Commissioner Nancy Navarretta, MA, LPC
Department of Mental Health and Addiction Services

CONNECTICUT

The State of Connecticut

Department of Mental Health & Addiction Services

Behavioral Health Recovery Program

– Clinical Recovery Supports –

– Recovery Support Services –

BHRP Provider Manual 2026

July 1, 2026

CONNECTICUT
Mental Health & Addiction Services

ABH
Creating Solutions Together

Contents

Section 1: General Information

Welcome

The Connecticut Department of Mental Health and Addiction Services (DMHAS), together with Advanced Behavioral Health, Inc. (ABH®), are pleased to welcome you to the Behavioral Health Recovery Program (BHRP) network.

As a provider in DMHAS BHRP, your organization joins a statewide network of providers who deliver a continuum of clinical and recovery support services. Embracing a recovery orientation in the treatment of mental health and substance use disorders, the network is devoted to ensuring access to a comprehensive, quality-driven and progressive delivery system.

The BHRP Provider manual has been developed to give providers a summary of the policies that guide the delivery of the Behavioral Health Recovery Program. It will summarize the BHRP policies and procedures - from covered services to referrals, from authorizations to appeals, from credentialing and contracting to claims submission. We welcome feedback about the contents in this manual as well as the BHRP policies. The BHRP Policies can be located at BHRP.

The guidelines presented here will assist your organization with obtaining authorizations for clinical and recovery support services, submitting claims and receiving payment in a rapid, efficient manner. Should there ever be any question or comment regarding the contents of this manual, or any aspect of BHRP, please call us on our toll-free number at Phone: (860) 638-5309 (ABH Inc.)

Important Notice – DMHAS reserves the right to interpret terms and provisions of this manual and to amend the manual as may be required to improve operation of the Program. To the extent that there are inconsistencies between this manual and the Provider Agreement or Regulations governing the Program, the Provider Agreement and Regulations shall apply.

Program Overview

The Department of Mental Health and Addiction Services (DMHAS) selected Advanced Behavioral Health (ABH), a behavioral health care company, to serve as the Administrative Services Organization (ASO) for the Behavioral Health Recovery Program (BHRP). DMHAS and ABH share a vision: The Behavioral Health Recovery Program will meet the goals of enhancing access to care and providing HUSKY D recipients under CT Medicaid Husky Health insurance (federal Medicaid Program Title XIX With the clinical and recovery support services that will assist individuals in their movement toward a meaningful and productive life. Integrating recovery as a value and an orientation will ensure a dynamic, responsive, and progressive client-centered service delivery system.

The Behavioral Health Recovery Program is responsible for responding to requests for prior authorization and continued stay authorization of recovery support services and the following clinical services for HUSKY D recipients: Acute Inpatient Mental Health Hospitalization and Intermediate (subacute) Inpatient Mental Health Hospitalization at an Institute for Mental Disease (IMD) hospital for Husky D recipients, or individuals with pending eligibility or those not meeting criteria for the Medicaid IMD demonstration pilot at Natchaug Hospital treatment.

Quick Reference Guide to the Connecticut Behavioral Health Recovery Program

DMHAS	DMHAS-State of Connecticut (860) 418-7000 **Deaf/Deaf-Blind/Hard of Hearing** : (860) 418-6974 www - Connecticut Department of Mental Health and Addiction Services Managed Services Division 410 Capitol Ave Hartford, CT 06134 www - Managed Services Division www - BHRP
BHRP Administrative Services Organization	Advanced Behavioral Health, Inc 213 Court Street Middletown, Connecticut 06457

Toll Free – (860) 638-5309
www - www.abhct.com
Fax – (860) 638-5302
TTY – (866)-604-3470

BHRP
Behavioral Health Recovery Services with BHRP | ABH®

Customer Service Center:
Clinical Services: 1 (800) 606-3677
Clinical Supports Fax Number: (860) 704 – 6145
Advanced Behavioral Health, Inc. (ABH)

Option 1 – Clinical Department
Option 2 – Customer Service/Claims
Option 3 – Case Management Referrals

Recovery Support Services: 1 (800) 658-4472
Advanced Behavioral Health, Inc. (ABH)

Services Provided by ABH include:

- Care Management and Authorization activities for clinical and basic recovery support services
- Case Management activities occur both in the field and in offices located throughout Connecticut
- Credentialing, Contracting, and Claims Adjudication through the Customer Service and Provider Relations Departments
- Information Systems offering technical support to the staff of ABH and to web portal users

Quality Management functions with a constant interface with Providers and with DMHAS
Care and Case Management are coordinated for HUSKY D recipients who are in need of support and assistance, to ensure appropriate coordination and continuity of care for those individuals who are frequent users of behavioral health care services. ABH routinely coordinates care with other programs and ASOs that provide behavioral health and medical services to HUSKY D recipients such as the Connecticut Behavioral Health Partnership and the HUSKY Health Program.

HUSKY D recipients may concurrently be involved in other programs for which ABH has oversight. A full list of these programs is available at www.abhct.com. Every effort is made to ensure high quality coordination of care between programs

Program Goals

Goals offer purpose and guidelines as stakeholders collaborate to shape the delivery of behavioral health care in the State of Connecticut, in a recovery oriented, progressive and fiscally responsible manner.

The goals of the DMHAS Behavioral Health Recovery Program (BHRP) are to:

- Facilitate the delivery and integration of high-quality behavioral health services to eligible individuals;
- Coordinate and link behavioral health services with a broad array of publicly funded human service programs, as well as informal community support systems available to HUSKY D recipients;
- Provide timely access to acute care behavioral health, case management and recovery support services managed by the BHRP;
- Assist individuals in restoring and/or maximizing independent functioning through the coordination of behavioral health with vocational services and/or entitlements assistance;
- Integrate recovery core values, recovery principles, and recovery language into all aspects of treatment delivery. To achieve a high quality of care, a recovery-oriented system of care will be age and gender appropriate, culturally competent, and attend to trauma and other issues that impact recovery; and,
- Create a model for healthcare and welfare reform that can be replicated for other programs serving low income adults within the State of Connecticut.

DMHAS believes that a truly collaborative relationship with providers creates the necessary framework for the success of this program. DMHAS enjoys great confidence in the skills and professionalism of the behavioral health providers in the State of Connecticut.

Section 2: Covered Services

Clinical Services

This section describes services available to HUSKY D recipients who meet service necessity criteria through the Behavioral Health Recovery Program. For all levels of care, it is expected that discharge planning should begin at the time of admission. The following clinical recovery supports are covered by the Behavioral Health Recovery Program:

1. **Acute (LOC 4.2MH) or Intermediate (Subacute, LOC 3.9MH) Psychiatric Hospitalization Services:** A medically necessary, inpatient behavioral health treatment service delivered in an institute for mental disease (IMD) that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to treatment of a psychiatric disability or co-occurring disorder, where an individual's admission is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. Acute or subacute psychiatric hospitalization is used when 24-hour medical and nursing supervision is required to deliver intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. Acute or subacute psychiatric hospitalization may be delivered to individuals committed under a physician's emergency certificate (PEC), pursuant to section 17a-502 of the Connecticut General Statutes and may occur on a locked psychiatric unit. The Mental Health Intermediate Care beds are used for individuals meeting criteria with a serious behavioral health disorder who require 24-hour medical and nursing supervision requiring stabilization, evaluation and need for appropriate placement to sustain gains made.

2. **Other Services:** Other services as identified and approved by the Department of Mental Health and Addiction Services.

Recovery Support Services

This section describes recovery support services available to HUSKY D recipients that are intended to assist the client in engaging in continuing care and recovery. The following services may be covered under the Behavioral Health Recovery Program. Current benefits and service maximums/limitations are posted at **Advanced Behavioral Health, Inc. (ABH)**.

1. **Basic Needs:** Goods which are provided to eligible recipients through the issuance of gift cards, transportation supports, Identification replacement, food resources, training/education assistance or other resources as defined and approved by DMHAS.

2. **Faith Recovery Support Services:** Assistance provided in a religious or spiritual setting

by spiritual leaders or staff via individual or group meetings that are designed to help persons in recovery forge supportive connections with self-selected faith communities to discover positive interests and valued social roles.

3. **Independent Housing:** Short term assistance provided to secure and maintain affordable and safe housing via a lease agreement with a landlord.

4. **Recovery Management Services:** Activities intended to assist individuals in identifying and utilizing relapse prevention skills and increasing self-sufficiency such as obtaining gainful employment and independent living in their communities. These activities can include linkage to clinical or recovery support services and will be reflected on an individualized recovery plan that incorporates the input of individuals and their natural supports.

5. **Recovery Oriented Vocational Services:** Assistance provided by a vocational provider directed toward improving and maintaining employment which may include: skills assessment and development, job coaching, job placement, resume writing, interviewing skills, and developing job retention skills.

6. **Shelter Recovery Housing:** A facility where the primary purpose is to provide temporary or transitional shelter, for the homeless or for specific populations of the homeless.

7. **Supported Recovery Housing Services:** A clean, safe, drug and alcohol-free transitional living environment with on-site case management services available a minimum of eight (8) hours per day five (5) days per week.

8. **Transportation:** Conveyance to and from Behavioral Health Recovery Program clinical recovery supports services and supported recovery housing services via bus pass or other means of passage.

9. **Wellness Services:** Activities directed toward improving overall health and well-being that enhance the eligible recipient's recovery and that are not covered by Medicaid.

10. **Other:** Any other support deemed appropriate and approved by DMHAS, or its designated agent that is intended to and has a high likelihood of enhancing the eligible recipient's recovery.

OUT OF STATE/OUT-OF-NETWORK PROVIDERS

Coverage for clinical recovery support services is limited to treatment services provided through a provider network that have been credentialed and contracted by the DMHAS Behavioral Health Recovery Program. Benefits for clinical services are not available for in-state or out-of-state providers who are not credentialed and contracted by the BHRP.

Additional Collaborative Resources

Medicaid Benefit Center	DSS Benefits Center: 855-626-6632 Hearing Impaired: 800-842-4524 or 711 Mon - Fri 7:30 am to 4:00 pm Website: www.connect.gov
Mental Health and Substance Use Services	Connecticut Behavioral Health Partnership: HUSKY Health 877-552-8247 Hearing Impaired: 711 Text and chat available at www.ctbhp.com Regular business hours: Mon-Fri 9:00 am to 7:00 pm, Crisis and Inpatient Admissions: 24/7 Website: www.ctbhp.com Access Health CT HUSKY A, B, and D: 855-805-4325 Hearing Impaired: 711 Mon-Fri 8:00 am to 4:00 pm (Hours extended during open enrollment) Website: www.accesshealthct.com HUSKY C: Online www.ct.gov/dss/myaccountlogin
Medicaid Claims Assistance	Gainwell Technologies Provider Assistance Center: provider enrollment, member eligibility, claims processing, and electronic claims submission. t HP by calling (800) 842-8440.
Medical Services	Community Health Network of Connecticut (CHNCT): Husky Health in Connecticut Member Services Department (866) 859 – 9889 Monday through Friday, 8:00 am to 6:00 pm Provider Call Center (800) 440 – 5071 Monday through Friday, 8:00 am to 6:00 pm

Laboratory	Laboratory Services: Laboratory services provided as part of ongoing medical care are handled by CHNCT, while laboratory services provided as part of ongoing behavioral health care will be submitted to and processed by Gainwell Technologies.
Pharmacy	Client Assistance Center: 866-409-8430 or 860-269-2031 Hearing Impaired: 711 Mon-Fri 8:00 am to 5:00 pm Website: www.ctdssmap.com
Transportation	Non-Emergency Medical Transportation Services: HUSKY A, HUSKY C & HUSKY D Members 855-478-7350 Mon-Fri 7:00 am to 6:00 pm Website: https://www.mtm-inc.net/connecticut/members/
Vision	Community Health Network of CT: 800-859-9889 Hearing Impaired: 711 Mon-Fri 8:00 am to 6:00 pm Website: Community Health Network of Connecticut, Inc.
United Way	Connect to local services such as utility assistance, food, housing, crisis intervention and more. Dial 211 or search the online data base at 211ct.org

Section 3: Eligibility

Verifying Member Eligibility

In order to be eligible for the Behavioral Health Recovery Program, an individual must be determined eligible by the Department of Social Services (DSS) for HUSKY D benefits.

Providers must verify an individual's eligibility for HUSKY D benefits by accessing the Automated Eligibility Verification System (AEVS), maintained by Gainwell Technologies, each time there is a request for clinical or recovery support services. Because an individual's eligibility status requires

periodic redetermination by DSS, providers will want to ensure that gaps in eligibility are identified at the time of admission to behavioral health services.

It is also highly recommended that providers periodically re-confirm eligibility for clients throughout the course of treatment/application for recovery supports. Payment of services is based on eligibility at the time the service was rendered. It is important to remember that the authorization of any specific service is NOT a guarantee of payment.
The AEVS eligibility inquiry will also indicate whether the recipient has a third-party payer who may be liable for some or all of the costs of behavioral health services.

DSS also offers providers the capacity to verify eligibility electronically. Additional information about other methods used by providers to confirm eligibility is available at the DSS website at www.ctdssmap.com.

Accessing the Automated Edibility Verification System

AEVS	Automated Eligibility Verification System (AEVS) NUMBER (800) 842-8440 (in-state, toll-free) (860) 269-2028 (Hartford area) (866) 604-3470 (TTY/TDD line) • **Web Eligibility Verification** o Enrolled providers may verify HUSKY Health member eligibility through the CMAP website at www.ctdssmap.com. Go to the Provider page and click on "SECURE SITE" and log on to their Provider Secure website using their web User ID and password followed by clicking on the Eligibility tab • **Automated Voice Response System (AVRS)** o Enrolled HUSKY Health providers may verify HUSKY Health member eligibility through Gainwell Technologies' Automated Voice Response System (AVRS) using a touch-tone phone. A HUSKY Health provider must be actively enrolled in the Connecticut Medical Assistance Program and must use their assigned AVRS ID and PIN # to utilize the automated system. The AVRS can be accessed by dialing 800-842-8440.

If, as a provider, you believe that the individual will meet criteria for eligibility for HUSKY D benefits but has not yet been enrolled as a HUSKY recipient, you should still contact ABH to obtain an authorization for clinical or recovery support services. If the individual is subsequently found to be eligible for HUSKY D, the Provider can ONLY be paid on a retroactive basis when there is a prior authorization on record for the requested dates of service. To learn how to register a client and submit an electronic request for the BHRP-Recovery Support Services, a brief virtual meeting including training is required in order to obtain staff-specific login and password. To register follow this link for registration information.

Clinical Services Eligibility

To be eligible for clinical services under the Behavioral Health Recovery Program, an individual must be eligible for Husky D benefits and be determined by DMHAS or ABH to need covered clinical recovery supports. Such determination shall be based upon an evaluation of necessity that includes, but is not limited to:

1. Evaluation of problems identified by the individual

2. Evaluation of the individual's history of behavioral health treatment services; and

3. Meeting the criteria for a diagnosis of one or more psychiatric disabilities, substance use disorder or either primary and co-occurring substance use and co-occurring psychiatric as specified in the following ranges of DSM-V-TR (or most recent version) disorders:ICD-10-CM Codes: F22-F29; F31.12-F39; F34.81-F39; F40.218-F41.9; F42.2-F42.9; F43.10-F43.9; F44.81-F44.9; F45.1-F45.9; F50.89-F50.9; F51.01-F51.5; F52.32-F52.9; F64-F64.9; F63.81-F91.9; F10.20-F19.99; F63, F65.3-F65.9; F06.8-F99; F90.0-F90.9, excluding ICD-10-CM codes for caffeine-related disorders, personality disorders, and tobacco-related disorders; "mild" specifier; "in partial remission" specifier; "in sustained full remission" specifier.

Recovery Support Services Eligibility

To be eligible to receive recovery support services through the Behavioral Health Recovery Program, an individual must have active Husky D insurance and be determined to meet the following requirements by a behavioral health clinical or supported recovery housing provider to

be:

1. Actively engaged in behavioral health treatment services;

2. In need of recovery support services and have no available resources to meet such needs.

Employment and/or employment readiness is an integral part of receiving BHRP Recovery Support Services. One of the goals of the program is to assist individuals in restoring independent functioning, including returning to work so that recovery supports can be maintained independently. Employment readiness encompasses many things and may include job searching, vocational training, treatment-related employment groups, online education, online resume posting, work therapy, etc. Applicants will use the Job Readiness Form to describe their employment readiness activities or submit copies of their two most recent forms of income verification.

Individuals who are no longer receiving HUSKY D benefits and/or are no longer in treatment may not be re-authorized for recovery support services.

Section 4: Service Limitations and Exclusions

Clinical Recovery Services Limitations, Exclusions and Payment Exclusions

Limitations

Covered services and procedures are limited to those listed in the DMHAS Behavioral Health Recovery Program clinical recovery supports fee schedule.

1. Group therapy sessions shall be limited to a maximum of twelve (12) individuals per group session, excluding the supervising clinician(s).

2. Education groups shall be limited to a maximum of twenty-four (24) individuals per group session, excluding the supervising professional(s).

Exclusions and Payment Exclusions

The following exclusions and non-payment for clinical recovery supports shall apply:

1. Any clinical recovery supports delivered to an eligible recipient with a primary DSM-V-TR diagnosis which is outside the range of diagnostic codes of DSM-V-TR disorders: ICD-10-CM Codes: F22-F29; F31.12-F39; F31.9F39; F34.81-F39; F40.218-F41.9; F42.2-F42.9; F43.10-F43.9; F44.81-F44.9; F45.1-F45.9; F50.89-F50.9; F51..01-F51.5; F52.32-F52.9; F64-F64.9; F63.81-F91.9; F10.20-F19.99; F63, F65.3-F65.9; F06.8-F99; F90.0-F90.9;

2. Services that DMHAS determines to be "experimental" in nature;

3. Services that ABH determines are not medically necessary;

4. Concurrent services or procedures that ABH determines to be similar or identical to services provided to the same eligible recipient;

5. Therapies, treatments or procedures that relate to gender affirming medical or surgical procedures;

6. Activities, treatments or items delivered to an eligible recipient for which the contracted provider does not usually charge others;

7. The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as they are admitted;

8. A leave of absence or pass from an inpatient facility that occurs with staff permission or against staff advice;

9. A leave of absence or pass from an inpatient facility with staff permission, if the absence is longer than 24 hours, unless authorized in advance by ABH;

10. Electroconvulsive therapy;

11. Hypnosis;

12. Psychological or intelligence testing;

13. Neuropsychological testing;

14. Clinical recovery supports delivered by a staff member who is not a licensed behavioral health professional, unless the following conditions are met:

    a. The staff member is employed by or under contract with a licensed facility whose medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health treatment services to eligible recipients.
    b. For acute psychiatric hospitalization, the staff member is actively pursuing behavioral health licensure and is under the direct supervision of licensed behavioral health professional with at least two (2) years of experience in the delivery of behavioral health treatment services.
    c. The supervising clinician has signed the eligible recipient's recovery plan.

15. Clinical recovery supports delivered by staff of a licensed facility at a location other than that which is specified on the facility's license.

Recovery Support Services Limitations, Exclusions and Payment Exclusions

Limitations

1. Recovery support services are limited to goods and services intended to assist the eligible recipient to progress towards recovery goals; and

2. Recovery support services will only be authorized when no other available resources are identified.

Exclusions

The following exclusions and non-payment for recovery support services shall apply:

1. Service locations that do not comply with all applicable laws, regulations, and ordinances regarding zoning, building, fire, health, and safety;

2. Independent housing:

a. When the eligible recipient is not named in the lease as the lessee or an authorized occupant;
b. Located outside of the State of Connecticut;
c. At a licensed behavioral health clinical services facility;
d. At a contracted supported recovery or shelter housing location; and
e. Where the eligible recipient must follow written or stated rules that are not part of the rental agreement or that are not permissible by law.

3. Supported recovery or shelter housing:

a. Facilities not currently certified and contracted by DMHAS or its designated agent;
b. Not authorized by DMHAS or its designated agent;
c. The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;
d. A leave of absence that occurs without staff permission;
e. A leave of absence or pass if the absence is longer than twenty-four hours, unless authorized in advance by DMHAS, or its designated agent;; and
f. Services that cannot be substantiated by appropriate documentation.

4. Transportation:

a. Services provided by an entity who is not currently contracted by DMHAS; and
b. Transport to locations other than the behavioral health clinical recovery services and basic recovery support providers contracted by the Behavioral Health Recovery Program.

5. Basic Needs Goods:

a. Goods other than clothing and personal items for the intended eligible recipient.

6. Recovery Management Services, Faith Recovery Supports, Recovery Oriented Vocation Services:

a. Provider or entity is not currently certified and contracted by DMHAS or its designated agent (see subsections 9 and 10 Credentialing and Contracting

of within the BHRP policies);

b. Provider or entity is not authorized by DMHAS or its designated agent.

Section 5: Service Authorizations of Clinical Services

This section describes how and when to obtain an authorization for all types of clinical recovery support services. **Services not authorized will not be reimbursed.**

Service authorizations for clinical recovery supports must be obtained for any recipient eligible or potentially eligible for HUSKY D benefits, regardless of the recipient's eligibility status at the time of admission. If the Provider believes that the client will meet criteria for eligibility for HUSKY D, but the client has not yet been enrolled as a HUSKY D recipient, the provider should still contact ABH to obtain an authorization. Services provided without authorization in accordance with the procedures contained in this manual will not be reimbursed. It is the primary responsibility of the provider to confirm eligibility at the time of admission and periodically (at least monthly) during the course of treatment.

Authorizations issued by ABH confirm that the clinical information provided meets the medical necessity requirements for the requested service. **An authorization does not confirm eligibility for HUSKY D benefits and is not a guarantee of payment.**

A prior authorization is required at the time of admission to ALL clinical recovery support services. All requests for continued care authorizations must be submitted no later than the date the previous authorization expires. Late requests for initial or continued stay authorization will result in an administrative denial of services occurring prior to contact with ABH.

Authorizations are issued for a specific time period. The authorization time period is fixed, and additional details can be found in the appendices; service units not used within the time frame authorized become void. Authorizations are issued for a specific service location and are not transferable.

Electronic Registration System (ERS)

The Electronic Registration System (ERS) was developed in order to create efficiency in the administrative process for contracted Providers of behavioral health care services. ERS uses internet technology to provide a safe and secure method for authorized users to view current and historical authorization information, provide discharge information for any level of care, monitor

authorization information in order to ensure timely re- authorization of and view the status of claims submissions.

Access to the ERS is granted upon completion of a brief training session on system functions and safe, appropriate use of confidential information. ERS users will be given an individualized login and password following training that allows access to site- specific, episode-specific, and client-specific authorization information. Depending on the level of security granted, users will be able to view and enter discharge notifications for a single site or all service locations for their organization. The same login/password will also allow users with the appropriate security access the ability to enter claims or view claims status information.

Discharge notification can be completed via the ERS and requires data entry of a limited amount of clinical information. Users who have difficulty completing the discharge notification using ERS are encouraged to contact ABH for assistance. If you are interested in obtaining access to ERS and are a contracted BHRP Provider, please contact ABH at (800) 606-3677, option 2. See Section 5 "Discharge Reviews" for further details on discharge requirements.

Review Process

Admission/Prior Authorization Requests for clinical recovery supports require a telephonic review to obtain authorization. DMHAS, at its discretion may permit select approved contracted providers to submit admission/prior authorization requests by written Treatment Review Form via secure fax to ABH, in lieu of a telephonic review.

All Requests for Prior Authorization or Continued Stay Authorization can be made by telephone 8:30 am to 5:00 pm, M-F (except holidays).

Clinical Recovery Supports Main Telephone Number: (800) 606 – 3677

Option 1 – Clinical Department
Option 2 – Customer Service/Claims
Option 3 – Case Management Referrals

Fax Number: (860) 704 – 6145

ABH will render a decision to approve or deny a request for prior or continued stay authorization after receipt of all information that ABH determines is necessary and sufficient to render a

decision, according to the following parameters:

1. Request received before 12:00 pm noon: authorization decision will be issued before 5:00 pm on the same business day;

2. Requests pending before 7:00 pm: authorization decision will be issued before 12:00 pm noon on the following business day;

3. Requests pending after 7:00 pm: an authorization decision will be issued before 5:00 pm on the following business day.

Providers receive verbal notification of the authorization determination at the conclusion of a telephonic review or an electronic transmittal of the decision for faxed requests. Authorization determinations are available electronically on ERS within two (2) business days. Authorization determinations are issued in writing to the provider within three (3) business days from the decision date.

Discharge Notification is required for every authorized clinical recovery support service. Discharge information can be entered via the ERS, by telephone, or through faxed notification. Discharge notifications entered using the Electronic Registration System (ERS) can be entered 24 hours/day, 7 days/week, 365 days/year.

Discharge Notifications can be submitted by fax at: (860) 704 – 6145, or may be submitted by authorized ERS users at: Behavioral Health Recovery Services with BHRP ®

Information Necessary to Obtain Prior Authorization

Information related to the individual's current clinical status is required at the time of the request for prior authorization for any behavioral health service. The information necessary to obtain an authorization for a new episode of care should identify the presenting problem and current status of the individual, as well as the solution-focused, recovery-oriented plan for intervention and care. The length of stay and treatment plan for the client should be individualized. Because the focus on continued care is critical in engaging and assisting the individual to move through the recovery continuum, discharge planning should begin at the time of admission to the current episode of care.

The following are key information elements necessary during the prior authorization review process:

1. Demographic Information

   a. The name of the individual for whom services are requested, as well as the Medicaid identification number, and social security number;
   b. Address of record, including telephone number when possible;
   c. Date of birth;
   d. Race, Gender, Language Preference; and
   e. Name of the Provider, and name of the caller requesting services.

2. Clinical Information

   The information identified below contributes to the decision of medical necessity and authorization of care.

   a. Level of care and treatment location requested;
   b. DSM-V-TR (or most recent edition) provisional or admitting diagnosis or diagnoses;
   c. Clinical presentation of the potentially eligible recipient or eligible recipient and justification for the requested clinical recovery support(s), including such factors as mental status, legal involvement, natural supports, and strengths;
   d. Current symptoms of a primary psychiatric disability, a substance use disorder or both;
   e. Clinical risk assessment and relapse potential;
   f. Psychiatric history, including previous treatment and medications;
   g. Medications used;
   h. Substances used;
   i. Medical history, status of current medical issues;
   j. Recovery plan objectives;
   k. Whether the individual is voluntarily agreeing to the treatment;
   l. The individual's preference for clinical recovery supports and provider;
   m. Projected Aftercare Plan;
   n. Projected length of stay or date of discharge;
   o. Name of the potentially eligible or eligible recipient's primary care physician, if any, and;
   p. All other information that that ABH may require to determine medical necessity.

Information Necessary to Obtain Continued Stay Authorization

The continued stay authorization review will determine whether previously authorized covered clinical recovery support services continue to be medically necessary. If a provider of a previously authorized clinical recovery support service, except for observation beds, determines that additional care may be necessary beyond that which has been previously authorized, the provider should contact ABH by telephone, not less than four (4) hours prior to the expiration of the existing authorization, for acute or subacute psychiatric hospitalization and not more than forty-eight (48) hours prior to the expiration of the existing authorization for other clinical recovery supports in order to obtain a continued authorization.

Requests for continued stay authorization should include progress made towards identified individualized goals as well as providing information about the current status of the client and presence of symptoms that would preclude management in a less restrictive level of care.

The following are key information elements necessary during a continued stay review:

1. Client identifying information including name and Medicaid ID number;
2. Current DSM-V-TR (or most recent edition) Axis I diagnosis or diagnoses;
3. Level of care requested;
4. Current clinical presentation of the individual in care and justification for the requested clinical recovery support, including factors such as mental status and strengths;
5. Recovery plan objectives;
6. Current symptoms of mental illness or substance use disorders, or both;
7. Clinical risk assessment and/or relapse potential;
8. Medication(s) used;
9. Whether the individual in care is voluntarily agreeing to continued treatment;

10. Progress, or lack of progress, made towards the goals identified by the individual in care and the treatment team;

11. The recipient's preference for clinical recovery supports and provider;

12. Provisional discharge or aftercare plan;

13. Projected date of discharge; and

14. All other information that ABH may require to determine medical necessity.

Continued authorization of a clinical recovery support service is confirmation that the member meets medical necessity criteria for that level of care and is not a guarantee of payment.

Recovery Planning

1. Clinical recovery support providers shall develop a recovery plan with participation from each eligible recipient that is documented in the clinical record (or if not, providers will document the reasons why the individual did not participate in development of their recovery plan).

2. Recovery plans will include:

    a. Eligible recipient's preferences, interests, strengths, and areas of health, as well as desired outcomes related to each;
    b. Activities, supports, housing, employment and other recovery supports that may assist with the achievement of the recipient's desired outcomes;
    c. Recovery plans will be reviewed regularly, and revised as needed;
    d. Recovery plans will be signed by the recipient, clinical provider or case manager responsible for the recovery plan.

Discharge Reviews

It is essential that key elements of discharge information be conveyed to ABH within a brief period following discharge. Providers should contact ABH to request a discharge review no more than two (2) business days and not less than four (4) hours before the eligible recipient's scheduled

departure. Reviews of unexpected discharges are due not later than one (1) business day following the date of discharge. Discharge information can be entered via the ERS at Behavioral Health Recovery Services with BHRP or fax submission at (860) 704-6145 or by telephone.

The information needed at time of discharge is:

1. Date of Discharge: this would also include the date the client steps down from one level of care to the next at the same agency;

2. DMS-V-TR (or its replacement) discharge diagnosis;

3. Progress made toward the accomplishment of recovery plan objectives;

4. Clinical presentation at the time of discharge, including mental status and response to treatment;

5. Clinical risk and relapse potential;

6. Medications prescribed at time of discharge and arrangements for any medications that may be needed following discharge;

7. Living arrangements and address upon discharge;

8. Recipient's involvement in discharge planning

9. Follow-up Level of Care;

10. Aftercare Provider;

11. Date of first aftercare appointment;

12. Discharge Type:

    a. Regular: successful completion at current level of care, plan in place for movement into the next, less restrictive level of care;
    b. Refused Care: the recipient refuses to accept referrals for ongoing treatment;
    c. Administrative: the recipient violates facility or program rules;

d. Noncompliance: the discharge is a result of lack of compliance to treatment recommendations or program expectations;
e. Against Medical Advice (AMA): the client has left treatment against the medical or clinical advice of program staff;
f. Absent Without Leave (AWOL): the client has left inpatient treatment without the knowledge or consent of program staff;

Transfer: the discharge is the result of admission to a general hospital for medical reasons, or the client has required a transfer to a higher level of behavioral health care; or Other: this category should be used when the discharge does not fit other discharge type descriptions (e.g., client incarcerated).

Section 6: Service Authorizations of Recovery Support Services

This section describes how and when to obtain an authorization for all types of recovery support services. **Services not authorized will not be reimbursed**.

Application for Services

Behavioral health treatment providers are the key link between the eligible recipient and the Behavioral Health Recovery Program. It is crucial that the treatment provider work with the eligible recipient throughout the recovery support services application process until a determination is received. Clinical treatment or supported recovery housing providers apply on behalf of eligible recipients through submission of the application to ABH. Additional training on the Recovery Support Services application portal is available by contacting ABH directly.

Recovery Support Services Main Telephone Number: (800) 658-4472
Recovery Support Services Fax Number: (866) 249-8766

At a minimum, a complete RSS application will include all of the following:

1. Identifying demographic information for the eligible recipient for whom the recovery support services are being requested, including current address, email address, and phone numbers;

2. A selection of the specific recovery support services being requested, as documented by the treatment provider in collaboration with the eligible recipient;

3. Behavioral health treatment information including the eligible recipient's provider identifying information, admission date, type of treatment, and anticipated discharge date; and

4. A valid consent form provided by ABH, signed by the eligible recipient authorizing the release of confidential information.

ABH may require additional information relevant to the type of recovery support(s) being requested and will request such information when necessary.

The requesting provider shall ensure that an application for recovery support services is submitted to ABH no later than thirty (30) business days after the treatment provider has conducted an assessment to determine the eligible recipient's need for recovery support service(s).

Initial Authorization of Request for Recovery Support Services

Upon receipt of a properly completed application for recovery support services, ABH may authorize such request, provided the following determinations have been made:

1. The information required by the eligibility subsection in Section 3 has been verified by DMHAS or its designated agent;

2. The requested behavioral health recovery support(s) is a covered service as outlined Section 2;

3. DMHAS, or its designated agent, has determined that there are no other available resources for which support(s) are being requested;

4. The eligible recipient has not exceeded the maximum behavioral health recovery support(s) program utilization management parameters allowance; and

5. Funding is available to provide the requested behavioral health recovery support(s).

ABH will notify the requesting provider regarding the disposition of the request for recovery support services via email no later than five (5) business days after the request was received.

Notification will prompt provider to login to the website to view details. Specific instructions on how to navigate to determinations is provided in the user manual.

Authorization of requests for recovery support services may extend for a period not to exceed thirty (30) days. After the first approved thirty-day period, eligible recipients may request basic recovery supports for additional periods in accordance with the Eligibility and Authorization section of this manual.

Prior authorization of covered recovery support services is not a guarantee of payment.

Applications that contain inaccurate or missing information may be held for up to five (5) business days while awaiting the necessary information to complete the review process. If the application is held in a "pending status" because of missing or inaccurate information, this time will not be considered to be part of the five-day processing limit. If the necessary information is not received within the "pending period", the application will be denied.

Continued Authorization of Request for Recovery Support Services

The behavioral health treatment provider or supported recovery housing provider may apply for continued authorization of recovery support services on behalf of an eligible recipient through submission of the web-based application to DMHAS, or its designated agent, after ensuring all fields have been completed accurately.

At a minimum, a request for authorization of additional recovery support services should include:

1. The eligible recipient's identifying information;
2. The type of recovery support services being requested;
3. Behavioral health clinical services information, including the individual's admission date, type of treatment, provider, and provider identifying information;
4. A valid release of information, provided to DMHAS, or its designated agent, signed by the eligible recipient consenting to the release of confidential information related to the behavioral health recovery support(s) application;
5. Evidence of specific steps taken by the individual toward independent functioning;

and

6. Any other information requested by DMHAS, or its designated agent, needed to determine ongoing qualification.

ABH will notify the requesting provider regarding the disposition of the request for authorization for recovery support services via email not more than five (5) business days after a complete application is received. Individuals who no longer meet the eligibility requirements as specified in Section 3 of this manual will not be re-authorized for recovery support services. Notification will prompt provider to log in to the website to view details. Specific instruction on how to navigate to determinations is provided in the User Manual.

Section 7: Claims Submission

General Requirements

Claims will only be paid when BHRP services are delivered to recipients who have been determined to be eligible as specified in Section 3 of this manual and the service provider received all applicable authorizations and continued authorizations as specified in this manual. Acceptance of a service provider's claim for payment will not be a guarantee of payment.

The minimum rules for reimbursement of covered clinical and recovery support services include the following:

Providers shall:

1. Hold an executed BHRP Provider Agreement with DMHAS or ABH;

2. Be reimbursed at the rate established by DMHAS for each covered services, or at the billed rate, whichever is lower; and

3. Not be reimbursed for excluded or unauthorized services.

Claim Filing Requirements

1. Paper Claims for clinical recovery support services that include all required data elements must be submitted on one of two national industry standard billing forms:

a. Center for Medicare and Medicaid Services - CMS-1500 for outpatient services; or
b. Uniform Billing Form - UB-04 or HCFA-1450 for institutional services.

2. Completed clinical recovery support service claim forms may be mailed to:

DMHAS Behavioral Health Recovery Program c/o
Advanced Behavioral Health
213 Court Street Middletown, CT 06457

3. A separate claim form must be submitted for each recipient;

4. Claim line items must indicate exact dates of service when billing for multiple units of the same procedure code;

Web-based single claims data entry is available to clinical recovery support providers with authorized access to the ABH Claims Entry System (ACES) through the ABH website (www.abhct.com). Web-based single invoice data entry is available for supported recovery housing providers with authorized access to the BHRP-RSS web portal on the ABH website. Providers with authorized access will also be able to review claims status for previously submitted claims. Clinical recovery support providers wishing to obtain access to the web-based claims system should contact the ABH Customer Service staff at (800) 606-3677, Option 2 to request a user-specific login and password. Recovery support services providers requiring access or assistance in submitting claims for housing services should contact the Recovery Support Services Program hotline at (800) 658-4472;

5. Electronic Batch Claims may be submitted by participating clinical recovery support providers in the standardized HIPAA 837 format that is compliant with current transaction code standards required by the Health Insurance Portability and Accountability Act (HIPAA). Specific information regarding file formats and submission method are available in the ABH Companion Guide located on the BHRP resource page of the ABH website at www.abhct.com Providers will also have access to claims status for previously submitted claims. Clinical recovery support providers interested in submitting batch-file claims should contact the ABH Customer Service staff to request a user-specific login and password and to schedule test submissions.

Electronic batch claim submission is not available for housing and shelter providers;

6. Payments for recovery support services such as personal care, clothing, security deposits, transportation, or utility payments are made either through check or gift card. Gift cards will be mailed to the requested provider's address for distribution in person; checks are mailed directly to the payable vendor and will include an Explanation of Benefits (EOB) which identifies the individual and covered service(s).

Clean Claims – Clinical Services

1. All claims for covered clinical recovery support services must be submitted within 180 days that include but are not limited to the following required data elements:

    a. Individual's name, address, and date of birth;
    b. Medicaid ID Number;
    c. Provider's name, address, Tax ID, Organization and Vendor ID numbers;
    d. Date(s) and place of service;
    e. Diagnosis (DSM-V or ICD-10 code);
    f. Procedure code (CPT or Revenue Code) and quantity;
    g. Provider charges; and
    h. Other information that may be required (i.e. Other Insurance information or the EOB for COB payment).

2. Specific instructions by line item appear below in the detailed description for the CMS-1500 and the UB-04 (CMS-1450) forms. See appendix for specific form details.

Invoice Submission – Supported Recovery Housing Services

1. All invoices for supported recovery housing services under BHRP-RSS must be submitted within 60 days of the service period and must contain all authorization data, including, but not limited to, the following:

    a. Individual's name and address;
    b. Individual's Medicaid ID;
    c. Individual's current DSM edition diagnosis or diagnoses, if applicable;
    d. Date(s) of covered behavioral health recovery support(s);
    e. Type of covered behavioral health recovery support(s) delivered to the

individual;

f. Behavioral health recovery support provider's name and address;
g. Behavioral health recovery support provider's I.D. number; and
h. Behavioral health recovery support authorization number.

Timeliness

All claims for clinical recovery support services rendered must be submitted within one hundred eighty (180) calendar days of the date(s) on which the clinical recovery supports were delivered unless there is a delay due to the need for coordination of benefits or DMHAS finds good cause. If the clinical recovery supports provider is unable to file a timely claim for payment because DSS has not yet determined an individual's eligibility for medical services, the clinical recovery supports provider should submit a claim for payment no later than three hundred sixty-five (365) calendar days after the date on which the clinical recovery supports were delivered.

Supported recovery housing services providers should submit invoices for payment no later than sixty (60) calendar days after the date on which the supports were delivered.

Claims/invoices that are not submitted within the above time frames will be denied reimbursement.

Incomplete Claims / Invoices

Claims/invoices will be denied if the required data elements are not provided. The provider will be notified via a completed Explanation of Benefits form or a Response File that will outline the incomplete or invalid information. To receive reimbursement for clinical recovery support service claims, the provider must resubmit them within the 180-day filing limit and with the identified fields corrected or completed. The required data elements for both CMS (HCFA) 1500 and UB-04 forms are listed in Appendix B of this manual.
To receive reimbursement for recovery support service , the provider must submit invoices no later than 60 calendar days after the date on which the services were provided.

BHRP Service Recipient Held Harmless

Providers may NOT, under any circumstances, bill or balance bill eligible recipients for any services provided under the Behavioral Health Recovery Program.

Third Party Liability – Clinical Services

1. The Provider must make a reasonable effort to determine whether or not eligible recipients have any other insurance or health care coverage and to promptly report any duplicate coverage to ABH;

2. The Provider must exhaust all avenues of other insurance coverage and payment prior to billing for covered services;

3. When a decision regarding reimbursement has been made by another insurance carrier, a copy of the disposition of payment or explanation of benefits (EOB) must accompany the CMS-1500 (HCFA-1500);

4. Attachment of the disposition of payment or EOB is not required with the UB-04. However, fields 50-55, 58-60 must denote the disposition from the other insurance carrier;

5. All timely filing rules are enforced from the date of disposition from the other insurance carrier;

6. The Provider agrees and understands that the Behavioral Health Recovery Program will not be obligated to pay the provider any portion of a secondary payment when the primary payment exceeds the compensation specified in the BHRP reimbursement schedule;

7. Claims involving coordination of benefits (COB) will require medical review and authorization. In order to receive payment, the Provider must obtain clinical authorization for care from both the primary insurer and ABH at the time of treatment.

Reconsideration of Paid Claims – Clinical Services

A provider may request reconsideration of a claim thought to be paid incorrectly by either calling the Clinical Recovery Supports line or by submitting a completed Claim Reconsideration Form within 180 days of the original date of service. Incomplete Claim Reconsideration Forms will not be processed. Completed forms may be either mailed or faxed to ABH. Any adjustment in payment will be reflected in and applied to the next weekly payment cycle following processing.

Claims for Payment Grievances

1. A clinical recovery supports provider with a claim inquiry (seeking information concerning the status of a submitted claim, an explanation of a paid claim or clarification of a claim denied for administrative reasons) should either log on to www.abhct.com and access the real time on-line status inquiry system or contact ABH through the toll free BHRP line at (800) 606-3677.

2. A recovery support services provider with a payment or invoice inquiry should contact ABH by calling the Recovery Support Services line at (800) 658-4472.

3. ABH representatives will research the inquiry and provide a response immediately or refer the inquiry for further investigation. In the latter case, the provider will receive a telephonic response within three (3) business days.

4. If a clinical or recovery supports provider's claim/invoice for payment is denied by ABH, the clinical or basic recovery supports provider may file a claim payment grievance with ABH. Clinical or recovery supports providers may initiate a first-level claim for payment grievance to ABH not later than thirty (30) calendar days after the date of the denial decision.

5. The first-level claim for payment grievance must include the following information:
    a. Provider Name
    b. Medicaid ID Number of the Client
    c. Client/Patient Name
    d. Date(s) of Service
    e. Billing Code(s)
    f. Claim Number (initial and subsequent submissions)
    g. Rationale for Complaint

The clinical or recovery supports provider will be notified in writing of the determination made on its first-level claim for payment grievance within thirty (30) calendar days of receipt of all information as determined necessary by ABH to render a decision.

6. A clinical or recovery supports provider may initiate a second-level claim for payment grievance not later than seven (7) calendar days following the date of the first-level claim for payment grievance denial decision. The second-level claim for payment

grievance should be submitted in writing and accompanied by all information determined necessary by DMHAS to render a decision on the second-level claim for payment grievance.

7. DMHAS will neither accept, nor review, a second-level claim for payment grievance that does not conform with the submission requirements as specified in this section of the manual, unless ABH has failed to respond to the clinical or recovery supports provider within the timeframe as specified in this section.

8. Any second-level claim for payment grievance decision issued by DMHAS will be final and will conclude the claim for payment grievance process. The second level claim for payment grievance shall not include any right to a hearing from either DMHAS or ABH.

Billing Codes - Clinical Services

Access to the listing of the CPT Codes and UB-04 Revenue Codes used for claims submission and reimbursement for authorized clinical recovery services is provided in Appendices of this manual. Please note that coding may vary by Provider and/or service level. Therefore, it is recommended that you refer to your Provider Agreement with DMHAS for coding that is specific to your facility.

Claims submitted with codes other than those listed on the rate schedule of your Agreement will be rejected. The codes requiring special authorization are listed separately. If you have questions concerning billing codes, it is recommended that you call ABH at (800) 606-3677 for claims assistance.

Section 8: Support for Contracted Providers

A participating provider in the Behavioral Health Recovery Program must be credentialed as outlined in the BHRP Policies and hold an executed contract with DMHAS (clinical recovery supports) or with ABH (recovery support services).

Credentialing

Credentialing includes the assessment and validation of provider qualifications to determine capability of providing services and whether requirements have been met. Required documentation includes but is not limited to:

1. Licensure, certification and/or accreditation.

2. Experience in providing services;

3. Insurance; and

4. Programmatic and staffing details.

Credentialing of new providers may be done via a competitive procurement process. DMHAS and ABH retain the right to deny credentialing and determine the current needs of the BHRP.

Re-credentialing of participating providers will be done every three (3) years.

Contracting

A contract specifies conditions and terms to which the clinical or recovery support services provider must adhere in order to participate in the BHRP. DMHAS shall bear no financial responsibility for services that are rendered in the absence of an executed contract.

Termination of Contracted Providers

DMHAS or ABH may terminate a contract with a provider after giving the provider a thirty (30) calendar day written notification or such notice as otherwise required by contract or regulation. DMHAS or ABH may terminate the contract for reasons that include, but are not limited to, the following:

1. Loss, revocation, suspension, surrender or non-renewal of any credential required, such as the facility license or another credential required as a condition of eligibility;

2. The provider has a diminished ability to provide services legally, including disciplinary action by a governmental agency or licensing board that impairs the contracted provider's ability to operate;

3. Failure to comply with DMHAS/ABH credentialing and re-credentialing requirement criteria;

4. Failure to notify ABH of any event that would affect or modify the information contained in the provider's credentialing application for participation in the BHRP;

5. Disciplinary action by any other state, governmental agency or licensing board;

6. Termination of, or failure to maintain, adequate insurance coverage;

7. Fraud, such as, the provider:

a. Presents a false claim for payment;
b. Accepts payments for services delivered that exceeds the amount due;
c. Solicits to deliver or delivers services for any eligible recipient, knowing that such eligible recipient is not in need of such services;
d. Accepts payment for services that were covered by another payor; or
e. Presents a claim for payment to DMHAS or ABH for services that were not delivered to an eligible recipient;

8. Failure to comply with the terms and conditions established in the contract;

9. Failure to deliver services to eligible recipients in an ethical manner;

10. Failure to implement corrective action required by DMHAS or ABH as the result of an audit;

11. Any other breach of the clinical or recovery supports provider contract that is not corrected by the provider not later than thirty (30) calendar days after receipt of notice from DMHAS or ABH; or

12. Failure to repay an overpayment made by DMHAS or ABH within the specified timeframe.

DMHAS or ABH may terminate a provider contract without prior notice, based upon any of the following circumstances:

1. Funding for the contract is no longer available; or

2. DMHAS determines that the provider poses imminent potential harm to the health or welfare of eligible recipients. DMHAS will provide written notification to the provider of the specific reasons for taking such action in writing within five (5) business days of contract termination.

ABH-DMHAS Responsibility

DMHAS and ABH recognize the value each contracted provider adds to the statewide continuum of care. The ABH Provider Relations staff will offer support regarding completion of the credentialing and contracting process. In addition, training requests for the Electronic Registration System (ERS), clinical recovery supports claims submissions, or any other inquiries related to participation in the clinical recovery supports portion of the BHRP, can be made by contacting an ABH Customer Service or Provider Relations staff member at (800) 606-3677. Requests for training related to basic recovery supports service request or invoice submission or

any other inquiries related to participation in the basic recovery supports portion of the BHRP can be made by contacting the Recovery Support Services line at (800) 658-4472.

Provider Responsibilities

Providers will:

1. Comply with all state and federal requirements pertaining to the communication, storage, dissemination, and retention of confidential information regarding potentially eligible recipients and eligible recipients including the Health Insurance Portability and Accountability Act (HIPAA); 45 CFR 164, 45 CFR 2; and 17a-688(c) and Chapter 899 of the Connecticut General Statutes; and other such laws and regulations as may apply. Additionally, the provider will assume responsibility for obtaining any release of information that may be necessary to meet contractual data transmittal and service coordination requirements;

2. Report every critical incident to DMHAS;

3. Submit to DMHAS or ABH timely and accurate information in the specified format. This information includes, but is not limited to, the following:

    a. Demographic data regarding the eligible recipients served;
    b. Descriptions of the services delivered;
    c. Descriptions of the provider's staff sufficient for DMHAS to assess the provider's cultural competency;
    d. Service recipient outcomes;
    e. Census counts; and
    f. Service recipient service records or charts;

4. Providers must report to ABH any event that would affect or modify the information contained in the provider's credentialing application for participation in the BHRP. Clinical recovery support providers may contact the ABH Provider Relations Department at (800) 606-3677, Option 2 to report any changes. Recovery support services providers may contact the Recovery Supports Help Line at (800) 658-4442 to report any changes.

Section 9: Appeals, Complaints and Grievances

There are two appeal levels that may be submitted as a result of a denial of request for clinical or recovery support services. This process is reflected in DMHAS Behavioral Health Recovery Program Policies.

This appeal process is available to a recipient or his/her authorized representative, who is dissatisfied with the decision of ABH to deny, reduce or terminate a covered behavioral health treatment service based on failure to meet medically necessary criteria, or failure to follow administrative guidelines for seeking authorization of covered services, or the decision of ABH to deny, reduce or terminate a recipient's application for recovery support services.

Providers who wish to appeal denial of claims/invoice payments may do so by following the procedures outlined in Section 7 of this Provider Manual - Claims for Payment Grievances.

First-Level Appeal

A first-level appeal may be filed by the individual or his/her authorized representative. The first-level appeal should be filed with ABH no later than seven (7) calendar days after the decision by ABH to deny, reduce or terminate covered clinical or recovery supports, unless good cause is shown for late filing as determined by ABH. A first-level appeal is not a "contested case" pursuant to Section 4-166(2) of the Connecticut General Statutes.
A first-level appeal should be filed in writing with all supporting information or records. (An appeal for recovery support services should be submitted on the "Appeal Request and Disposition Form for Recovery Support Services" found in the appendices of this manual or downloaded from www.abhct.com.) All records relating to a first-level appeal will be kept confidential unless disclosure is otherwise required by law or authorized in writing by the individual. The first-level appeal should be submitted to:

DMHAS Behavioral Health Recovery Program
Advanced Behavioral Health, Inc.
213 Court Street, 8th floor Middletown, CT 06457

A first-level appeal may also be filed with ABH via FAX at:
(a) Clinical recovery supports FAX# (800) 704 – 6145
(b) Recovery Support Services - (866) 249 – 8766

If the first-level appeal is related to a denial of clinical recovery supports due to failure to meet criteria used to determine medically necessary benefits, the decision will be made by a board-certified psychiatrist who was not previously involved in reviewing the service request.

ABH will send written notice of the first-level appeal decision by ABH to the individual or his/her authorized representative and to the provider not more than seven (7) calendar days after ABH has determined it has received all information necessary to render a decision.

If ABH fails to issue a first-level appeal decision within seven (7) calendar days, the individual or his/her authorized representative may treat it as a denial and request further review by filing a

second-level appeal.

Second-Level Appeal

An individual or his/her authorized representative may file a second-level appeal of a first-level appeal decision that denies, reduces or terminates covered behavioral health treatment services. The second-level appeal must be filed with DMHAS not later than seven (7) calendar days after the first-level appeal decision, unless good cause is shown for a late filing, as determined by DMHAS. A second-level appeal is not a "contested case" within the meaning of Section 4-166(2) of the Connecticut General Statutes.

The second-level appeal should be filed in writing with all supportive documentation. All records relating to the second-level appeal will be kept confidential, unless disclosure is otherwise required by law or authorized in writing by the individual.

All second-level appeals correspondence should be sent to:

Department of Mental Health & Addiction Services
Via Fax to 1-866-249-8766

The individual or his/her authorized representative and the provider will be sent written notice of the second-level appeal decision by DMHAS not later than seven (7) calendar days after DMHAS determines it has received all information necessary to render a decision. DMHAS will neither accept nor review a second-level appeal request if the first-level appeal request submitted to ABH is still being reviewed within the time period stated in this section.

Fair Hearings

Any individual who requested a covered service from ABH and had the covered service denied or, if delivered, reduced or terminated without the individual's consent and who has received an unfavorable second-level appeal from DMHAS, may request a fair hearing. The individual's request must be made within fifteen (15) calendar days of the second-level appeal decision. Fair Hearings must be requested in writing to the Department of Mental Health & Addiction Services at the address below:

Department of Mental Health & Addiction Services Managed Services Division
410 Capitol Avenue, 4th Floor PO BOX 341431
Hartford CT 06134

Complaints and Grievances

For the purposes of this section, grievances are defined as a complaint against a Provider in

matters other than the denial, reduction, or termination of covered services.

A recipient receiving services under the DMHAS Behavioral Health Recovery Program, or his/her authorized representative, may utilize the established grievance procedure to seek resolution of complaints concerning the quality or level of services provided.

Complaints related to clinical recovery supports can be offered by contacting ABH at (800) 606-3677, Option 2.

Complaints related to recovery support services can be offered by contacting the Recovery Support Services line at (800) 658-4442.

Section 10: Glossary of Terms

AEVS: *Automated Eligibility Verification System* – a system accessible to Providers, which allows for verification of eligibility for HUSKY benefits, and/or the existence of third-party liability for a recipient.

American Psychiatric Association (APA) Clinical Practice Guidelines: Evidence-based recommendations for the assessment and treatment of psychiatric disorders which are intended to assist in clinical decision-making by presenting systemically developed patient care strategies in a standardized format.

American Society of Addiction medicine (ASAM) Criteria: Comprehensive set of standards for placement, continued services, and transfer of individuals with substance use disorders (SUD) and co-occurring disorders.

Appeal: A formal request for review of a clinical or recovery support services provider's service authorization or payment decision.

ASO: *Administrative Services Organization* – An entity, operated by a private vendor, that provides utilization management, claims processing, and other administrative assistance to the Department of Mental Health and Addiction Services to facilitate the purchase and provision of mental health and addiction services for recipients. Advanced Behavioral Health, Inc. (ABH) is the ASO for the Behavioral Health Recovery Program.

Authorization: the approval of a request for clinical or basic recovery supports.

Authorized Representative: a person designated by the eligible recipient or a person authorized by law to act on behalf of an eligible recipient for the purpose of filing an appeal or grievance.

Available Resources: Community or financial resources that cover services offered under the

Behavioral Health Recovery Program.

Behavioral Health Recovery Supports Provider: An entity that has been contracted or otherwise recognized by DMHAS to provide behavioral health recovery support services under the Behavioral Health Recovery Program.

Behavioral Health Recovery Supports Service: Transitional supportive services provided as an adjunct to clinical treatment services to assist eligible recipients in achieving and maintaining recovery.

Behavioral Health Recovery Program (BHRP): A program administered by DMHAS that provides behavioral health clinical and/or recovery support services for individuals who are subsidized under the CT Medicaid Husky Health Insurance (federal Medicaid Program Title XIX) pursuant to Sections 1902(a)(10)(A)(i)(VIII) and 1902(k)(2) of the Social Security Act.

Behavioral Health Clinical Recovery Services: Services designed for the treatment of a substance use disorder(s) or both a substance use disorder and psychiatric disorder

Behavioral Health Clinical Recovery Services Provider: A behavioral health provider, under agreement with the CT DSS Medicaid Husky Health (federal Medicaid Program Title XIX) to provide services designed for the treatment of a substance use disorder(s) or both a substance use disorder and psychiatric disorder

Biopsychosocial Assessment: A service to holistically assess an individual's biological, psychological and social factors which are integrated and analyzed according to the role each plays in the context of an individual's substance use and recovery. The bio- psychosocial assessment shall be completed during the admission process

Case Management: Includes the process for an assessment followed by recovery planning and discharge planning intended to link individuals to clinical recovery supports or basic recovery supports.

Cash Assistance: Financial assistance provided by the state or federal government to individuals who meet specific employability, disability, income, asset, citizenship or other eligibility requirements as defined by these entities.

CFR: Code of Federal Regulations.

Commissioner: The commissioner of the Department of Mental Health and Addiction Services.

Co-occurring Disorder (COD): A concurrent psychiatric disorder and substance use disorder.

Critical Incident: Critical incidents, as defined by The Connecticut Department of Mental Health & Addiction Services Commissioner's Policy Statement No.81, are incidents that may have a serious impact on DMHAS clients, staff, funded agencies or the public, or may bring about adverse publicity.

DMHAS: Department of Mental Health and Addiction Services.

DSS: Department of Social Services.

Designated Agent: **An** organization under contract with DMHAS to provide utilization management, claims processing, or other administrative support services necessary for the operation of the Behavioral Health Recovery Program.

Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition): The American Psychiatric Association's current manual for the identification and diagnosis of mental disorders. This manual includes the descriptions, symptoms and the other criteria for diagnosing mental disorders including identifying codes for reporting a classification of mental and substance use disorders.

Direct Payment: Payment issued by DMHAS or its designated agent directly to entities for behavioral health clinical or recovery support services provided to eligible recipients.

Discharge Plan: The written summary of an individual'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.

Eligible Recipient: An individual who receives behavioral health clinical or recovery support services through the Behavioral Health Recovery Program under CT Medicaid Husky Health insurance (federal Medicaid Program Title XIX).

EMS – *Eligibility Management System:* the information system utilized by DSS to record eligibility information for recipients of Medicaid for the State of Connecticut. An EMS ID or Medicaid Number is a unique identifier assigned to persons who meet eligibility criteria for assistance under the Department of Social Services programs.

Faith Recovery Support Services: Services provided in a religious or spiritual setting by spiritual leaders or staff via individual or group meetings that are designed to help persons in recovery forge supportive connections with self-selected faith communities to discover positive interests and valued social roles.

Family: the individual's chosen natural support system which may include biological relatives, significant others, friends, and other supports.

Grievance: A complaint against a service provider in matters other than the denial, reduction, or termination of services offered under the BHRP.

Husky A: Connecticut's implementation of health insurance under federal Medicaid program (Title XIX) for pregnant women, parents or caretaker relatives who have a child/children on Husky A.

Husky C: Connecticut's implementation of health insurance under federal Medicaid program (Title XIX) for residents aged 65 or older, or who are aged 18 through 64 who are blind, or who have another disability. Formally known as Medicaid for the Aged/Blind/Disabled.

Husky D: Connecticut's implementation of health insurance under federal Medicaid program (title XIX) for low-income adults aged 19 through 64, also known as Medicaid for low-income adults (LIA).

Independent Housing: Short-term assistance provided to secure affordable and safe housing via a lease agreement with a landlord.

Institution for Mental Disease (IMD): means a hospital, nursing facility or institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services.

Intensive Case Management: a case management program designed to assist high- risk clients including high utilizers, in engaging and moving through the recovery continuum.

Job Readiness: Activities including, but not limited to, recent job searches, vocational/educational classes, and vocational/educational groups.

Licensed Behavioral Health Professional: An individual holding professional licensure in Connecticut for one of the following professions: physician who is board-certified in psychiatry, clinical social worker, marriage and family therapist, psychologist, nurse clinician who holds a clinical nurse specialty in psychiatry, licensed professional counselor, or alcohol and drug counselor (including certified alcohol and drug counselors).

Partial Denials: Any portion of a service request, duration, intensity or level of care determined to be ineligible in an otherwise eligible request.

Prior Authorization: The Contractor's process for approving payment for covered services prior to the delivery of the service or initiation of the plan of care based on the Contractor's determination that the requested service is medically necessary and medically appropriate.

Provider: A credentialed and contracted or subcontracted provider that can receive payment for BHRP Covered Services.

Payor of Last Resort: A state agency that will only make payments for behavioral health clinical or recovery support services to the extent that no other source of payment is available.

Quality Management: The process of reviewing, measuring, and working to continually improve the quality of services delivered.

Recovery: 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.

Recovery Management Services: Activities intended to assist individuals to identify and utilize relapse prevention skills and to increase self-sufficiency, such as obtaining gainful employment and independent living in their communities. These activities include linkage to clinical or recovery support services and are reflected in an individualized recovery plan incorporating the input of individuals and their natural supports.

Recovery Oriented Vocational Services: Services directed toward improving and maintaining employment and include skills assessment and development, job coaching, job placement, resume writing, interviewing skills, and developing job retention skills.

Recovery Plan: A written plan, based on the individual's strengths, needs, and preferences, developed with the individual or the individual's authorized representative, and completed during the admission process.

Supported Recovery Housing: a clean, safe, drug and alcohol-free transitional living environment under the Behavioral Health Recovery Program with on-site case management services available at least eight (8) hours per day, five (5) days per week.

Supported Recovery Housing Provider: An entity that has been contracted by DMHAS or a designated agent to provide supported recovery housing services for the Behavioral Health Recovery Program.

Transportation: Conveyance provided by bus pass, ride sharing or gas cards to and from Behavioral Health Recovery Program Services and supported recovery and shelter housing services.

Wellness Services: Activities directed towards improving one's overall health and well-being and enhancing the eligible recipient's recovery that may not be covered by Medicaid.

Section 11: Appendices, Forms, Policy Statement

Appendices

Appendix A – Clinical Level of Care Guidelines

Appendix B - CMS 1450 Claim form, Tips & Reference Manual

Appendix C - CMS 1500 claim form, Tips & Reference Manual

Forms and Policy Statement

Behavioral Health Recovery Program (BHRP)

Consent to Disclosure and Re-disclosure of Confidential Information and Records

Appeal Request and Disposition Form for Recovery Support Services

BHRP Policies are posted on the DMHAS and/or designated agent website: BHRP.