claims not later than 365 days after the date on which the service was provided or not later than 365 days after the date the designated agent received notification of the recipient's eligibility.

(e) Acceptance of a claim shall not be a guarantee of payment;

(f) The designated agent shall accept any claims forms approved by DMHAS, including but not limited to, the CMS-1500 (formerly HCFA-1500) and the UB-92 forms;

(g) The claims submitted by a provider for services rendered shall contain all information necessary to match the invoice with the service and, if applicable, service authorization data. For each claim submitted requesting payment for a service provided to an individual, necessary information shall include, but is not limited to, the following:

- (1) Individual's name and address;
- (2) Individual's EMS-ID number or Social Security number;
- (3) Individual's DSM-IV diagnosis;
- (4) Date(s) of service;

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- (5) Type of service rendered to the individual;
  - (6) Provider's name and address;
  - (7) Provider's I.D. number; and
  - (8) Service authorization number, if applicable.
- (h) Claims Payment:
- (1) Claims shall be paid in accordance with rates established by DMHAS;
  - (2) DMHAS may establish rates for the purchase of covered services by using rate setting methods including, but not limited to, the following:
    - (A) a per-session, per-diem, per-unit of time (hour, minute), or per-episode rate;
    - (B) a negotiated rate with a specific contracted provider for a particular service or level of care;
    - (C) an established per capita rate;
    - (D) rates for recipients in related diagnostic groups; and
    - (E) bundled rates for a defined group of services or service packages.
  - (3) DMHAS rates. In order to participate in the DMHAS GABHP, the provider shall agree to accept the rates set by DMHAS.
  - (4) The contracted provider shall be paid at the rate established by DMHAS for each covered behavioral health service or at the billed rate, whichever is lower;
  - (5) The contracted provider shall not be reimbursed for excluded services or for unauthorized services; and
  - (6) The contracted provider shall not bill the recipient for covered services.
- (i) DMHAS Payment for Missed Appointments. DMHAS shall not make payments to a contracted provider for appointments missed by a recipient. A contracted provider shall not bill a recipient for missed appointments.
- (j) Coordination of Benefits:

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(1) Coordination of benefits shall be the responsibility of each contracted provider. If the contracted provider identifies that a recipient has other medical coverage for behavioral health services, the contracted provider shall seek payment first from the other medical coverage. The contracted provider shall submit documentation to DMHAS's designated agent, substantiating either the amount of payment that was made by other medical coverage or that payment was denied due to exclusion of coverage. When the other medical coverage is lower than the full DMHAS payment for such service, DMHAS shall pay the difference between the other medical coverage and the DMHAS rate for such services;

(2) Any payment made by DMHAS to a provider for services rendered to a recipient who has been, or is subsequently found to be, eligible for any other medical coverage shall be subject to recovery by DMHAS for services that are covered by such other medical coverage. Upon determination that a recipient has other medical coverage, any payment made by DMHAS for such service shall, at the department's discretion, either be withheld from any payment due the contracted provider or refunded to DMHAS by the contracted provider. If the other medical coverage payment is lower than the DMHAS payment, the contracted provider may retain the portion of the DMHAS payment that represents the difference between the full DMHAS payment and the payment made by the other medical coverage, upon submission of appropriate documentation to DMHAS's designated agent; and

(3) Any payment made to a contracted provider by DMHAS for services rendered to a recipient who is, or is subsequently found to be, ineligible for the DMHAS GABHP as a result of a determination of eligibility for Medicaid shall be subject to recovery by DMHAS to the extent that the recipient's Medicaid eligibility overlaps with the period for which services were provided and to the extent that such services are reimbursable under the Medicaid program. Upon determination of an individual's Medicaid eligibility, any payment made by DMHAS for such service shall, at the discretion of DMHAS, either be withheld from any payment due the contracted provider or refunded to DMHAS by the contracted provider.

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**(NEW) Sec. 17a-453a-15. Provider claim grievance process**

If a contracted provider is not satisfied with the outcome of a claim denied by DMHAS's designated agent, said contracted provider may file a claim grievance with DMHAS's designated agent.

(a) The contracted provider shall submit the first-level claim grievance letter to DMHAS's designated agent not later than 180 days after the original date of service or not later than 180 days after the date the designated agent received notification of the recipient's eligibility. Contracted providers may grieve a claim that is denied because of non-timely filing to DMHAS's designated agent not later than thirty (30) calendar days after the date of the denial decision. The first-level claim grievance shall not include any right to an administrative hearing from either DMHAS or its designated agent;

(b) DMHAS, or its designated agent, shall notify the provider in writing of its decision within thirty (30) days following the receipt of all required documentation and information necessary to render a decision;

(c) If dissatisfied with the first-level claim grievance decision, the contracted provider may initiate a second-level claim grievance. The second-level claim grievance shall be submitted in writing directly to DMHAS, within seven (7) days following the date of the first-level claim grievance denial decision. The second-level claim grievance shall be submitted in writing and accompanied by information necessary and sufficient to render a decision on the claim grievance, as determined by DMHAS; and

(d) DMHAS shall neither accept, nor review, a second-level claim grievance that does not conform with the submission requirements defined in this section, unless the DMHAS's designated agent has failed to respond to the recipient, his or her authorized representative, or the provider within the time frame defined in this section. In such instances, the recipient, his or her authorized representative, or the contracted provider may forward a grievance request directly to the DMHAS Office of the Commissioner.

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(e) DMHAS shall retain control over all second-level claim grievance and decision processes. Any second-level claim grievance determination issued by DMHAS shall be deemed final and conclude the grievance process. The second-level claim grievance shall not include any right to an administrative hearing from either DMHAS or its designated agent.

**(NEW) Sec. 17a-453a-16. Audit**

(a) DMHAS, or its designated agent, may conduct audits of a contracted provider's clinical, programmatic, fiscal or other records to verify the accuracy of the contracted provider's claims for payment and the contracted provider's compliance with state and federal law and the contracted provider contract. Audits shall be conducted when care has been authorized, claims have been paid or when DMHAS deems it necessary to carry out its responsibilities under state or federal law.

(b) Audits may include, but are not limited to review of the following:

- (1) The contracted provider's claim(s) for services;
- (2) The services rendered by the contracted provider to an eligible or potentially eligible recipient;
- (3) The contracted provider's credentialing or re-credentialing information;
- (4) The provider's information supplied to DMHAS regarding a request for reconsideration of contract termination;
- (5) The contracted provider's compliance with state and federal law and the provider contract;
- (6) Whether the contracted provider has engaged in any fiscal irregularities;

(c) The contracted provider shall maintain records and permit DMHAS access to records as follows:

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(1) The contracted provider shall maintain all financial records related to the provision of behavioral health services to recipients for a period of not less than three (3) years after the date of expiration and or termination of the DMHAS GABHP contract;

(2) The contracted provider shall permit DMHAS access to the recipient's medical, clinical, service, or other records and the provider's fiscal records and financial statements;

(3) The contracted provider shall permit DMHAS to copy all records of recipients in order to carry out its audit responsibilities; and

(4) Upon request by DMHAS, the contracted provider shall provide DMHAS with a copy of any audit report prepared by an organization other than DMHAS.

(d) Audit methodology:

DMHAS shall select the contracted provider s to audit, define the scope of the audit and establish the frequency of audits based on consideration of factors that may include, but is not limited to, any the following:

- (1) Quality of clinical documentation;
- (2) Volume of claims submitted or paid;
- (3) Type of claims submitted or paid;
- (4) Quality-of-care concerns;
- (5) Service type;
- (6) Geographic area; and
- (7) Such other factors as deemed appropriate by DMHAS.

(e) Audit Resolution:

(1) When the audit is completed, DMHAS shall send the contracted provider a copy of the draft audit report. The contracted provider shall be given the opportunity to meet with a DMHAS representative in an exit conference to discuss the findings noted in the draft audit report.

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(2) During the exit conference, the contracted provider may submit additional documentation to DMHAS as a result of the findings noted in the draft audit report or the contracted provider may request to submit such documentation subsequent to the exit conference. The contracted provider shall submit all such documentation to DMHAS not later than thirty (30) calendar days after the exit conference. DMHAS will not consider documentation that is not submitted on time.

(3) DMHAS shall send the contracted provider a copy of the final audit report, with DMHAS's recommendations and a statement of the proposed audit adjustments, if any.

(f) Corrective Action.

(1) Not later than ten (10) business days after receipt of the final audit report, the contracted provider shall submit to DMHAS a corrective action plan to address adverse audit findings, if any, included in the DMHAS audit report. The corrective action plan shall contain the following elements:

(A) The name, address and telephone number of the contracted provider's staff person responsible for ensuring that corrective action is implemented;

(B) A detailed description of the corrective action planned; and

(C) The anticipated completion date of the corrective action.

(2) If the contracted provider does not agree with the audit findings or believes corrective action is not required, then the corrective action plan may include a statement to that effect and specific reasons in support of such opinion;

(3) If the DMHAS audit report includes information that indicates a threat to the health or welfare of a recipient, the contracted provider shall initiate corrective action not more than 24 hours following such notification. All other corrective actions shall begin not later than ten (10) business days after receipt of the DMHAS final audit report.

(g) Recovery of overpayment.

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(1) If audit adjustments require recovery of excess payments made to the contracted provider, DMHAS may adjust any payment currently due the contracted provider by DMHAS or its designated agent;

(2) If audit adjustments require recovery of excess payments made to a provider who is not currently under contract with DMHAS, recovery shall be sought in an action brought by the state of Connecticut against the provider.

(h) Progressive sanctions for non-compliance with GABHP standards. A contracted provider who, as a result of an audit, is found to be out of compliance with the provisions set forth in sections 17a-453a-1 to 17a-453a-18, inclusive, of the Regulations of Connecticut State Agencies shall be subject to progressive sanctions as may be determined by the commissioner, including but not limited to the following:

(1) Place the contracted provider on clinical review status;

(2) Reduce the number of referrals made to the contracted provider for one or more levels of care;

(3) Reduce the capacity for which DMHAS contracts with the contracted provider for one or more levels of care;

(4) Suspend referrals made to the contracted provider for one or more levels of care;

(5) Terminate the contracted provider's credentials for one or more levels of care;

(6) Terminate the provider's contract under the DMHAS GABHP; and

(6) Such other sanctions as the commissioner deems appropriate.

**(NEW) Sec. 17a-453a-17. Fair hearing to appeal audit recovery or progressive sanctions**

(a) Providers have a right to an administrative hearing in any of the following situations:

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(1) Following an audit conducted by DMHAS or its designated agent pursuant to section 17a-453a-16 of the Regulations of Connecticut State Agencies, the contracted provider is subject to recovery of payments;

(2) Following an audit conducted by DMHAS or its designated agent pursuant to section 17a-453a-16 of the Regulations of Connecticut State Agencies, the contracted provider is subject to progressive sanctions; and

(3) The DMHAS Commissioner has determined that the contracted provider's contract to participate in the DMHAS GABHP should be terminated for any of the reasons enumerated in section 17a-453a-13(e) of the Regulations of Connecticut State Agencies.

(b) Request for an Administrative Hearing. The contracted provider may request an administrative hearing in accordance with the following criteria:

(1) For hearing requests following a DMHAS audit where the contracted provider is subject to recovery of payment for an audit adjustment and/or progressive sanctions, the provider's request for an administrative hearing shall:

(A) Be submitted in writing to the DMHAS Commissioner, not more than thirty (30) days after the mailing date of notification from DMHAS of its intent to recover the audit adjustment and/or impose progressive sanctions on the contracted provider; and

(B) Contain a clear and concise statement of the issues the contracted provider seeks to address relating to the audit, and when applicable, the audit adjustment that is being sought by DMHAS.

(2) For hearing requests made by contracted providers when the DMHAS Commissioner has determined that the provider's contract to participate in the DMHAS GABHP should be terminated for any of the reasons enumerated in section 17a-453a-13(e) of the Regulations of the Connecticut State agencies, the provider's request for an administrative hearing shall:

(A) Be submitted in writing to the DMHAS Commissioner, not more than thirty (30) days after the mailing of notification from the DMHAS Commissioner of the decision to terminate the provider's contract;

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(B) Contain a clear and concise statement of the issues that the contracted provider seeks to address.

(c) Hearing Officer. The commissioner may appoint a hearing officer to provide the commissioner with a recommended decision.

(d) Scheduling and Notice of Hearing. As soon as possible following receipt of a hearing request the hearing officer shall schedule a hearing to be held not more than forty-five (45) days after the date of the request, provided that if a request for an expedited hearing is made by a party, the hearing officer shall attempt to expedite the hearing if the hearing officer determines that a delay would be significantly damaging to that party. A hearing request shall be acknowledged by letter from the hearing officer to the contracted provider, containing notice of the hearing in compliance with the requirements of section 4-177(b) of the Connecticut General Statutes.

(e) Disposal of Request for Hearing. A request for a hearing shall be disposed of only by one of the following definitive actions:

(1) Withdrawal of the request by the person who made it. This action shall be voluntary and may be made at any time prior to the hearing by a written statement of withdrawal addressed to the commissioner. The withdrawal shall be acknowledged in writing by the hearing officer and shall be the final action on the complaint.

(2) Dismissal of the request by the hearing officer. This action may be taken if:

(A) The contracted provider fails to appear at the designated time and place; or

(B) The issue is resolved prior to or during the hearing by voluntary agreement of both parties.

(3) Final decision by the Commissioner after receiving a proposed decision from the hearing officer following a hearing.

Nothing in this section shall preclude the issuance of any necessary interim order by the hearing officer during the pendency of the proceedings.

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(f) Conduct of the proceedings. The hearing shall be conducted as a contested case under the provisions of Chapter 54 of the Uniform Administrative Procedure Act, sections 4-166 to 4-189, inclusive, of the Connecticut General Statutes.

(g) Witnesses and testimony. All witnesses shall be under oath. The contracted provider may act as a witness on his or her own behalf and may bring additional witnesses. DMHAS and its designated agent may present witnesses.

(h) Exhibits. If a witness elects to retain possession of a document, a copy of the original may be admitted.

(i) Subpoenas. The hearing officer shall have the power to compel, by subpoena, the attendance and testimony of witnesses and the production of books and papers.

(j) The Administrative Hearing Record. The administrative hearing record shall consist of the hearing request, notices issued by the hearing officer, the transcript or recording of testimony, exhibits, all papers and requests filed in the proceeding, and the hearing decision.

(k) Final Decision. Upon conclusion of the hearing, the hearing officer shall prepare a proposed written decision and shall mail it to the parties by certified mail, return receipt requested, as well as providing it to the commissioner. The proposed decision shall contain a statement of the reasons for the decision and a finding of facts and conclusions of law on each issue of fact or law necessary to the decision. Any party may, not more than fifteen (15) days after the mailing of the proposed decision, provide the commissioner with written argument in support of, or in opposition to, the proposed decision and may request the opportunity for oral argument. The commissioner shall render a final decision which may, in whole or in part, modify or reject the proposed decision. A contracted provider aggrieved by the decision may appeal to the Superior Court in accordance with the provisions of section 4-183 of the Connecticut General Statutes.

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**(NEW) Sec. 17a-453a-18. Recipient appeals and fair hearing**

There are two (2) types of clinical appeals that a recipient may file with DMHAS, or its designated agent:

(a) First-level clinical appeal.

(1) A first-level clinical appeal may be filed by the recipient or his or her authorized representative. The first-level clinical appeal shall be filed with DMHAS's designated agent not later than seven (7) days after the decision by DMHAS's designated agent to deny, reduce or terminate behavioral health services, unless good cause is shown for late filing as determined by DMHAS's designated agent. A first-level appeal is not a "contested case" within the meaning of section 4-166(2) of the Connecticut General Statutes.

(2) A first-level clinical appeal shall be filed in writing with all supporting records. All records relating to a first-level clinical appeal shall be kept confidential, unless disclosure is otherwise required by law or authorized, in writing, by the recipient. A second-level appeal is not a "contested case" within the meaning of section 4-166(2) of the Connecticut General Statutes.

(3) DMHAS or its designated agent shall send written notice of the first-level clinical appeal decision by DMHAS's designated agent to the recipient or his or her authorized representative and to the contracted provider not later than seven (7) days after the designated agent has determined it has received all information necessary to render a decision.

(4) If DMHAS's designated agent fails to issue a decision within seven (7) days, the recipient or his or her authorized representative may treat it as a denial and request further review under the second-level clinical appeal.

(b) Second-level clinical appeal.

(1) The recipient or his or her authorized representative may file a second-level clinical appeal of a first-level clinical appeal decision that denies, reduces or terminates behavioral health services. The second-level clinical appeal shall be filed with DMHAS not later than seven (7)

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days after the first-level clinical appeal decision, unless good cause is shown for a late filing, as determined by DMHAS.

(2) The second-level clinical appeal shall be filed in writing with all supporting records. All records relating to the second-level clinical appeal shall be kept confidential, unless disclosure is otherwise required by law or authorized, in writing, by the recipient.

(3) The recipient or his or her authorized representative and the contracted provider shall be sent written notice of the second-level clinical appeal decision of DMHAS not later than seven (7) days after DMHAS has determined it has received all information necessary to render a decision.

(4) DMHAS shall neither accept nor review a written second-level clinical appeal if a first-level clinical appeal submitted to DMHAS's designated agent is still being reviewed within the time period permitted by this section.

(5) DMHAS shall notify the contracted provider and the recipient or his or her authorized representative of its second-level clinical appeal decision not later than seven (7) business days after determines it has received all information necessary to render a decision.

(c) Fair Hearing. Any recipient who requested behavioral health services from DMHAS's designated agent and had such behavioral health services denied or, if provided, reduced or terminated without the recipient's consent and who has received an unfavorable second-level clinical appeal from DMHAS, may request a fair hearing. The process for such a hearing shall be the same as that which is contained in sections 17a-451 (t)-1 to 17a-451 (t)-15 of the Regulations of Connecticut State Agencies.

Be it known that the foregoing:

Regulations  Emergency Regulations

are:

Adopted  Amended as hereinabove stated  Repealed

By the aforesaid agency pursuant to:

Section 17a-453a of the General Statutes.

Section ..... of the General Statutes, as amended by Public Act. No. of the Public Acts.

Public Act. No of the Public Acts.

After publication in the Connecticut Law Journal on Month, XX, Year the notice of the proposal to:

Adopt  Amend  Repeal such regulations

(If applicable):  And the holding of an advertised public hearing on June 26, 2008.

WHEREFORE, the foregoing regulations are hereby:

Adopted  Amended as hereinabove stated  Repealed

Effective:

When filed with the Secretary of the State.

(OR)

The \_\_\_\_ day of \_\_\_\_ 20\_\_.

In Witness Whereof:	Date 04/07/09	SIGNED (Head of Board, Agency or Commission) <i>[Signature]</i>	OFFICIAL TITLE, DULY AUTHORIZED Commissioner
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Approved by the Attorney General as to legal sufficiency in accordance with Sec. 4-169, as amended, C.G.S.:	SIGNED <i>[Signature]</i> 6/1/09	OFFICIAL TITLE, DULY AUTHORIZED ASSOC. ATTY. GENERAL
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Approved

Disapproved

Disapproved in part, (Indicate Section Numbers disapproved only)

Rejected without prejudice.

The Legislative Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes	DATE	SIGNED (Clerk of the Legislative Regulation Review Committee)
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Two certified copies received and filed, and one such copy forwarded to the Commission on Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State)	BY
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**INSTRUCTIONS**

One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.

Eighteen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.

Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.

Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.