

Sec. 17b-262-523. Definitions

For the purposes of sections 17b-262-522 through 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies the following definitions apply:

- (1) **“Acute”** means symptoms that are severe and have a rapid onset and a short course;
- (2) **“Border provider”** means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and that is enrolled as and treated as a Connecticut Medical Assistance Program provider. Such providers are certified, accredited, or licensed by the applicable agency in their state and are deemed border providers by the department on a case by case basis;
- (3) **“Claim”** means a request for payment submitted by a provider to the department, or its fiscal agent, in accordance with the billing requirements set forth by the department;
- (4) **“Client”** means a person eligible for goods or services under the department’s Medical Assistance Program;
- (5) **“Commissioner”** means the commissioner of the Connecticut Department of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes;
- (6) **“Copayment”** means a nominal fee, chargeable to the client and not payable from the department, for specified goods or services and which meets the requirements of section 1916 of the Social Security Act and 42 CFR 447.15 and 42 CFR 447.50 to 42 CFR 447.58, inclusive;
- (7) **“Coverable Medical Assistance Program good or service”** means any good or service which is payable by the Medical Assistance Program under its regulations;
- (8) **“Department”** means the Connecticut Department of Social Services or its agent;
- (9) **“Emergency”** means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;
- (10) **“Free of charge”** means a good or service for which no individual client has an obligation to pay and for which no third party payment is ever sought;
- (11) **“Lock-in”** means the department’s restriction of a client to a specific provider for certain Medical Assistance Program goods or services under the authority of section 17-134d-11 of the Regulations of Connecticut State Agencies;
- (12) **“Medical appropriateness or medically appropriate”** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate [medical]setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;
- (13) **“Medical Assistance Program”** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid;
- (14) **“Medical Assistance Program goods or services”** means medical care or items that are furnished to a client to meet a medical necessity in accordance with applicable statutes or regulations that govern the Medical Assistance Program;
- (15) **“Medical necessity or medically necessary”** means health care provided to correct

or diminish the adverse effects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring;

(16) **“Medicare”** means the federal health care program authorized by Title XVIII of the Social Security Act;

(17) **“Out-of-state provider”** means a provider who is licensed, certified, or accredited in a state other than Connecticut; has a business address outside of Connecticut; and does not meet the definition of “border provider”;

(18) **“Overpayment”** means any payment that represents an excess over the allowable payment under state law including, but not limited to, amounts obtained through fraud and abuse;

(19) **“Point of sale or POS”** means the department’s on-line, real time pharmacy electronic claims transmission. This process also includes prospective drug utilization review;

(20) **“Prior authorization”** means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

(21) **“Prospective drug utilization review or pro-DUR”** means a client-specific drug utilization review prior to dispensing;

(22) **“Provider”** means any individual or entity that furnishes Medical Assistance Program goods or services pursuant to a provider agreement with the department and is duly enrolled and in good standing or, as the context may require, an individual or entity applying for enrollment in the Medical Assistance Program;

(23) **“Provider agreement”** means the signed, written, contractual agreement between the department and the provider of services or goods;

(24) **“Provider enrollment or reenrollment form”** means the department’s form which requests the provider’s data such as, but not limited to: name, address, licensure or certification information, service protocols, and any other information required by the department to assess provider eligibility for participation in the Medical Assistance Program;

(25) **“Suspension”** means limiting program participation of providers who, although not convicted of program-related crimes, are found by the department to have violated rules, regulations, standards or laws governing any such program;

(26) **“Termination”** means precluding medical assistance program participation by providers that have been convicted of a crime involving medicaid or medicare;

(27) **“Third party”** means any individual, private or public organization, or entity that is or may be liable to pay all or part of the medical costs of injury, disease, or disability for a client pursuant to 42 CFR 433.136;

(28) **“Third party liability”** as it applies to Medical Assistance Program claims processing, means payment resources available from both private and public health insurance that can be applied toward Medical Assistance Program clients’ medical and health benefit expenses. A pending tort recovery or cause of action, worker’s compensation or accident insurance settlement is not a third party liability; and

(29) **“Type and specialty”** means the department’s categorization of Medical Assistance Program providers according to the type and specialty of the goods or services furnished

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by the provider.

(Adopted effective February 8, 1999; Amended April 1, 2003)