

Sec. 17a-453a-7. Continued stay authorization review

(a) The continued stay authorization review shall determine whether previously authorized covered behavioral health services continue to be medically necessary. If a contracted provider determines that additional care may be needed beyond that which has been authorized for a potentially eligible or eligible recipient, the contracted provider shall contact the 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 forty-eight (48) hours prior to the expiration of the existing authorization for other covered behavioral health services in order to obtain a continued stay authorization.

(b) The contracted provider shall furnish all information that may be requested by the designated agent for the purpose of determining continued stay authorization of covered behavioral health services requested for a potentially eligible or eligible recipient, including, but not limited to, the following:

- (1) Identifying information;
- (2) DSM-IV current diagnosis or diagnoses;
- (3) Level of care requested;
- (4) Clinical presentation of the potentially eligible or eligible recipient and justification for the requested covered behavioral health service, including such factors as 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 potentially eligible or eligible recipient is voluntarily agreeing to treatment;
- (11) Legal status of the potentially eligible or eligible recipient, if known;
- (12) Potentially eligible or eligible recipient's preference for a covered behavioral health service and contracted provider;
- (13) Treatment location;
- (14) Provisional discharge or aftercare plan or both;
- (15) Projected date of discharge;
- (16) Name of the potentially eligible or eligible recipient's primary care physician, if any; and
- (17) All other information that the designated agent may require.

(c) The decision regarding continued stay authorization shall be rendered by the designated agent not later than three (3) hours after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.

(d) Upon completion of the review, the designated agent shall:

- (1) Authorize the requested covered behavioral health service for a specific number of days or sessions of treatment over a specified time period;
- (2) Authorize a different covered behavioral health service than requested; or
- (3) Deny authorization when the information received by the designated agent does not demonstrate that the requested covered behavioral health service is medically necessary.

Regulations of Connecticut State Agencies

(e) Continued stay authorization of a covered behavioral health service is not a guarantee that DMHAS will pay a contracted provider's claim for payment.

(Adopted effective December 7, 2009)