Sec. 17b-262-526. General provider requirements

To maintain enrollment in the Connecticut Medical Assistance Program, a provider shall abide by all federal and state statutes regulations and operational procedures promulgated by the department which govern the Medical Assistance Program and shall:

(1) abstain from discriminating or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, sex, mental or physical disability, or sexual orientation pursuant to 45 CFR 80.3 and 45 CFR 80.4;

(2) accept as payment in full either the department's payment or a combination of department, third party payment, and any authorized client copayment which is no more than the department's schedule of payment, except with regard to the department's obligations for payment of Medicare coinsurance and deductibles;

(3) agree to pursue and exhaust all of a client's third party resources prior to submitting claims to the department for payment; to report any and all third party payments; to acknowledge the department as the [payor] payer of last resort; and to assist in identifying other possible sources of third party liability for which a legal obligation for payment of all or part of the Medical Assistance Program goods or services furnished exists;

(4) be qualified to furnish Medical Assistance Program goods or services; be currently certified and enrolled in the Medicare program if required by any federal or state statutes or regulations which govern the Medical Assistance Program goods or services furnished by a provider under the provider's assigned type and specialty;

(5) meet and adhere to all applicable licensing, accreditation, and certification requirements and all applicable state and local zoning and safety requirements pertaining to the provider's assigned type and specialty in the jurisdiction where the Medical Assistance Program goods or services are furnished;

(6) meet and adhere to any additional department requirements, after enrollment, promulgated in conformance with federal and state statutes, regulations and operational procedures which govern the provider's assigned provider type and specialty;

(7) maintain a specific record for each client eligible for Medical Assistance Program payment including, but not limited to: name; address; birth date; Medical Assistance Program identification number; pertinent diagnostic information and x-rays; current and all prior treatment plans prepared by the provider; pertinent treatment notes signed by the provider; documentation of the dates of service; and other requirements as provided by federal and state statutes and regulations pursuant to 42 CFR 482.61, and, to the extent such requirements apply to a provider's licensure category, record requirements set forth in chapter iv of the Connecticut Public Health Code (sections 19-13-D1 to 19-13-D105 of the Regulations of Connecticut State Agencies). Such records and information shall be made available to the department upon request;

(8) maintain all required documentation for at least five years or longer as required by state or federal law or regulation in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning goods or services provided, documentation shall be maintained until the end of the dispute,for five years, or the length of time required by state or federal law or regulation, whichever is greatest. Failure to maintain and provide all required documentation to the department upon request shall result

in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request, as permitted by state and federal law;

(9) notify the department in writing of all substantial changes in information which were provided on the application submitted to the department for provider enrollment or reenrollment in the Medical Assistance Program;

(10) disclose, in accordance with 42 CFR 455.106, any information requested by the department regarding the identity of any person who has ownership or a controlling interest in the provider's business who has been convicted of a criminal offense related to that person's involvement in Medicare or the Medical Assistance Program;

(11) furnish all information relating to the provider's business ownership, as well as transactions with subcontractors, in accordance with federal and state statutes and regulations;

(12) not deny goods or services to a client solely on the basis of the client's inability to meet a copayment; and

(13) agree to participate in studies of access, quality and outcome conducted by the department or its agents. The department shall reimburse providers for costs above and beyond nominal costs incurred by such participation.

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