Agency
Department of Social Services

Subject
Medical Assistance

Inclusive Sections
§§ 17-134d-1—17-134d-149

CONTENTS

Medical Assistance

Sec. 17-134d-1. Repealed

Repealed December 21, 1990.

Sec. 17-134d-2. Medical and remedial care and services

Medical assistance may be granted to eligible persons for the following items of medical and remedial care and services: (1) Inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and x-ray services; (4) skilled nursing home services; (5) services of a physician whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or otherwise; (6) medical service and care or an other type of remedial care recognized under Connecticut law, furnished by licensed practitioners within the scope of their practice as defined by Connecticut law; (7) home health care services; (8) private duty nursing services; (9) clinic services; (10) dental services; (11) physical therapy and related services; (12) prescribed drugs, dentures and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist; (13) other diagnostic, screening, preventive and rehabilitative services; (14) the first three pints of whole blood, when they are not available to the patient from other sources; (15) any other medical care recognized under Connecticut law including transportation, ambulance, oxygen, and podiatry; (16) family planning services, drugs, supplies and devices when such services are under the supervision of a physician; (17) services of Christian Science Practitioners listed in the Christian Science Journal, published by the First Church of Christ Scientist, Boston, Massachusetts; (18) care and services provided in Christian Science Sanatoria operated by, or listed and certified by, the First Church of Christ Scientist, Boston, Massachusetts.

(Effective March 2, 1971)

Sec. 17-134d-3—17-134d-6. Repealed

Repealed December 21, 1990.

Services for Functionally Disabled Clients Who Have No Vocational Objective

Sec. 17-134d-7. Definitions as used in these regulations

(a) The term "Functionally Disabled" as used herein shall mean physically and/or mentally unable to perform minimum daily personal and home management requirements.

(b) The term "Therapy" as used herein shall mean the remedial treatment of a physical and/or mental disorder.

(c) The term "Functional Therapy" as used herein shall mean remedial treatment relating to, or training in, the performance of minimum daily personal and home management acts.

(d) The term "Functional Objective" as used herein shall mean the goal or aim of the individual to perform minimum daily personal and home management acts.

(e) The term "Vocational Objective" as used herein shall mean the goal or aim of the

individual to become skilled in or learn a trade which will suffice as a career in a community setting.

(Effective October 9, 1980)

Sec. 17-134d-8. General provisions of services for functionally disabled clients who have no vocational objective

(a) Reimbursement is made for the following types of services rendered to Title XIX (Medicaid) recipients who are mentally and physically disabled and who have no vocational objective:

(1) Physicians Services

(b) Reimbursement is made for the following types of services when prior authorization is obtained:

(1) Physical Therapy

(2) Speech and Hearing Therapy

(3) Occupational Therapy

(4) Audiological Services

(5) Psychiatric and Psychological

(6) Day Care and Functional Therapy only if the service is part of a predominantly medical plan.

(c) Medical services are those services which are required in the diagnosis, treatment, care, or prevention of some physical or psychological problem which affects the health of an individual. Such services would be rendered by or under the direction of a physician or other health care practitioner under accepted standards of medical practice. For each individual receiving one of the above stated services, an individual plan of treatment is required. The plan must be implemented under the direct supervision of a health care professional and must address the total needs of the individual as well as clearly identify his medical needs. The evaluation to determine the needs of the individual need not be made at the facility, but all services must be provided at the facility.

(Effective October 9, 1980)

Reimbursement for all Out-Patient Hospital Laboratory Services Received by Title XIX (Medicaid) Recipients

Sec. 17-134d-9. Repealed

Repealed August 5, 1988.

Routine Medical Visits for Title XIX Recipients Residing in Homes for the Aged

Sec. 17-134d-10. Reimbursement for routine medical visits for title XIX recipients residing in homes for the aged

The department of income maintenance will pay for no more than four (4) routine medical visits during any twelve (12) month period for Title XIX recipients residing in homes for

the aged. Routine medical visits are defined as visits intended to check a resident's general medical condition rather than visits medically necessary to treat a specific medical problem of the resident. The Department of Income Maintenance reserves the right to review the medical necessity of visits and disallow reimbursement for those it determines not medically necessary.

(Effective June 1, 1981)

Sec. 17-134d-11. Medicaid recipient surveillance and utilization review program

(a) **Establishment of Recipient Surveillance and Utilization Review Program.**

In the Department of Income Maintenance a Recipient Surveillance and Utilization Review Program oversees, assesses and controls the use of medical services by recipients provided under the Medicaid Program by monitoring recipient utilization.

(b) **Identification of recipients' overutilization of services.**

Recipients who may be overutilizing, and/or unnecessarily or inappropriately using medical services under Medicaid shall be identified through recipient or provider exception reports, referrals from sources including town welfare departments and medical assistance providers of service, claims listing reports with additional information from billing invoices, or other appropriate means.

Provider and recipient exception reports show deviations from the statistical norm for the Medicaid recipient or provider population for the usage or provision of a particular service.

(c) **Recipient Surveillance and Utilization Review Committee.**

The Recipient Surveillance and Utilization Review Committee (R/SURC) is appointed by the Commissioner of the Department of Social Services and consists of a Medical Consultant (Physician), a Medical Social Worker and a professional consultant with expertise in the relevant area of utilization review to be conducted by the Department. The areas of utilization review and relevant consultants shall include, but are not limited to, the following:

(1) Pharmacy—a Pharmacist,

(2) Mental Health—a Psychiatrist/Psychologist,

(3) Durable Medical Equipment—a Physical Therapist, etc.

Cases identified as possibly overutilizing medical services shall be reviewed by R/SURC to determine if further action is appropriate.

(d) **Implementation.**

The R/SUR Committee, based on a review of information and individual circumstances, recommends a course of action, which may consist of:

(1) No Action

(2) No immediate action but the Department notifies the recipient of the misutilization or overutilization and reviews the profile within three (3) months after the notification. If the inappropriate utilization is not satisfactorily resolved at the end of three (3) months, the case is referred back to R/SURC for further action.

(3) Utilization Control

Upon the making of a determination by R/SURC that there has been unnecessary or inappropriate utilization of medical services, the Department may restrict or limit access to the medical services by a recipient to a specific provider or require prior authorization for all medical services when necessary to prevent duplication and/or abuse of services.

Such restrictions on the use of Medicaid are subject to the notice and fair hearing requirement.

If either restriction is recommended by R/SURC, a letter shall first be mailed to the recipient explaining the restriction being imposed and the reason for its imposition. The recipient is given ten (10) days to respond to the letter and include the name and address of the provider the recipient would like to have as the primary medical provider if it is a provider restriction. If no response is received within ten (10) days, the recipient is assigned to any one of the medical providers appropriate to the service being overutilized or placed on prior authorization restriction.

The recipient's notification also contains a statement of the right to appeal the restriction, along with an appeal application. Recipients are advised that the request for an appeal must be submitted within sixty (60) days.

Providers either chosen by recipients or selected on the basis of the recipient's most recent utilization profile are contacted by mail and asked to serve as the primary medical provider for the recipient in question for a period of no less than six months. In the event that the provider refuses to assume this responsibility, another provider is selected. This provider is contacted by telephone to assure that an assignment is made within a reasonable period of time. Once a recipient has been assigned a primary provider, the recipient is sent a notification by registered mail of the assignment.

The recipient's Medicaid I.D. Card shall indicate the provider restriction or prior authorization requirement.

(A) Duration of Utilization Control Restrictions.

Utilization Control restriction is for a minimum of twelve (12) months, even if the recipient becomes ineligible for medical assistance and then eligible again.

Prior to the twelve (12) month restriction period the restricted recipient's claims history, and the subsequently submitted invoices, shall be reviewed by R/SURC to determine whether the restriction should be continued for another twelve (12) month period.

If the recipient is to continue on restriction, a summary of the recipient's continued misuse or abuse of services shall be prepared. The Department shall explain the continued restriction and effective dates to the recipient.

If the restriction is to be terminated the recipient shall be informed of the termination of restriction and future monitoring of recipient use of services.

(Effective March 1, 1994)

Payment to Psychiatrists for Services Rendered by Non-Medical Allied Health Professionals in Their Employ

Sec. 17-134d-12—17-134d-15. Reserved

Sec. 17-134d-16. Repealed

Repealed May 11, 1998.

Sec. 17-134d-17—17-134d-19. Reserved

Acute Care General Hospital Inpatient Weekend Admissions and Discharges under Title XIX (Medicaid)

Sec. 17-134d-20. Acute care general hospital inpatient weekend admissions and discharges under title XIX (Medicaid)

The Department of Income Maintenance, Title XIX (Medicaid) program will not reimburse acute care general hospitals for inpatient weekend admittances (Friday/Saturday) or discharges (Sunday/Monday) unless they are medically necessary. Admissions and discharges on these restricted days must have medical necessity recorded by the attending or performing physician in the patient's medical record.

(Effective April 27, 1984)

Sec. 17-134d-21—17-134d-22. Reserved

Coverage of Nurse-Midwife Services under Medicaid

Sec. 17-134d-23. Repealed

Repealed March 6, 1998.

Provision of a Financial Incentive for Reporting Vendor/Provider Medical Assistance Fraud

Sec. 17-134d-24. Repealed

Repealed April 2, 1998.

Sec. 17-134d-25. Reserved

Sec. 17-134d-26—17-134d-27. Repealed

Repealed December 21, 1990.

Sec. 17-134d-28—17-134d-31. Reserved

Immediate Medical Coverage for Newborn Children

Sec. 17-134d-32. Repealed

Repealed December 21, 1990.

Sec. 17-134d-33. Medical transportation services

(a) **Scope**

These regulations set forth the requirements for payment of Medical Transportation Services rendered to persons determined eligible for such services under provisions of Connecticut's Medical Assistance Program in accordance with Section 17-134d of the General Statutes of Connecticut.

(b) **Definitions**

For purposes of Section 17-134d-33, the following definitions apply:

(1) Additional Recipient

An additional recipient is an eligible Medicaid recipient beyond the first recipient transported by a Medicaid transportation provider during the same trip.

(2) Additional Stop

All trips have one pickup point and one drop-off point. An additional stop is a pickup point or drop-off point other than the initial pickup and final drop-off points. Additional stops occur when multiple recipients are transported during a single trip.

(3) Air Transportation

Air transportation is transportation provided by a commercial airline.

(4) Alternative Method of Transportation

If the most appropriate type of transportation for a recipient is not available, a different type of transportation may be utilized. This would be an alternative method of transportation.

(5) Ambulance

An ambulance is a vehicle for transporting the sick and injured which is equipped and staffed to provide medical care during transit, and which is operating as an ambulance under the authority and in compliance with promulgated regulations of the Department of Health Services, Office of Emergency Medical Services, and registered as such by the Department of Motor Vehicles.

(6) Ambulance Night Call Charge

An ambulance night call charge is an additional fee that may be paid when an ambulance service is dispatched between the hours of 7:00 P.M. and 7:00 A.M. inclusive.

(7) Appropriate Method of Transportation

An appropriate method of transportation is the least expensive type of transportation which best meets the physical and medical circumstances of a recipient requiring transportation to a medical service.

(8) Assistance

Assistance is when a recipient must be physically helped from within or into a building

and/or from within or into the medical provider's site. Without such assistance it would be unsafe or impossible for the recipient to reach the livery vehicle or the medical provider's site.

This assistance is provided by an employee of the livery provider, the driver or a person in addition to the driver. This service is beyond a door-to-door service.

(9) Attendant

An attendant is an employee of an invalid coach or wheelchair accessible livery provider, and is a person in the vehicle in addition to the driver, who provides assistance in the transportation of passengers.

(10) Attendant Services

Attendant services are when an attendant must physically assist a recipient from within or into a building and from within or into the medical provider's site. Without such assistance it would be unsafe or impossible for the recipient to reach the invalid coach or wheelchair accessible livery vehicle or the medical provider's site. This service is beyond a door-to-door service.

(11) Available Transportation

Available transportation means that a public transportation system, an enrolled Medicaid provider, organization, agency, or individual offers appropriate transportation services to a recipient who requires transportation.

(12) Border Provider

A border provider is a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and who is enrolled as and treated as a Connecticut Medicaid provider. Such providers are certified and/or licensed by the applicable agency in their state.

(13) Cancelled Call

A cancelled call is notification to the transportation provider not to provide services to a recipient, prior to the time the vehicle is enroute to the pickup point.

(14) Critical Care Helicopter

A critical care helicopter is an aircraft which is operating as a critical care helicopter and in compliance with promulgated regulations under the authority of the Department of Health Services, Office of Emergency Medical Services. A critical care helicopter has mobile intensive care capabilities and is called to the scenes of severe accidents or illness.

(15) Department

The Department means the Department of Income Maintenance.

(16) Emergency

An emergency is defined as 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 patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(17) Emergency Ambulance Trip

An emergency ambulance trip is an ambulance trip made in accordance with the Department's definition of emergency and has as its destination:

(A) a hospital emergency room; or

(B) a general hospital or a psychiatric facility where a nonscheduled admission results; or

(C) a general hospital or a psychiatric facility where an emergency admission results after a recipient was seen at a hospital emergency room; or

(D) a second facility because an emergency medical service was not available at the original emergency room; or

(E) a critical care helicopter.

(18) Helicopter Assist

A helicopter assist is medical care provided at the scene to a recipient when such recipient is ultimately transported by a critical care helicopter.

(19) Invalid Coach

An invalid coach is a vehicle used exclusively for the transportation of non-ambulatory patients and is operating as an invalid coach under the authority and in compliance with promulgated regulations of the Department of Health Services, Office of Emergency Medical Services, and registered as such by the Department of Motor Vehicles, or is a wheelchair accessible livery vehicle.

(20) Livery

A livery vehicle is a sedan or van type vehicle capable of carrying up to ten passengers used for the transportation of ambulatory patients, who may require assistance, and which is operated by a livery carrier under the authority and in compliance with the statutes and regulations of the Department of Transportation and/or a transit district and registered as a livery vehicle by the Department of Motor Vehicles. Livery service is a door-to-door service.

A livery vehicle does not include a vehicle registered as a service bus vehicle with the following exception. If the Commissioner determines, in his/her sole discretion, that for access or other reasons use of service bus vehicles is appropriate, equitable and in the best interests of the state, he/she may authorize use of service bus registered vehicles and may impose any additional insurance or other requirements or limitations which he/she deems appropriate. Said authorization must be in writing.

(21) Loaded Mileage

Loaded mileage is the distance traveled by a motor vehicle while carrying passengers from a pickup point to a drop-off point. Mileage between Connecticut towns is determined in accordance with the Public Utility Control Docket Document (PUCA) #6770-A.

(22) Noncontiguous Town

Noncontiguous town is a town which does not border the town in which a provider's headquarters is housed. Noncontiguous towns are towns which do not border each other.

(23) Non-Emergency Ambulance Trip

Non-emergency ambulance trip is a pre-arranged ambulance trip that is not responding to an emergency injury or illness. However, ambulance services are needed because a

recipient may require medical care during transit, which an ambulance is equipped and staffed to provide.

(24) No-show

No-show is when a recipient fails to utilize a transportation service approved in writing by the Department, and which is not cancelled.

(25) Not Ambulatory

An individual who is not ambulatory is unable to walk despite the possible use of assistive devices (e.g., cane, crutch, walker) and/or the assistance of an attendant.

(26) Nursing Home

A nursing home is an intermediate care or skilled nursing facility (ICF, SNF, or ICF/MR) or Chronic Disease Hospital.

(27) Other Commercial Carrier

Other commercial carriers are those regulated carriers other than taxi, livery, wheelchair accessible livery, ambulance, invalid coach, and air transportation that transport the public for a fee and which meet all applicable state and federal permit and licensure requirements to operate as such.

(28) Out-of-State Trip

An out-of-state trip is a trip originating or ending outside Connecticut that is to transport a patient to or from a medical provider that is not located in Connecticut and is not a border provider.

(29) Prior Authorization

Prior authorization means approval for a service from the Department or the Department's agent before the provider actually provides the service. In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

(30) Private Transportation

Private transportation is transportation by a vehicle owned by a recipient or by a friend, relative, acquaintance or other individual, provided the vehicle is not licensed for commercial carriage. Individual does not mean communities, companies, corporations, societies or associations.

(31) Provider Agreement

The provider agreement is the signed written contractual agreement between the Department and the provider of services or goods.

(32) Provider Headquarters

Provider headquarters is the provider's base of operations closest to the pickup point. A provider may have more than one (1) headquarters.

(33) PUCA Document

PUCA Document is the Department of Public Utility Control Docket Document #6770-A and all its supplements which specify the mileage between Connecticut towns.

(34) Recipient

Recipient means a person eligible for services under the Department's Medical Assistance Program.

(35) Round Trip

A round trip is the dispatching of a vehicle to the recipient(s) pickup point, transporting the recipient(s) to a medical provider and transporting the recipient(s) back to the pick-up point.

(36) Shared Ride

A shared ride is when more than one recipient occupies a vehicle during the same trip.

(37) Special Attendant

A special attendant is a second attendant who is an employee of the ambulance provider, and who is in the vehicle in addition to the driver and one attendant. This attendant is needed due to the recipient's medical condition.

(38) Taxi

A taxi is a vehicle operating as a taxi under the authority and in compliance with promulgated regulations of the Department of Transportation and/or a transit district and registered as such by the Department of Motor Vehicles.

(39) Trip–Ambulance, Invalid Coach, Taxi and Wheelchair Accessible Livery

A trip is the dispatching of an empty vehicle to the recipient pickup point and transporting the recipient to a medical provider, or from a medical provider to the drop-off point.

(40) Trip–Livery

A livery trip is the dispatching of an empty livery vehicle to the recipient(s) pickup point and transporting the recipient(s) to a medical provider or from a medical provider to the drop-off point. A trip for livery services begins when an empty vehicle picks up a recipient(s) and ends when the last recipient is dropped off and the vehicle is empty.

(41) Unloaded Mileage

Unloaded mileage is the distance traveled by the motor vehicle carrying no passengers, enroute to the point of pickup or, enroute from the point of drop-off.

(42) Unpaid Health Care

Unpaid health care is a service(s) provided to a recipient which is voluntary in nature, and usually provided by a family member, neighbor, friend or other person(s) within the individual's support system.

(43) Waiting Time

Waiting time is the time that a vehicle is waiting at a medical provider's facility, to which the transportation provider transported the recipient, in order to transport the recipient to another destination, during the same trip.

(44) Wheelchair Accessible Livery

A wheelchair accessible livery vehicle is a vehicle specifically designed for the transportation of wheelchair mobile patients, and which is operating as a wheelchair accessible livery, under the authority and in compliance with promulgated regulations of the Department of Transportation and/or a transit district and registered as such by the Department of Motor Vehicles. Wheelchair accessible livery vehicles are treated the same

as invalid coach vehicles.

(c) **Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department, all commercial transportation providers must: 1. be regulated carriers, 2. meet and maintain all applicable state and federal permit and licensure requirements, and vehicle registration requirements, 3. provide the Department with a copy of their approved permit or license, 4. also meet and maintain all applicable Departmental enrollment requirements and 5. have a signed provider agreement on file. It is signed by the provider upon application for enrollment into the Medicaid Program and is effective on the approved date of enrollment. The provider agreement specifies conditions and terms (regulations, standards and statutes) which govern the program and to which the provider is mandated to adhere in order to participate in the program. There are no enrollment requirements for private transportation.

(d) **Eligibility**

Payment for medical transportation services is available for all Medicaid eligible recipients subject to the conditions and limitations which apply to these services.

(e) **Services Covered and Limitations**

(1) Services Covered

(A) Medicaid assures that necessary transportation is available for recipients to and from providers of medical services covered by Medicaid, and, subject to this regulation, may pay for such transportation.

(B) Payment for transportation may be made for eligible recipients under the Medicaid program, except as otherwise provided in these regulations, when needed to obtain necessary medical services covered by Medicaid, and when it is not available from volunteer organizations, other agencies, personal resources, or is not included in the medical provider's Medicaid rate.

(C) Transportation may be paid only for trips to or from a medical provider for the purpose of obtaining medical services covered by Medicaid. If the medical service is paid for by a source other than the Department, the Department may pay for the transportation as long as the medical service is necessary and is covered by Medicaid.

(2) Service Limitations

(A) The Department reserves the right to make the determination as to which type of transportation is the most appropriate for a recipient.

(B) The Department reserves the right to limit its payment of transportation to the nearest appropriate provider of medical services when it has made a determination that traveling further distances provides no medical benefit to the recipient.

(C) The Department may pay for only the least expensive appropriate method of transportation, depending on the availability of the service and the physical and medical, circumstances of the patient.

(D) Trips for out-of-state medical services may be paid for when the medical service meets the conditions for payment. Out-of-state services shall be paid for to the same extent

as in-state services. The conditions are:

(i) The out-of-state medical services are needed because of a medical emergency; or

(ii) Medical services are needed because the recipient's health would be endangered if required to travel to Connecticut; or

(iii) The Department determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in another state; or

(iv) It is general practice for recipients in particular localities of Connecticut to use the medical resources in another bordering state. The Department will allow for providers in these localities to be treated in the same manner as Connecticut providers. These providers are called border providers. *Note:* trips to receive a medical service from a border provider are not considered out-of-state trips.

(E) Ambulance Transportation

(i) Payment may be made for non-emergency and emergency ambulance trips if:

(aa) the patient's condition requires medical attention during transit; or,

(bb) the patient's diagnosis indicates that the patient's condition might deteriorate in transit to the point where medical attention would be needed; or,

(cc) the patient's condition requires hand and/or feet restraints; or

(dd) the ambulance is responding to an emergency; or,

(ee) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Loaded mileage may be paid for ambulance services if the vehicle must cross a town line in order to transport a recipient to or from a medical provider. One mileage charge for the mileage covered may be paid, regardless of the number of recipients transported. Mileage between towns is determined and paid according to the PUCA Document.

(iii) The Department shall not pay for a recipient who fails to utilize ambulance services.

(F) Invalid Coach

(i) Payment may be made for invalid coach trips if:

(aa) the patient is not ambulatory and must be transported in a wheelchair; or,

(bb) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Loaded mileage may be paid for invalid coach if the vehicle must cross a town line in order to transport a recipient to or from a medical provider. One mileage charge for the mileage covered shall be paid, regardless of the number of recipients transported. Mileage between towns is determined and paid according to the PUCA Document.

(iii) Wheelchair accessible livery services are treated the same as invalid coach services.

(iv) The Department shall not pay for a recipient who fails to utilize invalid coach services.

(G) Livery

(i) Payment may be made for livery transportation if:

(aa) the patient is ambulatory and may require assistance; or

(bb) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Livery providers are responsible for alerting the client of the vehicle's arrival and assisting the client into the vehicle if necessary.

(iii) If a recipient fails to use approved livery services and the trip was not cancelled, the provider may be paid only for a base rate, additional stop or mileage applicable to that recipient as set forth in subsection (i) (9) (D) Payment Limitations.

(iv) Payment may be made for waiting time, after the first fifteen minutes waited. No payment will be made for the first fifteen minutes waited.

(v) Loaded mileage may be paid for livery if the vehicle must cross a town line in order to transport a recipient to or from a medical provider. Mileage between Connecticut towns is determined and paid according to the PUCA Document.

(vi) Payment, in accordance with these regulations, shall be made by the Department for services provided which were approved by a written prior authorization form.

(H) Wheelchair Accessible Livery

(i) Payment may be made for wheelchair accessible livery services if:

(aa) the patient is not ambulatory and must be transported in a wheelchair or,

(bb) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Wheelchair accessible livery providers are responsible for alerting the client of the vehicle's arrival and assisting the client into the vehicle if necessary.

(iii) Wheelchair accessible livery providers must meet all Departmental regulations for invalid coach.

(iv) The Department shall not pay for a recipient who fails to utilize wheelchair accessible livery services.

(I) Taxi

(i) Payment may be made for taxi transportation provided no alternative less expensive means of transportation is available as determined by the Department.

(ii) The Department shall not pay for a recipient who fails to utilize taxi services.

(J) Air Transportation

Payment may be made for transporting a patient by airplane provided:

(i) a medical condition dictates the use of air transportation; or,

(ii) it is less expensive than an alternative means of transportation; or,

(iii) time constraints dictate the use of such transportation.

(K) Critical Care Helicopter

Payment may be made for critical care helicopter service if the utilization of this helicopter is justified rather than ground ambulance service. The factors that will be considered in determining if the use of a critical care helicopter was appropriate are those criteria published by the Department of Health Services, Office of Emergency Medical Services as Minimum Quality Standards for critical care helicopter responses, (Section 6.2), as they may be amended from time to time.

For informational purposes, as of the date of the adoption of this regulation, the factors are:

(i) condition of the patient;

(ii) time needed for rescue/extrication;

(iii) transport time to closest facility;

(iv) landing conditions;

(v) traffic conditions present at the time;

(vi) remoteness of the location; and

(vii) multiple number of patients.

(L) Other Commercial Carriers

Payment may be made for transportation by means of other commercial carriers provided no other alternative less expensive means of transportation is available as determined by the Department.

(M) Private Transportation

Payment may be made for the transporting of a patient by private transportation when no alternative less expensive transportation is available as determined by the Department.

(N) Exclusive Service Contracts

Providers who have contracts with organizations to provide transportation services shall not be paid higher rates for services than what the Department would pay another available provider for these same services. The Department is not bound to use the services of a provider because this provider has an exclusive contract with an organization.

(O) When an alternative method of transportation must be used for a recipient, the Department must approve the use of this type of transportation if it exceeds the appropriate type of transportation needed by the recipient.

(P) Services covered are limited to those listed in the Department's fee schedule.

(Q) When the Department approves a certain type of transportation and a provider uses a higher level of transportation, the Department is not bound to pay for the higher level of transportation.

(3) Services Not Covered

(A) For nursing home patients, transportation to a medical service shall not be paid:

(i) If the medical service is one that the nursing home is required to provide as part of the per diem payment to the home; or

(ii) If the service is one connected with the admission physical, annual physical or dental exams required by the public health code.

(B) Payment shall not be made to transport a relative or a foster parent of an eligible Medicaid recipient, unless the person needs to be present at and during the medical service being provided to the patient. For example, when family therapy is being provided to a child, the parent may be transported to the therapy service. Such payments shall be made in accordance with all other transportation regulations.

(C) Payment shall not be made for transportation services that are not approved, which require prior authorization by the Department.

(D) The Department shall not pay for transportation of a recipient to a medical provider when the visit is for the sole purpose of the recipient picking up a prescription or a written prescription order.

(E) The Department shall not pay for cancelled calls.

(F) The Department shall not pay for transportation to a medical provider when the visit is solely to pick up an item which does not require a fitting.

(G) The Department shall not pay for no shows for ambulance, invalid coach, wheelchair accessible livery or taxi services.

(H) Payment shall not be made to transport a recipient who is a hospital inpatient to any medical service outside the hospital except for a computerized axial tomography (CAT) scan and/or for magnetic resonance imaging (MRI). Transportation for these services is covered only when the services are not available in the hospital where the recipient is an inpatient.

(I) Payment shall not be made to transport a relative or a foster parent of a recipient who is a hospital inpatient, unless the person needs to be trained to provide unpaid health care in the home to the recipient. Without this health care being provided the recipient would not be able to return home.

(f) **Need for Service and Authorization Process**

(1) Need for Service

The Department may pay for transportation services which are required in order for a recipient to receive necessary medical care which is covered under the Medicaid Program.

(2) Prior Authorization

All transportation services require written prior authorization, except emergency ambulance, non-emergency ambulance with designated medical conditions, in-state invalid coach and wheelchair accessible livery services with designated diagnoses, bus, train, and private transportation within the same town.

Prior authorization for transportation services is required as listed below. Prior authorization, when required, may be given for single or multiple trips, depending on the circumstances. Multiple trips, where medical need has been shown, can be authorized for periods up to a maximum of three months at a time. An example would be a recipient receiving dialysis services.

(A) Ambulance

(i) Prior authorization is required for all non-emergency ambulance trips without designated medical conditions. A list of these conditions is contained in Appendix B to this policy.

(ii) Services taking place after Departmental working hours, that could not be arranged during working hours prior to the trip, require after-the-fact approval by the Department. These requests must be in writing. Written requests for such authorization must be received by the Department within fifteen (15) working days following the date the transportation services were provided. Otherwise the service shall not be covered. The same limitations and requirements for appropriateness of service apply for after hours services.

Consideration will be given to after-the-fact authorization requests received after fifteen (15) working days, if the failure to submit an authorization was for a recipient who had a pending application with the Department, or had other third party coverage. A written authorization request for the above situations must be received within ninety (90) working days of the date the transportation services were provided. Verification of other third party payment or denial must be attached to the request.

(B) Invalid Coach and Wheelchair Accessible Livery

(i) Prior authorization is required for all out-of-state trips regardless of the recipient's diagnosis.

(ii) Prior authorization is required for all in state trips unless the recipient's diagnosis indicates the need for an invalid coach. A list of these diagnoses is contained in Appendix A to this policy. The relevant diagnosis is the one that relates to the need for invalid coach services, and not necessarily the diagnosis for which the recipient is receiving treatment.

(iii) Services taking place after Departmental working hours, that could not be arranged during working hours prior to the trip, require after-the-fact approval by the Department. These requests must be in writing. Written requests for such authorization must be received by the Department within fifteen (15) working days following the date the transportation services were provided. Otherwise the service will not be covered. The same limitations and requirements for appropriateness of service apply for after hours services.

Consideration will be given to after-the-fact authorization requests received after fifteen (15) working days, if the failure to submit an authorization was for a recipient who had a pending application with the Department. A written authorization request for the above situations must be received within ninety (90) working days of the date the transportation services were provided.

(C) Livery and Taxi Services

(i) Prior authorization is required for all services by nursing homes for their nursing home recipients.

(ii) Services for recipients taking place after Departmental working hours, that could not be arranged during working hours prior to the trip, require after-the-fact approval by the Department. These requests must be in writing. Requests for such authorization must be received by the Department within fifteen (15) working days following the date the transportation services were provided. Otherwise the service will not be covered. The same limitations and requirements for appropriateness of transportation apply for after hours services.

Consideration will be given to after-the-fact authorization requests received after fifteen (15) working days, if the failure to submit an authorization was for a recipient who had a pending application with the Department. A written authorization request for the above situations must be received within ninety (90) working days of the date the transportation services were provided.

(D) Other Commercial Carriers and Air Transportation

All non-emergency commercial carrier transportation except bus and train transportation

within the same town require prior authorization.

However reimbursement will be made only if the recipient documents a visit to a medical provider for a needed service. Requests for reimbursement must be made within thirty (30) days of the date of the transportation.

(E) Private Transportation

Prior authorization is required for trips between towns and out-of-state private transportation. No prior authorization is required for private transportation for trips within a town. Reimbursement for all private transportation will be made only if the recipient documents a visit to a medical provider for a needed service. Requests for private transportation reimbursement must be made within thirty (30) days of the date of the transportation need.

(3) Prior Authorization Process

(A) Ambulance, Invalid Coach and Wheelchair Accessible Livery

Prior authorization for ambulance, invalid coach and wheelchair accessible livery trips is obtained from the Department's Central Office. The authorization request must be made by the transportation provider. Verbal authorization may be obtained during Departmental business hours from the Central Office.

To obtain authorization the following information is required:

(i) The provider name.

(ii) The recipient's name and Medicaid number.

(iii) Relevant diagnosis of the recipient which indicates the need for the type of transportation.

(iv) Origin and destination of trip.

(v) Reason for trip.

(vi) Date of trip.

(vii) Town code(s).

(viii) Procedure code(s).

(B) Livery, Taxi, Bus, Train, Air, Private and Other Commercial Carriers

(i) Out-of-State Trips

All out-of-state trips require prior authorization from the Department's Central Office, however, arrangements are made through the Department's District Office, as follows:

(aa) the request for transportation is made to the District Office by the recipient, the medical provider or someone acting on behalf of the recipient;

(bb) the District Office contacts Central Office;

(cc) the Department's Central Office staff will determine if the out-of-state service meets the criteria for payment, determine if the service has been approved, if prior authorization is required, and determine the most appropriate level of transportation;

(dd) Central Office will inform the District Office of the decision; and

(ee) the District Office will arrange for livery, taxi, bus, train or private transportation and Central Office will arrange for air transportation.

(ii) Livery, Taxi Trips from Nursing Home

All livery, taxi trips from nursing homes require prior authorization from the Department's Central Office. The authorization request must be made by the transportation provider. Verbal authorization may be obtained during Departmental business hours from the Central Office.

To obtain authorization the following information is required:

(aa) The provider name and provider number.

(bb) The recipient's name and Medicaid number.

(cc) Relevant diagnosis of the recipient which indicates the need for the type of transportation.

(dd) Origin and destination of trip.

(ee) Reason for trip.

(ff) Date of trip.

(gg) Town code(s).

(iii) Other Livery, Taxi Trips

Trips by livery and taxi other than those listed in (i) and (ii) above are arranged and authorized by the District Office, as follows:

(aa) the request for transportation is made to the District Office by the recipient, the medical provider, or someone acting on behalf of the recipient;

(bb) the District Office is responsible for verifying that the trip is for a medical purpose, and that the particular type of transportation is appropriate, necessary, and the least costly means; and if so

(cc) the District Office will then arrange and authorize the trip.

(iv) Bus, Train and Private Transportation

No prior authorization is required for trips within the same town, however, reimbursement will be made to the Medicaid recipient, only if the Department receives documentation of a visit to a medical provider. Documentation consists of a signed statement by the medical provider or his authorized representative, or a completed Departmental W-610 Form. Requests for transportation reimbursement must be made within thirty (30) days of the date of the transportation need.

Trips between towns require prior authorization. These trips are approved and arranged by the District Office, as follows:

(aa) the request for transportation is made to the District Office by the recipient, the medical provider, or someone acting on behalf of the recipient;

(bb) the District Office is responsible for verifying that the trip is for a medical purpose, and that the particular type of transportation is appropriate, necessary, and the least costly means; and if so

(cc) the District Office will arrange and authorize the trip; and then

(dd) the District Office arranges for reimbursement to be sent to the recipient.

(v) Other Commercial Carrier

When non-emergency transportation involves other commercial carriers, prior authorization must be obtained from the District Office. The District Office will either

arrange the transportation through a travel agent or the provider of service.

(vi) Air Transportation

Air transportation requires prior authorization from the Department's Central Office to be obtained as follows:

(aa) The request for transportation is made to the Central Office by the District Office, recipient, medical provider, or someone acting on behalf of the recipient.

(bb) Central Office will determine:

(11) if the medical service for which transportation is needed requires prior authorization, that the authorization has been approved;

(22) if the service is out-of-state, that the service meets the criteria for out-of-state services; and

(33) if air transportation is the most appropriate level of transportation, and, if so, will contact the ticket agent to make the arrangements.

(g) **Other**

(1) When two or more providers offer the same service, the least expensive one is used; there is no obligation to divide the business between them.

(2) When two or more providers offer the same service, at the same rate, the Department may consider whether to divide the business between them in proportion to the quantity of business each provider can furnish and based on a provider's past performance and any other factors the Department may deem appropriate. Whether to divide the business and how to divide the business shall be determined by the Department in its sole discretion.

(3) The Department shall not pay for transportation to a medical service if the provider of that medical service furnishes free transportation or has an obligation to furnish transportation.

(4) Providers of medical transportation must maintain records to support claims made for payment, including, but not limited to, daily drivers logs and other documents which record at least for each trip: patient's name, license number of vehicle used, the vehicle's pickup and drop-off time and place, the name of an attendant, if one is used, and the vehicle's pickup and drop off odometer reading for all out-of-state trips. All documentation shall be made available upon request to authorized Department, state and federal personnel in accordance with state and federal law.

(5) In addition to the records all providers must maintain for the Department, livery and taxi providers must keep a log for services that could not be authorized in advance, which is signed by a recipient when a transportation service is received.

(6) If the most appropriate transportation is not available, and prior authorization was not received for the alternative method of transportation utilized, the transportation company providing the service must document in the records and on the billing form why the appropriate transportation was not available. The Department in its sole discretion shall determine which level of payment is appropriate.

(7) The Department reserves the right to consider recipient and Departmental needs, when selecting which provider will render the service.

(8) Livery providers are responsible for alerting the recipient of the vehicle's arrival and assisting the recipient into and out of the vehicle.

(9) Mileage for a vehicle crossing Connecticut town lines is calculated and paid by the Department to providers according to the PUCA Document.

(10) The Department, in its sole discretion, may disallow some or all of the reimbursement paid to the provider for services rendered by a vehicle which was out of compliance with any of the requirements of subsection (c) Provider Participation as set forth above. The Department, in its sole discretion, in addition to, or in lieu of the disallowance of reimbursement, may suspend or terminate the provider from the Medicaid Program for any such violation.

(11) Nursing Homes

(A) Nursing home staff is responsible for assisting recipients to and from a livery vehicle at the nursing home site.

(B) Nursing home staff is responsible for determining if the cost of providing the medical service in the nursing home is less costly than providing the medical service outside the home. This cost effective determination would include the consideration of the cost of the transportation and the medical service compared to the cost of providing the medical service in the nursing home. When possible and appropriate, the needed medical service should be provided in the nursing home. If it is necessary to transport a recipient to a medical service because a medical provider is not available to come to the home, written documentation must be entered in the recipient's case record.

(12) Payment for transportation may be made for an applicant with the Department, when the transportation is to a medical evaluation requested by the Department in order to determine eligibility.

(13) Failure to maintain any of the documentation required by this regulation may result in the Department disallowing some or all of the reimbursement paid to the provider for services rendered.

(h) **Billing**

(1) Ambulance, Invalid Coach and Travel Agents

The provider submits the bill for service on the HCFA 1500, "Health Insurance Claim Form," to the Department's fiscal agent.

(2) Livery

The provider of service submits the bill on the Departmental livery claim form to the Department's fiscal agent.

(3) Taxi

The provider of service submits the bill on the Departmental taxi claim form to the Department's fiscal agent.

(i) **Payment**

(1) For all transportation payment shall be made at the lower of:

(A) The usual and customary charge to the public, if applicable

(B) The Medicare rate, if one exists

(C) The fee, as published by the Department in its fee schedule or

(D) The amount requested or billed

(2) Ambulance

Ambulance providers may be paid for a trip, I.V. level life support services, advanced life support services, waiting time, loaded mileage, additional recipient transported, a night call charge, special attendant, paramedic intercept, helicopter assist, out-of-state tolls and for services provided to a recipient who is not subsequently transported by the ambulance provider in accordance with this regulation.

(3) Invalid Coach

Invalid coach providers may be paid for a trip, waiting time, loaded mileage, additional recipient transported and attendant services in accordance with this regulation.

(4) Livery

Livery providers may be paid for a trip, loaded mileage, additional stops, waiting time, assistance, "no shows", and out-of-state tolls in accordance with this regulation.

(5) Taxi

Taxi providers may be paid for trips by an all inclusive metered rate and out-of-state tolls in accordance with this regulation.

(6) Wheelchair Accessible Livery

Wheelchair accessible livery providers may be paid for a trip, waiting time, loaded mileage, an additional recipient transported, and out-of-state tolls attendant services in accordance with this regulation.

(7) Payment may be made to:

(A) the provider of service if an ambulance, invalid coach, taxi, or livery provider;

(B) either the provider of the service, or an enrolled ticket agent, if the provider of service is any other commercial carrier except bus, or train;

(C) the Medicaid recipient, if the transportation is by private means, bus or train.

(8) Payment Fees

(A) The Commissioner of the Department establishes the fees contained in the Department's fee schedule.

(B) Payment fees for out-of-state trips performed by out-of-state providers shall be established by the Commissioner of the Department.

(C) The maximum payment for transportation services shall be at the fees established by the Department.

(D) Wheelchair Accessible Livery.

The Department's fees for wheelchair accessible livery shall be the same as the Department's fees for invalid coach services.

(E) Private Transportation

Payment may be made at the per mile fee established by the Department, but only if the total payment exceeds $1.00.

(F) Other Commercial Carrier and Air Transportation

Payment may be made at the lowest charge to the general public for the same service.

(9) Payment Limitations

(A) Multiple Passengers—Taxi

Taxi services are paid by the metered rate, regardless of the number of recipients transported.

(B) Multiple Passengers—Livery

(i) If during a trip, a livery vehicle picks up more than one recipient at the same point and transports those recipients to the same destination, the livery service may be paid as if the service were provided for one recipient.

(ii) In the event that a livery provider picks up several Medicaid recipients at several different pickup points and drops those recipients off at one common destination point, the livery provider may be paid one base rate, plus a shared ride fee for each additional pickup point. If the provider picks up several Medicaid recipients at one pickup point, and drops those passengers off at several different destination points, the livery provider may be paid one base rate, plus a shared ride fee for each additional drop-off point. If more than one recipient is picked up or dropped off at any additional stop, only one shared ride fee shall be paid for that stop.

(iii) In the event that a livery provider picks up several Medicaid recipients each at a different pickup point and drops those recipients off each at a different destination point (i.e. no common pickup or drop-off points) and all pickups and drop-offs occur within the same town, the livery provider may be paid one base rate for each recipient transported.

(iv) In the event that a livery provider picks up several Medicaid recipients each at a different pickup point and drops those recipients off each at a different destination point (i.e. no common pickup or drop-off points) and the trip involves loaded mileage between towns, the livery provider may be paid one base rate plus a shared ride fee for each additional drop-off point plus one loaded mileage charge for each unduplicated portion of the trip mileage. If multiple recipients are in the vehicle and travel together during a portion of the trip, only one mileage charge shall be paid for the common portion of the trip.

(v) Only one loaded mileage charge may be paid for the total miles traveled between towns, regardless of the number of recipients transported. If multiple recipients are transported in one trip, the total mileage for the trip cannot be charged for each recipient. Mileage between towns is calculated and paid according to the PUCA Document.

(C) Cancelled Calls

The Department shall not pay for cancelled calls for any type of transportation.

(D) No Show

The Department may pay for a livery service approved in writing by the Department and not cancelled, which a recipient does not utilize, provided the vehicle went to the pickup point. For livery the base rate may be paid for a “no show” for single recipient trips. For multiple recipient trips, a base rate or an additional stop, whichever is appropriate, and mileage if appropriate may be paid for the portion of the trip incurred for the “no show.” A “no show” fee will not be paid for nursing home residents.

(E) Waiting Time

Waiting time shall only be paid when it is cost effective or the Department has determined it is necessary in order for a recipient to receive a medical service.

(i) Ambulance

One-hour's waiting time may be paid for all or any portion of the first hour. After one hour of actual waiting time, additional waiting time may be paid in fifteen (15) minute increments for all or any portion of the fifteen minutes.

When waiting time is provided as part of a round trip, the Department shall not pay for two base rates and waiting time. One base rate and waiting time may be paid.

(ii) Invalid Coach

No payment shall be made for the first one-half hour of waiting; thereafter waiting time may be paid in fifteen (15) minute increments for all or any portion of the fifteen minutes.

When waiting time is provided as part of a round trip, the Department shall not pay for two base rates and waiting time. One base rate and waiting time may be paid.

(iii) Livery

No payment shall be made for the first fifteen minutes of waiting; thereafter waiting time will be paid in 15 minute increments for all or any of the fifteen minutes.

When waiting time is provided as part of a round trip, the Department shall not pay for two trips and waiting time. One trip and waiting time may be paid.

(iv) Taxi

Waiting time may be paid in accordance with the tariff established by the Department of Transportation and/or a state approved transit district and is considered part of the metered rate.

(F) Mileage

(i) Ambulance

The Department may pay for loaded mileage if the vehicle must cross a town line in order to transport a recipient(s) to or from a medical provider. Loaded mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6770-A and all its supplements.

(ii) Invalid Coach

The Department may pay for loaded mileage if the vehicle must cross a town line in order to transport a recipient(s) to or from a medical provider. Loaded mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6670-A and all its supplements.

(iii) Livery

(aa) The Department may pay loaded mileage for livery if the vehicle must cross a town line in order to transport a recipient(s) to or from a medical provider. This mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6670-A and all its supplements.

(bb) Wheelchair accessible livery may be paid at the same fees as invalid coach.

(iv) Taxi

Mileage may be paid in accordance with the tariff established by the Department of

Transportation and/or a state approved transit district and is considered part of the metered rate.

(G) Attendant

Invalid Coach

Attendant services may be paid when provided by an employee other than the driver.

(H) Assistance

Livery

Livery assistance services provided by the driver or another employee may be paid for each recipient assisted. Payment may be made for assistance at either or both the pickup point and drop-off point except assistance from or into a nursing home from a livery vehicle will not be covered. Physically helping a recipient only into or out of the livery vehicle is not considered assistance.

(I) Items Included in Fees

All payment rates include all expenses, including tolls and telephone calls.

(J) Private Transportation

Payment shall be made based on the mileage from the recipient's home to the medical provider.

(j) **Rates**

Payment is in accordance with the following schedule:

	Ambulance	Invalid Coach	Wheelchair Livery	Livery	Taxi
Trip (Base Rate)	X X	X X	X X	X X	Metered Rate All inclusive
Waiting Time	X	X	X	X	
Loaded Mileage	X	X	X	X	
Additional Pt.	X	X	X		
Additional Stop				X	
Attendant		X	X		
Special Attendant	X				
Assistance				X	
Advanced Life	X				
I.V. Level	X				
Paramedic Intercept	X				
No Show				X	
Night Call Charge	X				
Out-of-State Tolls	X	X	X	X	X

Helicopter Assist	X
Special Services	X

Sec. Appendix A.

The following are the diagnoses codes which would be acceptable justification for invalid coach transportation. Invalid coach trips with these diagnoses do not require prior authorization.

170.2	Malignant neoplasm of bone, vertical column
170.6	Malignant neoplasm of bone, pelvic bones, sacrum, and coccyx
170.7	Malignant neoplasm of bone, long bones of lower limb
170.8	Malignant neoplasm of bone, short bones of lower limb
333.4	Huntington's chorea
334.0	Friedreich's Ataxia
342	Hemiplegia
344.0	Quadriplegia
344.1	Paraplegia
357.2	Diabetic Neuropathy
444.22	Thrombosis—lower extremity
820	Fx neck femur (within six (6) months)
822	Fx patella (within six (6) months)
823	Fx tibia and fibula (within six (6) months)
896	Below knee amputation
897	Above knee amputation

Sec. Appendix B.

The following are conditions which would be acceptable justification for non-emergency ambulance. Non-emergency ambulance trips for clients with these conditions or needing these services do not require prior authorization.

Casts Which Prevent Hip Flexion
Four Point Restraints
Comatose
Intravenous Running
Suctioning During Transport
Isolette
Prone Positioning (e.g. due to decubiti or skin flaps)

(Effective July 25, 1989)

Sec. 17-134d-34. Reserved

Orthodontic Services Provided Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Sec. 17-134d-35. Orthodontic services provided under the early and periodic screening, diagnosis and treatment (EPSDT) program

(a) **Orthodontic services will be paid for when**

(1) provided by a qualified dentist; and

(2) deemed medically necessary as described in these regulations.

(b) **Definition**

(1) Qualified Dentist

"Qualified Dentist" means a dentist who:

(A) Holds himself out to be an orthodontist in accordance with section 20-106a of the Connecticut State Statutes, or

(B) Documents completion of an American Dental Association accredited post graduate continuing education course consisting of a minimum of two (2) years of orthodontic seminars, and/or submitting three (3) completed case histories with a comparable degree of difficulty as those cases meeting the department's requirements in section (e) of the department's orthodontic policy if requested by the orthodontic consultant.

(2) The Department

"The Department" means the State Department of Income Maintenance.

(3) Preliminary Handicapping Malocclusion Assessment Record

"Preliminary Handicapping Malocclusion Assessment Record" means the method of determining the degree of malocclusion and eligibility for orthodontic services. Such assessment is completed prior to performing the comprehensive diagnostic assessment.

(4) Comprehensive Diagnostic Assessment

"Comprehensive Diagnostic Assessment" means a minimum evaluative tool for an orthodontic case which determines the plan for treatment necessary to correct the malocclusion. The assessment includes, but is not limited to, the following diagnostic measures: Radiographs; full face and profile photographs or color slides.

(c) **Services Covered and Limitations**

The Department may reimburse a qualified dentist for the following orthodontic services (including permanent and/or deciduous dentition);

(1) Orthodontic screening—one (1) per provider of the same recipient;

(2) Orthodontic consultation—one (1) per provider for the same recipient;

(3) Preliminary assessment study models—one (1) per provider for the same recipient;

(4) Comprehensive diagnostic assessment—one (1) per provider for the same recipient;

(5) Initial appliance—one (1) per provider for the same recipient;

(6) Active Treatment—up to a maximum of thirty (30) months;

(7) Retainer appliances—retainers may be replaced only once, per dental arch, for the same recipient.

(d) **Other Limitations**

Orthodontic services are limited to recipients under twenty-one (21) years of age.

(e) **Need for Services**

When an eligible recipient is determined to have a malocclusion, the attending dentist should refer the recipient to a qualified dentist for preliminary examination of the degree of malocclusion.

(1) The need for orthodontic services shall be determined on the basis of the magnitude of the malocclusion. Accordingly, the "Preliminary Handicapping Malocclusion Assessment Record," available from the Department, must be fully completed in accordance with the instructions sections of the form. The Department deems orthodontic services to be medically necessary when a correctly scored total of twenty-four (24) points or greater is calculated from the preliminary assessment. However, if the total score is less than twenty-four (24) points the Department shall consider additional information of a substantial nature about the presence of other severe deviations affecting the mouth and underlying structures. Other deviations shall be considered to be severe if, left untreated, they would cause irreversible damage to the teeth and underlying structures.

(2) If the total score is less than twenty-four (24) points the Department shall consider additional information of a substantial nature about the presence of severe mental, emotional, and/or behavior problems, disturbances or dysfunctions, as defined in the most current edition of the Diagnostic Statistical Manual of the American Psychiatric Association, and which may be caused by the recipient's daily functioning. The department will only consider cases where a diagnostic evaluation has been performed by a licensed psychiatrist or a licensed psychologist who has accordingly limited his or her practice to child psychiatry or child psychology. The evaluation must clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional, and/or behavior problems. And that orthodontic treatment is necessary and, in this case, will significantly ameliorate the problems.

(3) A recipient who becomes Medicaid eligible and is already receiving orthodontic treatment must demonstrate that the need for service requirements specified in subsections (e) (1) and (2) of these regulations were met before orthodontic treatment commenced, meaning that prior to the onset of treatment the recipient would have met the need for services requirements.

(f) **Prior Authorization**

(1) Prior authorization is required for the comprehensive diagnostic assessment.

The qualified dentist shall submit:

(A) the authorization request form;

(B) the completed Preliminary Handicapping Malocclusion Assessment Record;

(C) Preliminary assessment study models of the patient's dentition; and,

(D) additional supportive information about the presence of other severe deviations described in Section (e) (if necessary).

The study models must clearly show the occlusal deviations and support the total point

score of the preliminary assessment. If the qualified dentist receives authorization from the Department he may proceed with the diagnostic assessment.

(2) Prior authorization is required for orthodontic treatment for the initial appliance; first, second, and third year of active treatment; and for replacement of retainers. No authorization shall be given if there is evidence that little or no progress has been made at the end of each yearly period. In this case, the qualified dentist shall be required to resubmit the authorization request. The authorization shall be based on reasonable progress made in active treatment as deemed by the Department. There will be no monthly payment allowed during this period.

(A) For the initial appliance and the first year of active treatment (1st through 12th month) the qualified dentist shall submit, prior to initiating treatment:

(i) the authorization request form;

(ii) the diagnosis;

(iii) a written treatment plan;

(iv) a description of the appliance to be utilized;

(v) the length of time treatment is necessary;

(vi) the length of the retention period necessary after active treatment;

(vii) a list of all other medical or dental treatment which is necessary in preparation for, or completion of, the orthodontic treatment.

(B) For the second year of active treatment (13th through 24th month) the qualified dentist shall submit, prior to initiating continued treatment:

(i) the authorization request form covering the second (2nd) year of active treatment;

(ii) study models and/or photographs clearly showing the progress of treatment to date.

(C) For the third (3rd) year of active treatment (25th through 30th month) the qualified dentist shall submit prior to initiating continued treatment:

(i) the authorization request form covering the third (3rd) year of active treatment;

(ii) study models and/or photographs clearly showing the case is ready for retention.

(D) Replacement of retainers with documentation to justify.

(E) Any requests for modification of the treatment plan as authorized by the Department's orthodontic consultant must be submitted to the orthodontic consultant in writing providing evidence in support of such a request. However, no authorization shall be given beyond thirty (30) months of active treatment.

(g) **Other Requirements**

(1) The recipients, together with the parent or guardian, should have the desire and the ability to complete an extended treatment plan as determined by the qualified dentist performing the treatment or other professionals involved with the recipient or family.

(2) When an orthodontic case is authorized by the Department, local Early Periodic Screening, Diagnostic and Treatment (EPSDT) staff will contact the recipient and the qualified dentist to help facilitate the recipient's participation in and completion of the treatment plan.

(3) The course of orthodontic treatment must be completed prior to the recipient's twenty

first (21st) birthday.

(4) The qualified dentist shall maintain a specific record for each recipient eligible for Medicaid reimbursement including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information and X-ray, a current treatment plan, pertinent treatment notes signed by the qualified dentist; and documentation of the dates of service. Records or documentation must be maintained for a minimum of five (5) years.

(5) For the retention period the qualified dentist shall submit, prior to initiating placement of retainers, study models and/or photographs clearly showing the case is ready for retention.

(h) **Payment Limitation**

(1) Payment for orthodontic services shall be made in accordance with the Department's dental fee schedule.

(2) An initial payment and monthly payments are made for active treatment of orthodontic services.

(3) The initial payment covers the placement of the initial appliances.

(4) No payment is made for monitoring growth and development.

(5) A dentist, other than a qualified dentist as defined in these regulations, may receive payment for an orthodontic screening. The screening includes an oral examination and/or examination of the patient's records for the purposes of completing Sections I, II and IIIA-D of the Preliminary Handicapping Malocclusion Assessment Record Form No. W-1428.

(6) The fee for the orthodontic consultation includes a dental screening and the completion of the preliminary assessment form. No separate payment shall be made to a qualified dentist for the orthodontic screening.

(7) The number of monthly payments is limited to the number of months of active treatment stipulated in the treatment plan as approved by the Department.

(8) The monthly installment rate for active treatment is based on an average of one (1) visit per month and will be payable once a month during the authorized active treatment period no matter how many times the orthodontist sees the patient during this period.

(9) Payment for the comprehensive diagnostic assessment includes all diagnostic measure, e.g., X-rays, photographs or slides, and the written treatment plan. No separate payment is made for individual diagnostic materials except the preliminary assessment study models.

(10) For a recipient who becomes ineligible for Medicaid during the authorized term of active treatment, the final payment from the Department shall be made for the month in which the recipient becomes ineligible for Medicaid or EPSDT services, whichever comes first.

(11) The cost of the initial retainer appliance, including: fitting, adjustments and all necessary visits, is included in the first twenty-four (24) monthly active treatment installments.

(12) The fee for the replacement of retainer appliances includes the fitting and all necessary visits.

(Effective January 27, 1988)

Sec. 17-134d-36. Administratively necessary days

(a) Administratively Necessary Days are inpatient hospital days reimbursed by Medicaid for services to a Title XIX eligible patient and to a patient who will eventually be determined eligible. A patient qualifying for ANDs does not require an acute hospital level-of-care. Instead, the patient requires medical services at the skilled nursing or intermediate level-of-care. The patient is forced to remain in the hospital because the appropriate medical level-of-care placement in the skilled nursing or intermediate care facility is not available.

(b) ANDs are covered under the Title XIX program when the following procedures and conditions are met:

(1) The Medicaid patient is no longer at the acute care level of service but is at a skilled nursing level-of-care or at an intermediate level-of-care;

(2) Discharge to a skilled nursing facility or intermediate care facility level-of-care bed is impossible due to the unavailability of a bed;

(3) The patient's timely discharge and placement to the appropriate skilled nursing facility or intermediate care facility is planned and arranged by the hospital. Clear evidence of this active and continuous process is documented in the patient's hospital medical record;

(4) The hospital places the patient who is on administratively necessary day one (1) through administratively necessary day seven (7) on the active waiting list at five (5) skilled nursing facilities or intermediate care facilities, whichever is medically appropriate;

(5) In cases where additional ANDs are necessary beyond the seventh (7) day the hospital places the patient on the active waiting list of an additional five (5) facilities. The hospital is required to maintain the patient on the active waiting list of a minimum of ten (10) facilities at all times after the seventh (7) administratively necessary day.

(A) All contacts made by the hospital to facilities must be clearly documented in the patient's medical record with dates of contact and facility name;

(B) After the patient is discharged the name of the facility must be recorded in the patient's medical record.

(6) The patient receiving ANDs accepts the first available skilled nursing or intermediate care facility placement in the State of Connecticut that is medically appropriate.

(A) The Department will not pay for ANDs when the patient refuses to be placed in the first available facility. Payment ceases on the day of refusal.

(B) If the patient refuses the first available placement the hospital sends the following information to the Medical Director for Medicaid, Department of Income Maintenance, 110 Bartholomew Avenue, Hartford, CT 06106:

Name and address of person refusing bed
Patient's name and address (if different)
Medicaid Number (if available)
Name of hospital
Date of admission
Date bed available
Name and address of facility with bed

Date bed refused
Reason for refusal

(C) The requirements in the Medical Services Policy, 150.1 F. IX, a., regarding prior authorization requirements for ANDs are repealed.

(D) ANDs shall be reviewed by the Department in accordance with Medical Services Policy on utilization review, 150.1 F. I.–V., as it exists now or as it may be amended from time to time.

(Effective October 1, 1986)

Coverage of Occupational Therapy Services by Home Health Agencies

Sec. 17-134d-37. Repealed

Repealed March 7, 2007.

Sec. 17-134d-38. Reserved

Sec. 17-134d-39. Reimbursement plan for medical transportation under the medical assistance program

(a) Medical Transportation Services provided under the Medical Assistance Program will be purchased through a Volume Purchase Plan (V.P.P.), if this method will be more cost efficient than the present method of reimbursement, which is based on a fee schedule and metered rate for taxi.

(b) Under the V.P.P. the Department will contract with a provider(s) who will provide one or more of the designated types of transportation. Such providers must meet state licensure requirements, certification and registration requirements, current Departmental Medical Assistance requirements and provide the most cost efficient medical transportation service available.

(c) The V.P.P. will be implemented through a competitive bidding process. The Department will define geographical areas, populations to be served and the type of transportation needed by the identified populations. These elements will be identified by the Department for purposes of the competitive bidding process.

(d) In order to assure that competitive bidding will result in cost savings to the State, the geographical area covered by the proposed bid must account for a minimum of ten percent (10%) of total expenditures for that particular type of transportation, and the estimated savings to the State resulting from the proposed bid must be at least 10 percent (10%) of the total expenditures for that particular type of transportation in that geographical area, or the Department will not award a contract.

(e) The contract will be awarded to the lowest responsible bidder(s), with the Department reserving the right to reject all or any bid and not award a contract to any of the bidders, if this best serves the interests of the State. The Department also reserves the right to award a contract for one, some, or all of the different types of medical transportation provided under

the Medical Assistance Program.

(Effective September 30, 1986)

Sec. 17-134d-40. Acute care hospital outpatient clinic reimbursement rate Hospital Outpatient Clinic Visit Rates

Each outpatient clinic visit shall be reimbursed at a reasonable rate to be determined by the reasonable cost of such services, not to exceed one hundred sixteen percent (116%) of the combined average fee of the general practitioner and specialist for an office visit according to the fee schedule for practitioners of the healing arts approved under Section 4-67C of State Statutes.

(Effective June 27, 1986)

Long Term Care Facility Preadmission Screening and Community Based Services Program

Sec. 17-134d-41. Repealed

Repealed July 8, 1998.

See § 17b-342

Sec. 17-134d-42. Reserved

Sec. 17-134d-43. Medicaid requirements for organ transplantation

(a) Organ transplantations are covered under the Medicaid program if they are of demonstrated therapeutic value, medically necessary and medically appropriate, and likely to result in the prolongation and the improvement in the quality of life of the applicant.

(b) The following organ transplantations have been deemed to satisfy the criteria of subsection (a) of section 17-134d-43, in all cases, and the costs associated with such procedures will be covered under Medicaid without the necessity of the patient obtaining prior authorization from the Department:

(1) bone;
(2) bone marrow;
(3) kidney;
(4) cornea.

(c) Except as provided in subsection (b) of section 17-134d-43, prior authorization must be obtained from the Department before the costs associated with an organ transplantation will be covered under Medicaid.

(d) The final decision as to whether authorization will be granted for a patient to incur Medicaid covered costs associated with an organ transplantation is made by the Department on a case-by-case basis. No such authorization will be granted unless the Department is fully satisfied that the conditions of subsection (a) of section 17-134d-43 have been met.

(e) In order to assist the Department in determining whether a request for prior

authorization satisfies the criteria of subsection (a) of section 17-134d-43, there has been established a Transplant Advisory Committee of the Department of Income Maintenance. The members of the committee are appointed by the Commissioner, provide the Department with technical assistance and expertise in the field of organ transplantation, and are drawn from the medical health and insurance communities.

(f) The Transplant Advisory committee has developed, and continues to review and modify, specific medical criteria as they relate to particular organ transplantation procedures. In addition, the committee may provide technical assistance to the Department in reviewing a particular prior authorization request. In no event, however, are the criteria (guidelines) or recommendations of the committee binding on the Department. A final decision that a prior authorization request fails to satisfy the provisions of subsection (a) of section 17-134d-43 would not be rendered without considering the medical opinion of a qualified organ transplantation expert(s) in the community.

(g) The medical criteria developed by the Transplantation Advisory Committee, and any amendments thereto, are on file in the Department and available to all interested parties. The advisory nature of any such criteria, to assist the Department in determining whether the subsection (a) of section 17-134d-43 prior authorization standards have been satisfied, is emphasized.

(Effective May 1, 1987)

Sec. 17-134d-44. Reserved

Sec. 17-134d-45. Repealed

Repealed July 11, 2011.

Sec. 17-134d-46. Customized wheelchairs in nursing facilities as defined in 42 USC 1396r(a), as amended from time to time, and ICFs/MR as defined in 42 USC 1396(d)d, as amended from time to time

(a) **Conditions of Participation**

Nursing facilities as defined in 42 USC 1396r(a), as amended from time to time, and ICFs/MR as defined in 42 USC 1396(d)d, as amended from time to time, are required as conditions of participation in the Medical Assistance Program to provide or to arrange for the provision of customized wheelchairs and related services on behalf of Title XIX assisted patients who require such customized wheelchairs and related services.

(b) **Definition of Customized Wheelchair**

A customized wheelchair is defined as a wheelchair specifically manufactured to meet the special medical, physical and psychosocial needs of a recipient who cannot independently maintain proper body alignment. The wheelchair must be individualized to preclude the use of the wheelchair by any other person except the recipient for whom it was originally developed.

(c) **Identification of Potential Patients**

Nursing facilities and ICFs/MR shall identify Title XIX patients who potentially require customized wheelchairs as a result of the patient's possessing certain physical disabilities. These physical disabilities would be of such a nature as to require adaptations to a standard wheelchair needed to support and properly position the disabled person's body in proper body alignment in a wheelchair. An Interdisciplinary Team (IDT) assessment shall be performed in accordance with subsections (d) through and including (h) of this section as follows for each disabled person who potentially requires a customized wheelchair. The IDT assessment shall determine whether or not such person in fact requires a customized wheelchair, and shall determine the appropriate design and characteristic of any such customized wheelchair. It is the facility's obligation to identify recipients who may require customized wheelchairs and related services, and to initiate required interdisciplinary assessments. The Department's medical review teams may identify patients who potentially require such services in the regular course of periodic inspections of the adequacy of care provided by such facilities. Upon notification from the Department that a Title XIX assisted patient may require a customized wheelchair and related services, nursing facilities and ICFs/MR are required to conduct an interdisciplinary assessment in accordance with subsections (d) through and including (h) of this section.

(d) **Assessment Appropriateness**

An assessment of a disabled patient's need for a customized wheelchair must be made whenever an assessment is appropriate. This is indicated by the presence of disabilities which preclude effective use of a standard wheelchair, and which require adaptations to be made to a wheelchair to properly position and support the disabled person's body.

(e) **Composition of Interdisciplinary (IDT) Team**

(1) An assessment to be adequate must be made by an Interdisciplinary Team (IDT) process. The IDT shall include at a minimum, the participation of all the following:

(A) The patient's attending physician;

(B) A physician who is board certified or board eligible in orthopedics or physical medicine;

(C) A registered physical therapist (RPT) who is licensed by the State of Connecticut and is qualified to assess the patient's needs or by a registered occupational therapist who is licensed by the State of Connecticut (L/OTR) and qualified to assess the patient's needs; and

(D) A representative of the professional nursing staff of the facility (registered nurse) or licensed practical nurse.

(2) The Interdisciplinary Team may include any other professional deemed appropriate to assess the patient's needs.

(f) **Purpose of the ID Team**

(1) The purpose of the Interdisciplinary Team is as follows:

(A) To ensure appropriate assessment of the patient's need for a customized wheelchair;

(B) To ensure appropriate design of any required customized wheelchair; and

(C) To provide appropriate instructions to the facility on the appropriate use and

maintenance of the customized wheel chair.

(2) It is not necessary that all of the members of the Interdisciplinary Team required by this subsection for purposes of assessment be members of the staff of the facility or be retained on an ongoing basis as consulting members of a standing facility-based Interdisciplinary Team.

(3) Nursing facilities and ICFs/MR are encouraged to obtain the required Interdisciplinary Team assessment of a patient's need for an adaptive wheelchair by arranging for consultations by qualified orthopedists, physiatrists, physical therapists, and occupational therapists who have experience in the provision of such equipment on behalf of disabled patients.

(g) **Facilitator**

(1) The description of a Facilitator is as follows:

A professional member of the staff of the facility or regularly retained consultant to the facility shall be nominated as the "facilitator" of the Interdisciplinary Team and may include the attending physician, a registered physical therapist, a registered speech therapist, a registered occupational therapist, or a registered nurse. Preferably, the facilitator should be a registered physical therapist or registered occupational therapist.

(2) Responsibilities of the Facilitator

The individual selected by the facility is responsible for all the following:

(A) Must attend and participate in the assessment performed by the orthopedist or physiatrist;

(B) Must attend and participate in any assessment performed by a physical or occupational therapist (if such physical or occupational therapist is not also the facilitator);

(C) Be responsible to ensure that all required assessments are performed; and

(D) Ensure that all required documentation is processed in a timely fashion, and that communication with the vendor is maintained throughout the prior authorization process.

(h) **IDT Assessment Requirements**

The recipient must receive all of the following:

(1) A physical examination by the attending physician;

(2) An orthopedic or physiatric examination by an orthopedist or physiatrist; and

(3) A rehabilitative examination by a physical therapist or occupational therapist.

The examinations shall be a part of the recipient's medical records and must have been done within three (3) months prior to the date of request for a customized wheelchair on the Form W619, see subsection (j) of this section. The examinations shall include films as deemed appropriate by the attending physician and the medical consultant.

(i) **Application Process for Customized Wheelchair**

(1) Requirements of Facility

Nursing facilities and ICFs/MR shall incorporate the required IDT assessments into the patient care plan. Whenever the required interdisciplinary assessment indicates that a Title XIX assisted patient requires a customized wheelchair, the facility is required to arrange with the supplier of durable medical equipment for the provision of an appropriate

customized wheelchair.

(2) Prior Authorization Requirements

Prior authorization by the Department is required in order for the Department to make payment to a supplier of durable medical equipment for the cost of a customized wheelchair. Prior authorization procedures must be followed in accordance with Section 189 (Durable Medical Equipment) of the Department's Medical Services Policy Manual.

(j) **Inservice Training**

(1) The Durable Medical Equipment provider is responsible on date of delivery to assist in the teaching and training of the recipient and nursing facility staff as to the proper use and care of the customized wheelchair. Date of delivery is defined as the final delivery of the product as authorized on the Form W619 "Authorization Request for Medical and Surgical Supplies" and Form W628 "Customized Wheelchair Prescription," with the customized wheelchair set up and in place at the recipient's place of residence.

(2) The monitor, see subsection (1) (2) of this section, shall ensure that the nursing staff of the facility (including all direct care staff who provide basic care on behalf of the patient) receive appropriate training in the proper use and care of the customized wheelchair.

(3) Documentation of all inservice training must be evident.

(k) **Twenty-four (24) Hour Positioning Plan**

(1) Responsibility for Development

A 24 hour positioning plan must be in place on the date of the delivery of the customized wheelchair. The 24 hour positioning plan must be developed by the professional staff of the facility (nursing, physical, occupational, or speech therapy in conjunction with the attending physician), monitored as per subsection (1) (2) of this section and incorporated into the patient's plan of care pursuant to an order of the attending physician.

(2) Components of Twenty-four (24) Hour Positioning Plan

The 24 hour positioning plan shall describe periods of time when the patient shall be seated in the customized wheelchair and shall also describe a time schedule for the patient to be therapeutically positioned in bed, on mats or with other pieces of adaptive equipment. The positioning plan shall take into account the patient's ability to be seated in a customized wheelchair for limited or extended periods of time, depending on the circumstances of the patient. Emphasis must be placed on seating the patient in a customized wheelchair at mealtime. The positioning plan must be modified, as needed, depending on the circumstances of the patient in order to promote enhanced psychosocial functioning made possible by seating in a customized wheelchair for longer periods of time as the patient develops increased physical capacity for being adaptively seated. The 24 hour positioning plan adopted by the attending physician must indicate the name and title of the individual responsible for overseeing implementation.

(*l*) **Monitoring Program Requirement**

(1) Establishment of Monitoring Program

A monitoring program must be established by the professional staff of the facility (nursing, physical therapy, occupational therapy in conjunction with the attending physician)

and incorporated into the patient's plan of care pursuant to an order of the attending physician.

(2) Assignment of Responsibility

The monitoring program must assign responsibility to a monitor who is an individual member of the professional staff of the facility, identified by name and title, to monitor the patient's physical adaptation to the customized wheelchair (including monitoring for decubitus or any other adverse health effects) and for monitoring the compliance of the facility's nursing and direct care staff with the 24 hour positioning plan. The monitor is also responsible for overseeing the documentation of all monthly and quarterly progress notes. The monitor shall be the head nurse of the unit in which the patient resides.

(3) Reassessment

In addition, at least yearly, the attending physician in conjunction with the rehabilitative staff must reassess the patient and determine whether or not the design of the customized wheelchair continues to be appropriate to meet the patient's needs. Payment for X-rays, or orthopedic, physiatric consultation will be made by the Department if needed as part of the reassessment.

(4) Monthly Progress Notes

A member of the professional nursing staff of the facility must make progress notes at least monthly in the patient's permanent record which shall address any health issues related to use of a customized wheelchair (e.g., any problems or change with the condition of the patient's skin), whether the nursing and direct care staff are complying with instructions on the use of the customized wheelchair and are properly implementing the required 24 hour positioning plan, and whether any modifications should be made on the use of the wheelchair or in the 24 hour positioning plan.

(5) Quarterly Progress Notes

A member of the rehabilitation staff (physical, occupational, or speech therapist) must make progress notes at least quarterly which shall address any health issues related to the customized wheelchair, facility compliance with instructions on the use of the customized wheelchair and the 24 hour positioning program, whether the customized wheelchair continues to be appropriate to meet the needs of the patient and whether any modifications should be made on the use of the customized wheelchair or to the 24 hour positioning plan. In addition, the rehabilitation staff progress notes must consider and make recommendations to the attending physician on whether any other rehabilitation (physical therapy, occupational therapy, or speech therapy) services are indicated as a result of the seating of the patient in a customized wheelchair, e.g., occupational therapy services designed to promote independent feeding.

(6) Maintaining Medical Records

All medical records required by this Section, including any assessments, the plan of care (with incorporated 24 hour positioning plan and monitoring program) and progress notes shall be maintained by the facility and be available for inspection by authorized Department personnel as well as by the personnel of other state agencies who are authorized by law to

make investigations concerning the quality of health care.

(m) **Costs and Methods of Payment for Services**

(1) Per Diem Rate Inclusion

All costs pertaining to required physical therapy, occupational therapy, speech therapy and nursing services, including any retention of expert consultancy services for assessment and training purposes as well as the cost of required monitoring services, must be incurred by the facility and are reimbursed to the facility through the per diem rate system established pursuant to Section 17-314 of the Connecticut General Statutes as required for reimbursable nursing facility services.

(2) Direct Payment

The costs of physician services, including attending physician services and consulting orthopedic or physiatric physician services, as well as the costs of X-ray services and any necessary medical transportation services, are paid directly to the provider of such ancillary services subject to the limitations, conditions and prior authorization requirements contained in Department policy applicable to physician, X-ray and medical transportation services. The cost of the customized wheelchair is paid directly to the durable medical equipment provider as an ancillary service, subject to the limitations, conditions and prior authorization requirements contained in Section 189 (Durable Medical Equipment) of the Department's Medical Services Policy Manual.

(n) **Services Required of Nursing Facilities and ICFs/MR**

Required services related to the provision of customized wheelchairs which nursing facilities and ICFs/MR shall provide as conditions of participation in the Medical Assistance Program are those related services mandated by subsections (c) through (n) of this Section, including all of the following:

(1) identifying of potential recipients of customized wheelchairs;

(2) conducting interdisciplinary assessment;

(3) arranging for and ordering of the customized wheelchair where appropriate;

(4) training of facility staff (including direct care staff);

(5) implementing a 24 hour positioning program; and

(6) developing and implementing a monitoring program including periodic nursing notes and physical, occupational, or speech therapy progress notes.

(Effective April 24, 1989; Amended October 1, 2001)

Sec. 17-134d-47. Repealed

Repealed October 1, 2001.

Sec. 17-134d-48. Repealed

Repealed March 7, 2007.

Sec. 17-134d-49. Reserved

Sec. 17-134d-50. Medicaid reimbursement clinical diagnostic laboratory services furnished by acute care hospitals

(a) **Definitions**

(1) This regulation defines the method of reimbursement of clinical diagnostic laboratory services provided by acute care hospitals to Connecticut Medical Assistance recipients.

(2) For the purposes of this regulation, "Clinical Diagnostic Laboratory Services" means those clinical diagnostic laboratory tests and related specimen collections subject to the statewide Clinical Diagnostic Laboratory Test Fee Schedule established by the State Medicare carrier for outpatient hospital-based laboratories effective July 1, 1984 in accordance with Section 2303 of Public Law 98-369. The procedures covered by this definition shall include or exclude any subsequent additions or deletions made by the State Medicare carrier for outpatient hospital-based laboratories. Each test covered is identified and described using the Health Care Financing Administration Common Procedures Coding System (HCPCS) five (5) digit procedure code and terminology or local codes and descriptions assigned by the State Medicare carrier.

(3) "Hospital Outpatient" means a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and is directly receiving outpatient hospital services (rather than supplies alone). Where the hospital uses the category "day patient," i.e., a person who directly receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient.

(4) "Hospital Nonpatient" means a person who is not registered on the hospital records as an outpatient or is not directly receiving services from the hospital but the hospital provides all or part of the required testing.

(5) For the purposes of these regulations, "hospital" means acute care Connecticut-based or border hospital.

(6) "Department" means the Department of Income Maintenance.

(7) "Rate Year" means beginning January 1, 1987 the Medicaid rate year shall be concurrent with the Medicare rate year.

(b) **Services Covered**

Clinical Diagnostic Laboratory Services, as defined in these regulations, and Specimen Collection Fees, as provided in these regulations, are eligible for payment as set forth below provided the requirements set forth below are met.

(c) **Services Not Subject to the Fee Schedule**

Laboratory tests not subject to the fee schedule pursuant to this regulation include:

(1) Laboratory tests furnished to a hospital inpatient as defined in § 150.1B of the Department's Medical Services Policy Manual;

(2) Those laboratory tests furnished by hospital-based end-stage renal dialysis (ERSD) facilities the cost of which are included in the ERSD composite rate payment;

(3) Laboratory tests and services as identified by the State Medicare carrier to be

performed by a physician; and

(4) Certain blood tests and test primarily associated with the provision of blood products as identified by the State Medicare carrier.

(d) **Need for Service**

In order to be eligible for reimbursement any clinical diagnostic laboratory service performed and for which payment is sought must be reasonable, necessary, and furnished under the direction of a physician for the diagnosis or treatment of a particular illness or injury of the patient upon whom the test was performed.

(e) **Payment Rate**

(1) Pursuant to Section 2303 (g) (2) and (j) (2) of Public Law 98-369 enacted effective July 18, 1984, clinical diagnostic laboratory services provided to hospital outpatients and nonpatients and performed on and after July 1, 1984 and paid on or after October 1, 1984 shall be reimbursed no more than the statewide fee schedule for clinical diagnostic laboratory tests, including amounts for specimen collections as permitted under these regulations, established by the State Medicare carrier for outpatient/nonpatient hospital-based laboratories; or the amount of the charges billed for the tests. Effective for outpatient clinical laboratory services rendered on or after July 1, 1986, the rate shall be the lesser of the amount determined under such Medicare fee schedule, the limitation amount for that test pursuant to Section 9303 (b) of the Public Law 99-272 enacted effective July 1, 1986, or the amount of the charges billed for the tests;

(2) In order to remain in compliance with Section 2303 (g) (2) and (j) (2) of Public Law 98-369 for the rate period July 1, 1985 through June 30, 1986 and Section 9303 (b) of the Public Law 99-272 enacted effective July 1, 1986 for the rate period July 1, 1986 through December 31, 1986 and the current rate year, i.e., January 1, 1987 through December 31, 1987 and all subsequent Medicare rate years, the rates for clinical diagnostic laboratory services as defined in these regulations shall be reimbursed as follows:

(A) For the Medicare rate period July 1, 1985 through June 30, 1986, payments by the Department shall be made in accordance with the Medicare Fee Schedule as it existed on July 1, 1985. The rates established by the Department shall be the lesser of the Medicare Fee Schedule for such period or the amount of the charges billed for the tests;

(B) For the Medicare rate period July 1, 1986 through December 31, 1986, the rates established by the Department shall be the lesser of the Medicare Fee Schedule in effect on July 1, 1985, the limitation amount pursuant to Section 9303 (b) of the Public Law 99-272 for the amount of the charges billed for the tests.

(C) For the Medicare rate period beginning on and after January 1, 1987, the rates of payment shall be based upon the lesser of the amount of the Medicare Fee Schedule, the limitation amount pursuant to Section 9303 (b) of the Public Law 99-272 or the amount of the charges billed for the tests;

(D) Any subsequent changes mandated by Congress or of the United States Department of Health and Human Services shall be implemented by the Department as soon as practicable retroactive to the effective date of said mandatory change.

(f) **Payment Limitations**

(1) The amount paid by the Department for the clinical diagnostic laboratory services including amounts for specimen collections as permitted under these regulations constitutes payment in full to the provider hospital.

(2) There is no payment of Medicare coinsurance and deductible for clinical diagnostic laboratory tests subject to these regulations.

(3) When the hospital obtains laboratory tests for outpatients or nonpatients under arrangements with independent laboratories or other hospital laboratories, either the originating hospital (or hospital laboratory) may receive payment for all tests, or the originating hospital and the reference laboratories may receive payment for the tests they perform. The hospital may not receive payment for tests under arrangement if it does not operate a laboratory.

(4) Pursuant to said Section 2303 (g) (2) and (j) (2) of Public Law 98-369, it will be necessary to verify that any amounts expended by the Department between October 1, 1984 and January 31, 1986 inclusive, for clinical diagnostic laboratory tests did not exceed the amount that would be recognized under the Social Security Act by Medicare. If any such payments are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.

(5) The methodology to be employed to accomplish this verification in subsection (f) (4) of these regulations will be one of the two methodologies set forth below at the election of the hospital. However, once a hospital has elected one methodology it may not wait for the results of that methodology and then request the other methodology. Each hospital must notify the Department of its election by March 31, 1986. Failure of a hospital to provide notification of said election or failure of a hospital to provide the necessary information required by whichever option the hospital has selected may result in the Department's deferral of payment for clinical diagnostic laboratory services of that hospital until said hospital has furnished the required information.

METHOD I

(6) The Department will take a random sample of claims paid for clinical diagnostic laboratory services under the applicable UB82 revenue codes for each hospital using the Department's claims payment history for each hospital. The sample will be randomly taken from all hospital claims paid using the summary, ratio-to-cost methodology and for which payment was made by the Department on or after October 1, 1984 for dates of service between July 1, 1984 and January 31, 1986 inclusive. The claims data base will be collected until the Department, at its sole discretion, determines that a sufficient number of clinical tests within said dates of service have been paid. The Department will provide each hospital with a record of each recipient claim payment included in the sample. The record will show the amount billed by the hospital, dates of service, the amount paid, and the date of payment by the Department for each applicable revenue code. This method will require the hospitals to provide to the Department a corresponding report indicating the details of each recipient

claim in the sample. The detail report must include:

(A) the recipient's name and Medicaid identification number;

(B) the HCPCS for each test in the sample claim;

(C) the corresponding fee schedule rate, if available, and hospital charge for each test in the sample claim;

(D) date of service of each test and specimen collection;

(E) the total of the above details including the totals of the amounts that would have been billed and the amount that would have been paid using the Medicare Fee Schedule (if available);

(F) the hospital should report applicable specimen collection fees in the same manner as described above as long as the collection fees are in conformance with the specimen collection section below;

(G) it is possible that some of the sample claims selected may represent a mixture of tests which are subject to, and tests which are not subject to, the Medicare Fee Schedule. The total charges for the tests which are not subject to the Medicare fee schedule must also be set forth on the hospital's detail report in order to reconcile the total of the charges on this report with the total charges on the Department's claims sample report sent to the hospital. Details for tests not subject to the fee schedule, as provided for in these regulations, need only show the aggregate amount billed.

(H) the Department will compare the ratio of the total amount billed by the hospital and paid by the Department with the ratio of the total amount billed by the hospital and paid using the Medicare Fee Schedule. The ratio of the amount paid to the amount billed is the percent of the amount billed to the amount paid. If the ratio resulting from the Department's sample claims is larger than the ratio resulting from the hospital's details of the sample claims using the fee schedule, an overpayment will exist. To determine the actual amount of the overpayment, the total amount billed by the hospital corresponding to the claims paid for the period beginning October 1, 1984 through January 31, 1986 will be multiplied by the ratio resulting from the total amounts calculated from the hospital's detailed report. If the total actually paid for said period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the total amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for the period October 1, 1984 through January 31, 1986. If the Department determines that the hospital has been overpaid, the Department shall notify the hospital. If payment arrangements satisfactory to the Department are not made by the hospital within thirty (30) days of said notification, the Department, in its sole discretion, may recoup the overpayment from the next payment or payments due from the Department to the hospital.

METHOD II

(7) At the election of the hospital, the Department will collect claims data for clinical diagnostic laboratory services from each hospital's record of payments for a sample period. The sample period will reflect claims paid at the current Medicare fee schedule including

related specimen collection fees which meet the requirements of the specimen collection section below. The sample period shall include dates of service for a three month period beginning February 1, 1986 through April 30, 1986 which have been paid pursuant to the Medicare Fee Schedule.

(A) The Department will use its Medicaid Management Information System (MMIS) to collect the data necessary to determine any overpayment. The data will be collected until the Department, in its sole discretion, determines that a sufficient number of clinical tests with dates of services within the sample period have been paid.

(B) The data to be collected will be the total of the amounts billed by each hospital during the sample period and the total amount paid by the Department to each hospital covering dates of service in the same period. The amount billed should represent the hospital's usual and customary charges for clinical laboratory services and the Department's payment will be the amounts allowed in accordance with the current Medicare Fee Schedule.

(i) For the retroactive period covered by dates of service commencing July 1, 1984 (and paid by the Department on or after October 1, 1984) through June 30, 1985, the total amount billed in the sample period shall be adjusted for any across-the-board changes in the hospital's usual and customary charges set for clinical diagnostic laboratory services subject to the Medicare Fee Schedule and occurring on and after July 1, 1985. If such increases occurred, the hospital will be required to furnish the Department with the following information regarding its usual and customary charge history for clinical diagnostic laboratory services and specimen collection fees as defined in these regulations during the period July 1, 1985 through April 30, 1986:

(aa) the date(s) the across-the-board charge rate change(s) became effective between July 1, 1985 and April 30, 1986;

(bb) the amount of across-the-board change, e.g., percent or dollar amount.

The total amount paid for the sample period will be adjusted by the amount of the Medicare Fee Schedule rate increase which became effective July 1, 1985. The ratio of the adjusted amounts billed to the adjusted amount paid during the sample period shall represent the ratio of the total amount that should have been billed and paid during the aforementioned retroactive period for clinical laboratory services. Said ratio will be applied to the total amount actually billed by the hospital for the aforementioned retroactive period. The resulting amount shall represent the total amount which the Department should have paid to the hospital in said period. If the total amount which was actually paid to the hospital for said period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for said retroactive period.

(ii) For the retroactive period beginning with dates of service July 1, 1985 through January 31, 1986, the unadjusted ratio calculated from the actual amount billed and paid for the sample period shall be applied to the total amount billed for said retroactive period. If the total amount which was actually paid to the hospital for said retroactive period is

greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the total amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for said retroactive period.

(iii) The Department shall notify the hospital of the overpayment resulting from either or both retroactive periods. If payment arrangements are not made by the hospital within thirty (30) days of said notification satisfactory to the Department, the Department in its sole discretion, may recoup said overpayment(s) from the next payment or payments due from the Department to the hospital.

(iv) If the amount of difference for either retroactive period utilizing Method I or Method II reveals that the Department paid less than would have been paid pursuant to Medicare, no payment shall be made by the Department to the hospital.

(8) Should any claims for clinical diagnostic laboratory services rendered prior to February 1, 1986 be submitted after the date that any overpayment has been calculated, the ratio used in determining the overpayment using either Method I or Method II shall be applied in calculating the amount of reimbursement for said services.

(9) Pursuant to said Section 9303 (b) of the Public Law 99-272, it will be necessary to verify that any amounts expended by the Department for dates of service on and after July 1, 1986 and received for payment on or before November 30, 1986, for clinical diagnostic laboratory tests did not exceed the amount that would be recognized under said Section. If any such payments are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.

(10) Such amount of overpayment found pursuant to subsection (f) (9) of these regulations will be recouped from the next payment or payments due from the Department to the hospital.

(g) **Specimen Collections**

(1) Payment for drawing or collecting specimens is allowed for those hospitals who have an established rate and routinely charge for specimen collections.

(2) The payment of specimen collections is the lower of:

(A) the Medicare rate;

(B) the Medicaid prevailing rate; and

(C) the hospital's usual and customary charge.

(3) Payment will be made only in those cases in which the hospital has drawn or collected the specimen from the patient.

(4) Only one (1) collection fee is allowed for each type of specimen (e.g., blood, urine, etc.) for the same patient encounter regardless of the number of specimens drawn or collected.

(5) Payment is allowed in circumstances such as drawing blood samples through venipuncture (i.e., inserting into vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

(6) When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

(7) A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal (such as a throat culture, a routine capillary puncture for clotting, or bleeding time).

(8) A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, e.g., venipuncture or sample by catheterization. A specimen collection fee is not allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. It must be indicated in the SNF patient record that no staff is available to draw the sample.

(9) The amount allowed by the Department for drawing or collecting a specimen at the laboratory facility covers the specimen drawing service and materials and supplies used.

(10) The amount allowed for drawings done in the recipient's home or in a nursing home covers the travel expenses of the technician, specimen drawing service, and materials and supplies used.

(Effective August 5, 1989)

Sec. 17-134d-51. Reserved

Sec. 17-134d-52. Repealed

Repealed June 26, 1989.

Sec. 17-134d-53—17-134d-55. Reserved

Sec. 17-134d-56. Reimbursement of clinic outpatient services and clinic off-site medical services furnished by free-standing clinics

(a) **Definitions**

(1) "Free-Standing Clinic" means a facility providing medical or medically related clinic outpatient services or clinic off-site services by or under the direction of a physician or dentist and the facility is not part of, or related to, a hospital. Such facilities provide mental health, rehabilitation, dental and medical services and are subject to Sections 171 through 171.4 of the Department's Manual.

(2) In addition to the provisions set forth in the Department's Manual, Section 171B, "Clinic Outpatient Services" means services performed at the clinic, a satellite site, school, or community center.

(3) "Clinic Off-Site Services" means diagnostic, preventive, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist employed by or under contract to a free-standing clinic to a Medicaid eligible recipient at a location which is not a part of the clinic. Such locations are the recipient's home, acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded. Off-site services, as may be restricted by location in accordance with Section (b) of this regulation, include: Mental Health Services, Occupational Therapy

Services, Physical Therapy Services, Speech Therapy Services, Audiological Services, Physician's Services, Respiratory Therapy Services, Primary Care Services, and Dental Services. Such services are subject to the provisions of the Department's Manual Sections 171 through 171.4 except as modified by this regulation.

(4) "By or under the direction of a physician or dentist" means a free-standing clinic's services may be provided by the clinic's allied health professionals (as defined in Sections 171.1.B through 171.4.B of the Department's Manual) whether or not a physician is physically present in the clinic at the time that services are provided. The physician:

(A) must assume professional responsibility for the services provided;

(B) assure that the services are medically appropriate, i.e., the services are intended to meet a medical or medically-related need, as opposed to needs which are social, recreational or educational;

(C) need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

(5) "Outpatient" means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

(6) "Plan of Care" means a written individualized plan. Such plan shall contain the diagnosis, type, amount, frequency, and duration of services to be provided and the specific goals and objectives developed and based on an evaluation and diagnosis for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

(7) "Satellite Site" means a location separate from the primary clinic facility at which clinic outpatient services are furnished on an ongoing basis meaning with stated hours per day and days per week.

(8) "Home" means the recipient's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(9) "Department's Manual" means the Department of Income Maintenance Medical Services Policy Manual. References to manual sections in this regulation shall mean those sections as they may be amended from time to time.

(10) "Medical or Medically-Related Service" means services which are required in the diagnosis, treatment, care, or prevention of some physical or emotional problem.

(11) "Eligible Person" means a person eligible for the Medical Assistance Program in accordance with Section 17-134b of the General Statutes of Connecticut and regulations promulgated pursuant to Section 17-134d of the General Statutes of Connecticut

(b) **Service Limitations**

In addition to the provisions set forth in the Department's Manual, Sections 171.1E, 171.2E, 171.3E, 171.4E which are incorporated by reference herein, the following limitations apply:

(1) Clinic outpatient services and clinic off-site services as defined in Section (a) of this regulation which are provided to a resident of a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded, and which are deemed routine services for such facilities are not covered for patients in such facilities. These services may include but are not limited to: occupational therapy services, physical therapy services, audiological services, speech services, respiratory therapy services, routine laboratory and routine radiologic services, consultation services, skilled nursing, other rehabilitative and personal care services;

(2) Reimbursement of a visit for a clinic patient is limited to one (1) per day for the same clinic provider to the same patient involving the same treatment modality, illness or injury regardless of the location at which the service is furnished. Encounters with more than one health professional and multiple encounters with the same health professional employed by or under contract to the same clinic provider that take place on the same day, regardless of the location, constitute a single visit, except when the patient, after the first encounter, suffers a new illness or injury requiring additional diagnosis or treatment.

(3) Clinic off-site services as defined in Section (a) of this regulation which are provided to hospital patients are covered only for services personally performed by clinic-based physicians and dentists who are not providing such services as salaried staff of the hospital.

(c) **Need For Service**

In addition to the provisions set forth in the Department's Manual, subsections 171.1F.I, 171.2F.I, 171.3F.I, and 171.4F.I, which are incorporated by reference herein, the following conditions apply to clinic outpatient and clinic off-site services:

(1) Such services are performed within the scope of the clinic's license or permit issued under State law; or, within the scope of the accreditation award; whichever applies;

(2) Such services are made a part of the eligible person's individual medical record;

(3) Such services are prescribed by a physician;

(4) Each recipient shall have an individual written plan of care.

(d) **Documentation Requirements**

(1) A record of each service performed must be on file in the recipient's individual medical record.

Such service record must include, but is not limited to:

(A) the specific services rendered;

(B) the date the services were rendered;

(C) for therapy services, the amount of time it took to complete the session on that date;

(D) the name and title of the person performing the services on that date;

(E) the location at which the services were rendered;

(F) for mental health and rehabilitation clinics, the recipient's individual medical record must contain at least a monthly summary documenting the progress made toward the goals and objectives in accordance with the recipient's plan of care;

(G) for medical and dental clinics the recipient's individual medical record must contain a progress note for each encounter.

(2) All documentation must be entered in ink and incorporated into the patient's permanent medical record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request in accordance with Title 42 Section 431.107 of the Code of Federal Regulations. Failure to maintain documentation required in these regulations may result in disallowance of payment for any service for which documentation was not maintained.

(3) Documentation as required in these regulations must be maintained for a minimum of five (5) years.

(4) In the case of clinic off-site services, all individual medical records must be on file at the clinic in the manner prescribed in this subsection.

(e) **Prior Authorization**

The following services whether performed at the clinic, a satellite site, school, community center, or off-site require prior authorization from the Department as follows:

(1) Individual, group and family psychotherapy or counseling, and parent interviews, provided by mental health clinics in accordance with Section 171.1 of the Department's Manual, in excess of thirteen (13) visits in ninety (90) days or twenty-six (26) visits in six (6) months to the same recipient when performed at the clinic, a satellite site, school, community center, recipient's home, or hospital. The number of visits accumulate regardless of the location where the services are performed;

(2) Individual, group, or family psychotherapy or counseling performed in a skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded, from the date of first treatment;

(3) Individual, group, or family psychotherapy or counseling provided by a rehabilitation clinic, from the date of first treatment, regardless of the location;

(4) Individual, group, or family psychotherapy or counseling provided by mental health clinics to individuals whose etiology stems from alcohol or drug dependence, from the date of first treatment;

(5) Occupational therapy, physical therapy, speech, language, or hearing therapy, and respiratory therapy, from the date of first treatment, regardless of the location;

(6) Partial evaluations and medical check-ups provided by rehabilitation clinics in accordance with the provisions of Section 171.2F of the Department's Manual, regardless of the location;

(7) Complete evaluations, provided by rehabilitation clinics in accordance with the provisions of Section 171.2F of the Department's Manual, regardless of the location;

(8) Dental services in accordance with subsection 171.3 F.II of the Department's Manual;

(9) Day Treatment programs with the exception of Methadone Maintenance Treatment Programs;

(10) Respiratory Therapy.

(f) **Other Requirements**

(1) Clinics providing medical day treatment programs including, but not limited to: psychiatric; traumatic brain injury; early childhood; substance abuse; and other rehabilitative

day programs; are required to furnish all services at the clinic except for a home visit for the purposes of evaluating the recipient's home environment if required by the recipient's plan of care.

(2) In addition to the provider enrollment eligibility provisions set forth in the Department's Manual, Section 120C, which are incorporated by reference herein, the following enrollment requirements pertain to clinics and satellite sites as defined in Section (a) of this regulation.

(A) All clinics and satellite sites operated by clinics established under Section 17-424 of the Connecticut State Statutes must comply with all Department of Children and Youth Services (DCYS) statutory, regulatory and preferred practice requirements and document to the Department DCYS approval of such sites.

(B) All satellite sites operated by clinics licensed by the Department of Health Services (DOHS) must also be approved by the DOHS to provide clinic services at such locations, and document to the Department DOHS approval of such sites.

(C) Rehabilitation clinics operating satellite sites must document to the Department that the clinic has applied for or received accreditation for services at such sites.

(D) All satellite sites operated by dental clinics must have received a permit from the Connecticut State Dental Commission to provide dental services at such locations and document to the Department the Commission's approval of such sites.

(E) All clinics must document to the Department the names and titles of satellite clinical staff and scheduled hours of operation (hours per day/days per week) and description of services provided at such sites.

(F) All such sites must otherwise comply with the provisions of Sections 171 throught 171.4 of the Department's Manual covering clinic services.

(G) In cases in which the clinic has a special arrangement to provide services in another organized facility, the clinic must submit to the Department a copy of a written agreement between the clinic and such facility stipulating the services to be provided at such facility.

(H) There must be adequate private office space in which to conduct direct patient care and treatment and administrative services.

(g) **Payment**

(1) Clinic outpatient services and clinic off-site services shall be paid in accordance with the provisions set forth in the Department's manual Sections 171.1I, 171.2I, 171.3I, and 171.4I which are incorporated by reference herein.

(2) Travel costs incurred by clinic staff in furnishing clinic outpatient and clinic off-site services as defined in Section (a) of this regulation, are considered to be included in the amount the Department shall pay for such services in accordance with Section 171.1I, 171.2I, 171.3I and 171.4I of the Department's Manual.

(3) All payments that are made utilizing the fee schedule shall be made in accordance with the fee schedule in effect on the date the service is furnished.

(Effective December 11, 1989)

Sec. 17-134d-57—17-134d-59. Reserved

Sec. 17-134d-60. Repealed

Repealed March 7, 2007.

Sec. 17-134d-61. Reserved

Sec. 17-134d-62. Repealed

Repealed March 7, 2007.

Sec. 17-134d-63. Medicaid payment to out-of-state and border hospitals

(a) **Definitions**

For the purposes of this regulation, the following definitions apply:

(1) "Allowed Cost" means the Medicaid costs reported by each Connecticut instate hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

(2) "Border Hospital" means an out-of-state general hospital which has a common medical delivery area with the State of Connecticut and is deemed a border hospital by the Department on a hospital by hospital basis.

(3) "Connecticut In-state Hospital" means a general hospital located within the boundaries of the State of Connecticut and licensed by the Connecticut State Department of Health Services.

(4) "Department" means the State of Connecticut Department of Income Maintenance.

(5) "Department's Manual" means the Department's Connecticut Medical Assistance Provider Manual which contains the Medical Services Policy as amended from time to time.

(6) "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 patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(7) "General Hospital" means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries.

(8) "Inpatient" means a patient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental, or other health related services and is present at midnight for the census count.

(9) "Medical Necessity" means medical care provided to:

(A) Correct or diminish the adverse effects of a medical condition;

(B) Assist an individual in attaining or maintaining an optimal level of well-being;

(C) Diagnose a condition; or

(D) Prevent a medical condition from occurring.

(10) "Out-of-State Hospital" means a general hospital located outside of the State of Connecticut and is not deemed by the Department to be a border hospital.

(11) "Outpatient" means a person receiving medical, dental, or other health related services in the outpatient department of an approved general hospital which is not providing room and board and professional services on a continuous 24-hour-a-day basis.

(12) "Prior Authorization" means approval for a service from the Department or the Department's agent which may be required by the Department before the provider actually provides the service. Prior authorization is necessary in order to receive reimbursement from the Department. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

(13) "Provider Agreement" means the signed written contractual agreement between the Department and the provider of medical services or goods. It is signed by the provider upon application for enrollment and is effective on the approved date of enrollment. The provider is mandated to adhere to the terms and conditions set forth in the provider agreement in order to participate in the program.

(14) "Rate Year" means the twelve (12) month period beginning on October 1st of each year.

(15) "Total Customary Charges" means the revenue generated by the aggregate of the total customary charges reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

(b) **Rate Setting**

(1) For inpatient and outpatient services rendered on and after the effective date of this regulation, the Department shall pay out-of-state and border hospitals, at a fixed percentage of each out-of-state and border hospital's usual and customary charge. The standard methodology to be employed shall be the fixed percentage calculated in accordance with subsections (b) (1) (A) and (B) of this regulation. However, for inpatient services, the hospital may elect to have its fixed percentage determined in accordance with subsection (b) (1) (C) of this regulation.

(A) For inpatient services the standard fixed percentage shall be calculated by the Department based on the ratio between the allowed cost and total customary charges for Title XIX recipients for all Connecticut in-state general hospitals.

(B) For outpatient services the standard fixed percentage shall be calculated by the Department based on the ratio between the aggregates of the amount paid by the Department and the amount billed to the Department for all Connecticut instate hospital outpatient services. The amount billed represents the hospital's usual and customary charges for outpatient services and the Department's payment represents the amount paid up to the amount allowed in accordance with the Department's current outpatient fee schedule for each Connecticut in-state hospital and as may be amended from time to time. The amount

paid by the Department to Connecticut in-state hospitals shall include amounts paid in accordance with limits of payments as may be required by federal law. The fixed percentage shall be determined by the Department utilizing data taken from its most recent and deemed the most complete twelve (12) month period as reported in its Medicaid Management Information System.

(C) However, for inpatient services as defined in this regulation, each out-of-state and border hospital may have its fixed percentage optionally determined based on its total allowable cost under Medicare principles of reimbursement pursuant to Title 42 of the Code of Federal Regulations, Part 413, and as may be hereafter amended. The hospital must submit its most recently available Medicare cost report within the time period specified in subsection (b) (2) (A) below. The Department shall determine from the filed Medicare cost report the ratio of total allowable inpatient cost to gross inpatient revenue. The resulting ratio shall be the hospital's fixed percentage not to exceed 100%. If an out-of-state or border hospital chooses to file for a fixed percentage under this subsection it must maintain all the supporting documentation to justify the amounts claimed. The Department, in its discretion, may audit said hospital and make any adjustment required in favor of the provider or the state resulting from the audit.

(D) The Department shall pay out-of-state and border hospitals utilizing the methodology as set forth in subsection (b) (1) (A), or (B), or (C) of this regulation unless a different methodology is required by federal law, in which case, the required federal methodology shall be employed.

(2) Upon the effective date of this regulation and annually thereafter, meaning at the beginning of the rate year, as defined in this regulation, the Department shall notify each out-of-state and border hospital enrolled in the Connecticut Medicaid Program as to the standard fixed percentages for that rate year.

(A) Each year each out-of-state and border hospital shall have ten (10) days from the date of receipt of said notification to submit a request in writing to the Department, if it wishes to have its inpatient fixed percentage calculated using the optional methodology set forth in accordance with subsection (b) (1) (C).

(B) Failure of the hospital to notify the Department of said election within ten (10) days or failure of the hospital to provide the necessary information described in subsection (b) (1) (C) within said time shall result in the Department making payment to the hospital for inpatient services for the applicable rate year using the standard methodology in accordance with subsection (b) (1) (A) of this regulation.

(C) Upon the effective date of this regulation, the fixed percentages set in accordance with subsections (b) (1) (A) or (B) or (C) of this regulation shall expire at the end of the rate year in which this regulation is made effective.

(D) A hospital which enrolls in the Connecticut Medicaid Program during any rate year may elect to have its inpatient fixed percentage determined in accordance with subsection (b) (1) (C) of this regulation. Such initial fixed percentage shall expire at the end of the rate year in which said fixed percentage is approved by the Department. Thereafter, if the

hospital wishes to elect the optional methodology it must comply with the provisions of subsection (b) (1) (C).

(E) If a hospital elects to have its inpatient fixed percentage set in accordance with subsection (b) (1) (C), it may not request a change in said methodology during the rate year in which the fixed percentages are approved by the Department.

(c) **Provider Participation**

In order to receive payment from the Connecticut Medicaid Program:

(1) Out-of-state and/or border hospitals must submit a copy of a current and effective license or certification as a hospital issued by the appropriate official state governing body within the boundaries of the state in which the hospital is located.

(2) The out-of-state and/or border hospital must enter into a provider agreement with the Department.

(3) The Department shall determine when an out-of-state hospital qualifies for enrollment as a border hospital.

(d) **Prior Authorization**

(1) Border Hospitals

Prior authorization, as defined in this regulation, for inpatient and outpatient services, shall be required for such services in accordance with the Department's Manual, Sections 150.1 and 150.2 pertaining to Connecticut in-state hospitals.

(2) Out-of-state Hospitals

(A) Prior authorization for inpatient and outpatient services shall be required for all non-emergency cases as described in subsection (e) of this regulation.

(B) The following services shall *not* require prior authorization:

(i) Care in an emergency situation as defined in this regulation;

(ii) Newborns and/or deliveries; or

(iii) Outpatient services for a child for whom the State of Connecticut makes adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.

(e) **Need for Service**

(1) Out-of-state hospitals who treat Connecticut Title XIX recipients and are enrolled in the Connecticut Medicaid Program as a border hospital are bound by the same rules and regulations as Connecticut in-state hospitals participating in Title XIX program as set forth in the Department's Manual.

(2) The Connecticut Title XIX program reimburses for medically necessary and appropriate services provided in out-of-state hospitals, other than border hospitals as defined in this regulation, under the following conditions:

(A) For emergency cases as defined in this regulation and necessitating the use of the most accessible general hospital available that is equipped to furnish the services;

(B) For non-emergency cases, when prior authorization is granted by the Department, for the following reasons:

(i) Medical services are needed because the recipient's health would be endangered if they were required to travel to Connecticut; or

(ii) On the basis of the attending physician's medical advice that the needed medical services or necessary supplementary resources are more readily available in the other State.

(Effective May 23, 1990)

Sec. 17-134d-64—17-134d-67. Reserved

Sec. 17-134d-68. Requirements for monitoring psychiatric admissions to nursing homes

(a) **Scope**

(1) Medicaid is a program of "cooperative federalism" wherein federal financial participation is available for a percentage of the cost of medical assistance provided by a state under its Medicaid program. Under federal requirements, however, federal financial participation is not available for the cost of nursing facility services that are provided by facilities that are also considered to be institutions for mental diseases (IMDs) except for patients aged 65 and older. The purpose of these regulations is to establish requirements designed to prevent nursing homes which participate in the Medicaid program from being characterized as IMDs unless the IMD serves only patients aged 65 and older or unless the IMD is prepared to accept payment from some source other than Medicaid for all patients under 65 years of age. Specific remedies available to the Department under these regulations include the denial of authorization for the admission of psychiatric patients, the termination of Medicaid provider agreements, and the imposition of fiscal sanctions equal in amount to the loss of federal financial participation attributable to the facility's characterization as an IMD.

(b) **Definitions**, for purposes of this section, are as follows:

(1) "Department" unless otherwise specified, means the Department of Income Maintenance.

(2) "Facility" means a nursing home as defined in subsection (b) (5) below.

(3) Institution for mental disease (IMD), is defined as an institution which is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care and related services in accordance with 42 CFR 435.1009 as amended from time to time. Interpretive guidelines issued by the Health Care Financing Administration indicate that a final determination of a facility's status rests on a cumulative weighing of all applicable guidelines and that a key criterion is the presence in the facility of 50% or more patients with a disability in mental functioning.

(4) "Mental disorder" means a mental disease as defined in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) with the exception of mental retardation, senile dementias (including Alzheimer's disease) and organic brain syndromes. Specifically, nursing home placements primarily for ICD-9-CM diagnosis 295.0-309.9 and 312-314.9 are considered psychiatric placements. Alcoholism is not treated as a psychiatric condition except in the cases in which federal guidelines so direct.

(5) "Nursing Home" means any chronic and convalescent facility or any rest home with

nursing supervision, as defined by Section 19a-521 of the general statutes, which has a provider agreement with the Department of Income Maintenance to provide services to recipients of medical assistance pursuant to Part IV of Chapter 302 of the General Statutes of Connecticut and to accept reimbursement for the cost of such services pursuant to said program, or which receives payment from the state for rendering care to indigent persons. For purposes of this regulation only, intermediate care facilities for the retarded are specifically excluded from this definition.

(6) "Patient Review Team" means the unit of the Department of Income Maintenance which is responsible for completing inspections of care in nursing homes in accordance with the requirements of federal law.

(7) "Provider" means a nursing home as defined in subsection (b)(5) above or the designated representative(s) of the facility.

(8) "Psychiatric patient" means a patient whose primary reason for institutionalization is a mental disorder as defined in subsection (b) (4) above. For purposes of residence in the nursing home, a patient admitted primarily for non-psychiatric reasons and who also has a psychiatric condition that is stable will not be considered a psychiatric patient. If the condition changes such that the primary reason for continued institutionalization falls inside the diagnoses specified above as mental disorders, the patient will be considered a psychiatric patient. If the condition of the patient changes during residence in a nursing home such that the primary reason for continued institutionalization falls outside the diagnoses specified as mental disorders, the patient will no longer be considered a psychiatric patient for purposes of residence in the nursing home.

(c) **Remedies**

(1) In order to assure that a facility which participates in the Medicaid program does not operate as an institution for mental diseases, the Department is authorized to impose any combination of the following remedies:

(A) require the facility to submit a plan of correction;

(B) require the facility to receive prior authorization for new admissions of psychiatric patients who are or will be eligible for Medicaid;

(C) refuse payment to the facility for new psychiatric admissions or newly eligible psychiatric patients;

(D) terminate the provider agreement; and

(E) recover the amount of all federal disallowances from the facility by recoupment from current Medicaid payment to the facility as per Regulations of Connecticut State Agencies, Section 17-311-53 or by bringing any appropriate legal action against the facility.

(2) Whenever a federal disallowance is made as a result of a facility being determined to be an institution for mental diseases, the facility shall be deemed to be indebted to the Department in the amount of such disallowances unless such penalties are waived under the terms in subsection (f) (5).

(3) Nothing herein shall authorize the Department to impose sanctions against facilities on the basis of these regulations for services delivered prior to the effective date of these

regulations.

(d) **Procedures**

The following procedures will be instituted in order to assure that nursing homes which participate in the Medicaid program do not operate as institutions for mental disease:

(1) The Department of Income Maintenance will identify facilities which are at risk of classification as institutions for mental disease.

(A) Determination that a facility is "at risk" of classification as an institution for mental disease does not mean that the facility is, in fact, an IMD as defined above. Rather, the "at risk" determination is an early warning signal designed to allow the Department and the facility to initiate advanced corrective measures to avoid endangering future federal financial participation.

(B) Criteria which shall be considered in making a determination that a facility is at risk of IMD classification may include any of the following:

(i) The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;

(ii) The facility is accredited as a psychiatric facility by the Joint Commission on Accreditation of Hospitals;

(iii) The facility specializes in providing psychiatric care and treatment;

(iv) The facility is under the jurisdiction of the Connecticut Department of Mental Health;

(v) More than 40% of the facility's Medicaid patients are psychiatric patients as defined in subsection (b) (8) above;

(vi) More than 40% of the patients in the facility have been transferred from a state mental institution for continuing treatment of their mental disorders;

(vii) The average age in the facility is significantly lower than that of a typical nursing home;

(C) Information which will be used in making the determination that a facility is at risk of IMD classification includes but is not limited to:

(i) Primary diagnoses as reported on billing documents submitted to the Department by the facility;

(ii) Information about the primary reason for institutionalization as collected by the Patient Review Team from the facility's medical records; and

(iii) Statistics on discharges provided by the Department of Mental Health.

(2) Any facility which meets the criteria listed in subsection (d) (1) (B) above may be determined to be at risk of IMD classification. The Department of Income Maintenance shall notify each facility in writing that has been determined to be at risk of IMD classification that the facility:

(A) is considered at risk of classification as an institution for mental diseases;

(B) must receive prior authorization from the Department prior to the admission of Title XIX psychiatric patients or psychiatric patients with a Title XIX application pending;

(C) will normally not receive prior authorization for Medicaid payment for new

psychiatric admissions or newly eligible psychiatric patients until the Medicaid psychiatric population is below 45% of the total Medicaid patient population or until the total psychiatric population is below 50% of the facility's total census;

(D) must submit an acceptable plan of correction as a condition of continued participation in the Medicaid program; and

(E) will be held responsible for any federal financial penalties imposed on the Department because of the failure of the facility to comply with federal requirements.

(3) Although the Department will provide guidance through this monitoring effort, the burden of responsibility shall rest with the facility to assure that it is in compliance with federal regulations and interpretive guidelines issued by Health Care Financing Administration in relation to its total patient census.

(4) The Department may, at its discretion, terminate the provider agreement for failure to comply with these regulations.

(e) **Plan of Correction**

(1) A facility which is determined to be at risk of being classified as an IMD must submit an acceptable plan of correction to the Department. The plan of correction must:

(A) be submitted in writing to the Department within thirty (30) days from the issuance of notice by the Department;

(B) include steps which have been taken and/or steps which shall be taken in order to assure that the facility will be in compliance with this regulation and applicable federal requirements;

(C) include a timetable which outlines the deadlines for each step;

(D) establish a procedure for internal evaluation to assure that the plan of correction will be implemented properly; and

(E) be approved by the Department.

(2) Among the options available to the facility in order to continue participating in the Medicaid program, are the following steps as appropriate depending upon the circumstances of the facility:

(A) Gradually decrease the percentage of psychiatric patients through attrition;

(B) Develop plans for orderly transfer of psychiatric patients; or

(C) Request reclassification of the facility or a unit within the facility as an institution for mental diseases with Title XIX reimbursement available only for persons aged sixty-five (65) and older.

(f) **Effective Date of Adverse Action**

(1) Adverse action taken by the Department shall be effective on the eleventh (11th) day following the issuance of notice by the Department provided that the facility has not perfected a timely appeal.

(2) The provider shall have the opportunity to appeal provided that the appeal is received in writing by the Commissioner of Income Maintenance on or before the tenth (10th) day following the issuance of notice by the Department. If such appeal is filed, the adverse action shall be effective on the date the decision is reached.

(3) Regardless of whether an appeal has been filed, the provider shall submit a plan of correction within thirty (30) days following the issuance of notice by the Department.

(4) Computation of time in subsections (f) (1) and (f) (2) above and in subsection (g) (1) below shall be subject to the exclusion of weekends and holidays to the extent that they are excluded in Section 17-311-15 of the Regulations of Connecticut State Agencies, as amended from time to time.

(5) The Department may waive the imposition of remedies against a facility which has submitted an approved plan of correction and which has demonstrated good faith in attempting to implement the terms of the plan of correction, but which has been prevented from compliance due to conditions out of its control.

(g) **Appeals**

(1) Appeals Process for Providers

The provider may appeal a decision of the Department in accordance with Section 17-311-27 through 17-311-40 of the Regulations of Connecticut State Agencies, provided that the appeal is received on or before the tenth (10th) day after the issuance of notice by the Department. The following actions may be appealed:

(A) determination that the facility is at risk of classification as an IMD;

(B) imposition of fiscal sanctions against the facility; or

(C) termination of the provider agreement.

(2) Appeals Process for Recipients

The recipient may appeal the following actions by the Department:

(A) classification as a psychiatric patient in accordance with the definition above;

(B) abuse of discretion in denying prior authorization to the facility determined to be at risk of IMD classification; or

(C) determination to suspend, reduce or discontinue assistance.

(h) Admission policies which limit admissions of psychiatric patients to nursing homes which have been determined to be at risk of classification as institutions for mental diseases under the terms of these regulations shall not be deemed or considered in violation of Section 19a-533 of the General Statutes of Connecticut (the "waiting list" statute) provided that:

(1) the admission policy was fairly and consistently applied to all applicants for admission, irrespective of the source of payments for each applicant;

(2) the intent of the admission policy is not to discriminate against indigent applicants and that the policy, fairly and consistently applied, has not had the effect of discriminating against such applicants by denying admission to a disproportionate number of such applicants.

(Effective February 3, 1989)

Sec. 17-134d-69. Reserved

Title XIX Rates for Community Health Centers

Sec. 17-134d-70. Definitions for the purposes of this regulation

"Allowable Primary Health Services Cost" means the costs as reported in the annual report after any cost adjustment, cost disallowances or reclassifications.

"Annual Report" means the annual cost and performance reporting document which consists of forms provided by the Department and other documents submitted by the Community Health Centers. The annual report shall include but not be limited to actual revenues, actual costs, actual visits, imputed visits, projected grants and contributions, cost adjustments, cost disallowances, and audited financial statements.

"Annual Report Period" means the period from July 1st through June 30th.

"Billable Primary Health Service Visit" means any visit which is billable to any payer whether or not the visit is actually billed.

"Commissioner" means the Commissioner of Income Maintenance or his designated representative.

"Cost Adjustments" means the disallowed primary health services overhead costs which are in excess of 30% of the total primary health services costs.

"Cost Disallowances" means costs such as, but not limited to: Entertainment; Fines and penalties; Bad debts and cost of action to collect receivables; Advertising except for recruitment of personnel; Contingency reserves; Legal, accounting and professional services incurred in connection with rehearings, arbitrations or judicial proceedings pertaining to the reimbursement approved by the Commissioner; Fund Raising; Amortization of Goodwill; Directors Fees; contributions; membership dues for public relations, advertising and political contributions and costs not related to patient care. Medicare rules will be used to determine the allowability of specific cost items as set forth in Subchapter 18, Part A of Title 42 of the U.S. Code, Section 1395 et. sec. and the regulations promulgated thereunder.

"Community Health Center (CHC)" means a non-profit medical facility which is not a part of a hospital but is organized and operated to provide primary health and supplemental health services as defined in this regulation. Such facilities are further distinguished by their service to low income and medically underserved populations.

"Department" means the Department of Income Maintenance.

"Full-Time Equivalent" means the total number of hours paid for the year divided by 2080.

"Imputed Primary Health Services Visits" means the minimum number of visits based on the following standards which are assessed as visits per full time equivalent:

—3,500 visits per full time equivalent for the services of physicians

—2,100 visits per full time equivalent for the services of physician assistants

—2,100 visits per full time equivalent for the services of nurse practitioners

"Primary Health Services Operating Revenue" means the operating revenue for primary health services reported in the Annual Report.

"Primary Health Services" means services of physicians, physicians' assistants, nurse practitioners, and other allied health professionals, for the ongoing, continuous or repetitive management of a patient's health care inclusive of services and supplies and the overall coordination of all services provided to the patient. Services include but are not limited to:

(1) first-step management for acute patient problems and follow-up management of current problems including emergency medical services;

(2) chronic disease management;

(3) health education;

(4) nutrition counseling;

(5) preventive health services (including perinatal services and well child services);

(6) medical social work services (including counseling, outreach, referral for assistance, and follow-up);

(7) women's health services;

(8) family planning services;

(9) diagnostic laboratory and x-ray (where such services are *not* independently certified;

(10) transportation as required for primary care visits (where such transportation is furnished by the health center).

"Projected Primary Health Services Grants and Contributions" means the anticipated primary health grants and contributions for the rate period following the annual report period.

"Public Health Service Grants" means funds awarded to community health centers to support the cost of operation of such facilities pursuant to 42 U.S.C. 254c.

"Rate Period" means the 12 month period from April 1st through March 31st.

"Supplemental Health Services" means services necessary for the adequate support of primary health services. Services include but are not limited to:

(1) mental health services;

(2) pharmaceutical services (where such services are independently certified);

(3) dental services;

(4) rehabilitation services, such as: physical therapy, occupational therapy; speech, language and/or hearing services;

(5) laboratory and x-ray (where such services are independently certified);

(6) vision care services.

"Title XIX Rate" means the rate established pursuant to these regulations to reimburse Community Health Centers for primary health services for eligible Title XIX recipients.

(Effective October 12, 1989)

Sec. 17-134d-71. Submission of annual report

(a) On or before March 1, 1989 and December 1, 1989 and on December 1 annually thereafter, each Community Health Center, hereafter called "CHC," shall submit its annual report in a form and manner prescribed by the Commissioner.

(b) The annual report shall cover the period from July 1 to June 30 immediately

preceding the filing date and shall be used to determine Title XIX rates effective April 1.

(c) By January 31 for those CHCs which have filed their annual reports on or before December 1, 1989 and annually thereafter, the Department will review the Annual Report and communicate with the CHCs in writing the Department's comments and/or questions about the submitted Annual Report.

(Effective October 12, 1989)

Sec. 17-134d-72. Determination of the Title XIX rates by the commissioner

The rate for each CHC shall be derived from the annual report and shall be established by the Commissioner on a prospective basis as follows:

(a) For each CHC allowable primary health services cost shall be subtracted from primary health services operating revenue.

(1) If a gain results, meaning a positive amount, the commissioner will determine whether to allow the projected primary health services grants and contributions, excluding public health service grants, in whole or in part for enhancement of primary health services.

(2) If a shortfall results, meaning a negative amount, the dollar amount of the shortfall is subtracted from projected primary health services grants and contributions excluding public health service grants. If this calculation results in a positive amount the Commissioner will determine whether to allow the excess revenue in whole or in part for enhancement of primary health services.

(3) The amount of projected primary health services grants and contributions, excluding public health service grants, not allowed by the Commissioner for enhancement of primary care services shall be subtracted from allowable primary health services costs to determine adjusted primary health services costs.

(b) The lower of allowable primary health services cost or adjusted primary health services cost determined in (a) of this Section is divided by the larger of actual billable primary health services visits or imputed primary health services visits to determine the cost per a primary health services visit.

(c) The cost per a primary health services visit determined in (b) of this Section shall be adjusted for the 21 month time lag between the annual report period and the rate period by use of the Gross National Product (GNP) deflator percentage increase or decrease to determine a per visit cost adjusted by the GNP.

(d) The per visit cost adjusted by the GNP as determined in (c) of this Section for each CHC shall be ranked from high to low and the median per visit cost determined. The maximum allowed per visit cost shall be 125% of the median per visit cost.

(e) For each CHC the Title XIX rate shall be the lower of the per visit cost adjusted by the GNP as determined in (c) of this Section or the maximum allowed per visit cost as determined in (d) of this Section.

(f) Subsequent to the first rate period, the median per visit cost shall be the lower of the median per visit cost as determined in (d) of this Section or the previous year's median per visit cost as adjusted for the 12 month time lag between the rate periods by use of the

consumer price index related to medical care services percentage increase or decrease.

(Effective October 12, 1989)

Sec. 17-134d-73. Reconsideration of Title XIX rates

(a) If at any time a CHC becomes aware that its projected primary health services grants and contributions, excluding public health services grants may have a 25% variance above or below the amount used to determine its Title XIX rate, the CHC must report such variance to the Commissioner. The Commissioner may adjust the current Title XIX rate or may consider such variance in the next annual determination of Title XIX rates.

(b) In the event of material changes in circumstances during a rate period any CHC may submit a written request to the Commissioner for a revised Title XIX rate. As used in this subsection "material" is defined as a 25% change in the Title XIX rate. The written request shall include at a minimum:

—the rate requested,

—the requested effective date, and

—the documentation in support of the requested rate.

(c) In no event shall the rates established pursuant to subsection (a) or (b) of this section exceed the maximum allowed per visit cost for the particular rate period.

(Effective October 12, 1989)

Sec. 17-134d-74. Request for a rate by a new CHC entering the Title XIX program

(a) A new CHC shall file a pro forma annual report based on budgeted data. The Commissioner shall establish a Title XIX rate in accordance with Sections 17-134d-70 through 17-134d-78 of these regulations.

(b) A Title XIX rate established under this section shall remain in effect until the ensuing April 1. In the event that an annual report is not available for a six month period ending June 30th, the rate to be established the ensuing April 1 shall be the current rate adjusted by the GNP percentage increase or decrease from the current rate period to the next rate period.

(c) In no event shall the Title XIX rates established pursuant to subsection (a) or (b) of this section exceed the maximum allowable per visit cost for the particular rate period.

(Effective October 12, 1989)

Sec. 17-134d-75. Record maintenance and retention

Each CHC shall maintain all supporting records of its annual report for a minimum period of 10 years. The records shall be available for review without regard for changes in ownership. Any cost for which adequate documentation is not maintained may be disallowed.

(Effective October 12, 1989)

Sec. 17-134d-76. Audits

The Department shall have the right to audit all supporting accounting and business

records and all records relating to the provision of services to clients funded by the Department. If the audit discloses discrepancies in the accuracy and/or allowability of actual cost and actual statistical data as submitted in the annual report, the Title XIX rate for the rate period will be adjusted. Payment either in favor of the CHC or the State shall be made.

(Effective October 12, 1989)

Sec. 17-134d-77. A statutory limitation on the Title XIX rate

Title XIX rates paid by the State for care of persons eligible for assistance under the provision of Chapter 302, Part III of the Connecticut General Statutes shall not exceed the rate of payment for similar services to the general public.

(Effective October 12, 1989)

Sec. 17-134d-78. Hearings

Any CHC which is aggrieved by any rate decision pursuant to these regulations may within ten days after written notice of such rate decision obtain by written request to the Commissioner, a hearing on all items of aggrievement. The hearing shall be conducted in accordance with the procedures specified in Sections 17-311-1 through 17-311-40 of the Regulations of Connecticut State Agencies.

(Effective October 12, 1989)

Sec. 17-134d-79. Requirements for the reservation of beds in nursing homes

(a) **Definitions**

(1) The definitions contained in Section 19a-537 of the Connecticut General Statutes apply to this subsection and subsections (b), (c) and (d) of this section; and

(2) "Level of Care" is further clarified, for purposes of this section, to refer to the level of care for which the nursing home is licensed, i.e., a chronic and convalescent nursing home or a rest home with nursing supervision. A change in level of care would occur only when the patient, upon return from the hospital, requires care consistent with these licensing standards which is different from his/her care requirements just prior to the time of admission to the hospital. This determination of change in level of care also applies when a patient is required to change from one licensed level to another within a facility which is licensed to provide both chronic and convalescent nursing home care and rest home with nursing supervision care.

(3) "Objective information," for purposes of this section, means an estimate of the patient's projected length of hospital stay obtained by the nursing home from a hospital staff person. This prognosis may be obtained from the patient record or the plan of care or given by a physician or other health professional under his direction or by another qualified professional such as a social worker or discharge planner.

(b) **Requirements**

(1) Nursing homes are required to reserve the bed of a self-pay resident who is hospitalized as long as payment is available to reserve the bed and to inform the self-pay

resident and his/her relatives or other responsible person upon admission to the nursing home and upon transfer to a hospital about this requirement.

(2) Nursing homes are required to inform residents who are recipients of medical assistance and their relatives or other responsible person upon admission to the nursing home and upon transfer to a hospital of the conditions under which the nursing home is required to reserve the bed of a resident.

(3) Nursing homes are required to reserve the bed of a resident who is a recipient of medical assistance for each admission to the hospital for up to fifteen days unless the nursing home documents that it has obtained objective information from the hospital that the patient will not return to the nursing home at the same level of care within fifteen days of hospitalization including the day of admission to the hospital.

(4) The bed reserved for a hospitalized resident shall not be made available for use by any other person unless the nursing home records in the resident's medical record the medical or administrative reasons justifying the change in the resident's bed and documents that a consultation between the medical director or nursing staff of the nursing home and the treating physician has determined that the change in bed assignment is not anticipated to result in serious harm to the resident.

(5) Nursing homes shall be reimbursed for reserving the bed of a resident who is a recipient of medical assistance except as shown in subsection (b) (5) (C) of this section providing the following conditions are met:

(A) For reimbursement to a maximum of seven days including the day of admission to the hospital, the nursing home must document

(i) that on the date of admission it has a vacancy rate of not more than three beds or three percent of licensed capacity, whichever is greater, at the same level of care as the hospitalized person, and

(ii) that it has contacted the hospital, documented the contact in the patient's file, and did not receive information that the person would be unable to return to the same level of care within fifteen days of admission to the hospital.

(B) For reimbursement to a maximum of eight additional days, the nursing home must document

(i) that on the seventh day of hospitalization it has a vacancy rate of not more than three beds or three percent of licensed capacity, whichever is greater, at the same level of care as the hospitalized person, and

(ii) that on or before the seventh day but after the third day of hospitalization the nursing home contacted the hospital for an update of the patient's status, documented the contact in the patient's file, and the updated information obtained did not indicate that the patient would be unable to return to the same level of care within fifteen days of admission to the hospital.

(C) If at any time the nursing home receives or obtains objective information from the hospital that the resident will not return to the same level of care within fifteen days of admission to the hospital, then the nursing home shall not request or receive reimbursement

for reserving the resident's bed for any days after such information is received including the day the information is received.

(6) If the nursing home is not required to reserve the resident's bed under this section or the hospitalization period exceeds the period of time that a nursing home is required to reserve the resident's bed, the following conditions apply:

(A) The nursing home shall provide the first available bed at the time notice is received of the resident's discharge from the hospital;

(B) The nursing home shall grant to resident priority of admission over applicants for new admission to the nursing home;

(C) If reservation of the bed is requested by the resident who is a recipient of medical assistance, his/her relative or other responsible person, the nursing home may charge a fee to the resident or other responsible person to reserve the bed not exceeding the per diem Medicaid rate for the number of days the resident is absent from the facility; and

(D) If reservation of the bed is required by residents who are not recipients of medical assistance, their relative or other responsible person, the nursing home may charge a fee not exceeding the maximum self-pay rate established by the Department for the reserved bed.

(7) Documentation for compliance with this section is required as follows:

(A) Upon a resident's admission to the hospital, the nursing home must document in the resident's medical record the contact with the hospital as described in subsection (b) (3) of this section to determine if the reservation of the resident's bed is required. Any subsequent contact with the hospital which affects reservation of bed requirements is subject to these same documentation requirements.

(B) For a change in bed assignment as described in subsection (b) (4), of this section, the nursing home must document in the patient's medical record

(i) the medical or administrative reasons for the change, and

(ii) the date and results of the consultation between nursing home medical staff or nursing staff and the treating physician.

(C) For reimbursement for the first seven days and the additional eight days of bed reservation or any part thereof as described in subdivisions (5) (A) and (5) (B) of this subsection, the nursing home must document

(i) the vacancy rates on the first and seventh day of the resident's admission to the hospital. The daily log, patient census, or other similar nursing home record may be used for documentation provided it clearly shows the date of vacancy rate determination and the level of care of the vacant beds, and

(ii) in the resident's medical record, the contacts with the hospital on the first day of admission and on or before the seventh day but after the third day of the resident's admission to the hospital.

(D) Information obtained from hospital contacts which is recorded in the resident's medical record as required in subparagraphs (A) and (C) (ii) of this subdivision shall include the date of the contact, the hospital contact person's name, the source of the information

and the length of stay information.

(c) **Violations**

Violations listed in subdivisions (1) through (7) of this subsection are separate and distinct from each other and one penalty may be imposed for each one of the seven subdivisions that are violated per incidence of hospitalization.

Violations include:

(1) The nursing home made the bed assigned to a hospitalized resident available to another person in violation of subsections (b) (1)–(4) of this section;

(2) The nursing home made an undocumented change in the resident's bed as described in subsection (b) (4) of this section;

(3) The nursing home requested reimbursement for reserve-bed days after it had objective information indicating that the hospitalized resident would not return to the nursing home at the same level of care or within fifteen days of admission in violation of subsection (b) (5) of this section;

(4) The nursing home failed to provide a resident with the first available bed at the time notice is received of the resident's discharge from the hospital in violation of subsection (b) (6) (A) of this section;

(5) The nursing home failed to grant the resident priority of admission over applicants for new admissions to the nursing home in violation of subsection (b) (6) (B) of this section;

(6) The nursing home failed to document the appropriate vacancy rate or hospital contacts;

(7) The nursing home charged hospitalized residents who are recipients of medical assistance for reserving their beds when the nursing home was required to reserve the bed but was ineligible for Medicaid reimbursement because it did not meet the vacancy rate requirement set forth in subsections (b) (5) (A) (i) and (b) (5) (B) (i) of this section.

(d) **Remedies**

(1) Compliance with this section shall be monitored by the Department on a post-audit basis or whenever a complaint is received. The Department is authorized to impose a penalty not greater than $8500 for each violation; and

(2) In addition, the Department shall recoup any payments made to the facility for reserve-bed days for cases in violation of requirements by setting off the amount of such payments against any other payments due the facility or by other methods.

(3) If a violation is discovered prior to payment for reserve-bed days which, because of the violation, would result in inappropriate payment, the Department may deny payment for those reserve-bed days.

(4) Prior to imposing a penalty, and/or recouping payments, the Department shall notify the nursing home of the alleged violation and the accompanying penalty and/or recoupment.

(5) The provider may appeal a decision or a finding of an alleged violation by the Department in accordance with Section 17-311-27 through Section 17-311-40 of the Regulations of Connecticut State Agencies, provided that the appeal is received on or before the fifteenth (15th) day after the receipt of notice of violation or issuance of denial.

Computation of time within which an appeal must be received by the Department shall be computed in accordance with Section 17-311-15 of the Regulations of Connecticut State Agencies, as amended from time to time. Imposition of any penalty and/or recoupment shall be stayed pending the outcome of the administrative hearing for the appeal.

(Effective March 26, 1990)

Sec. 17-134d-80. Title XIX utilization review requirements for medicaid services in general hospitals

(a) **Definitions**

For purposes of this regulation, the following definitions apply:

(1) Acute Care means the medical care needed for an illness, episode, or injury which requires short term, intense care and hospitalization for a short period of time.

(2) Admission means the formal acceptance by a hospita1 of a patient who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services.

(3) Adverse Determination means the initial negative decision by a reviewing body regarding the medical necessity, quality, or appropriateness of health care services provided or proposed to be provided to a patient.

(4) Appropriateness of Setting Review means the review of services provided or proposed to be provided to determine if the services could have been delivered safely, effectively and more economically in another setting.

(5) Criteria means the pre-determined measurement variables on which judgment or comparison of necessity, appropriateness or quality of health services may be made.

(6) Department means the State of Connecticut Department of Income Maintenance or its agent.

(7) Department's Manual means the Department's Connecticut Medical Assistance Provider Manual, which contains the Medical Services Policy, as amended from time to time.

(8) Diagnosis

(A) Admitting Diagnosis means the patient's condition which necessitated or prompted the admission to the hospital, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(B) Principal Diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care and coded using International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(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 patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(10) Evaluation means an assessment or examination in which actions and their results are measured against predetermined criteria in order to verify medical necessity, appropriateness, and quality.

(11) Free Standing Clinic means a facility providing medical or medically related clinic outpatient services or clinic off-site services by or under the direction of a physician or dentist and the facility is not part of, or related to, a hospital. Such facilities provide mental health, rehabilitation, dental and medical services and are subject to Sections 171 through 171.4 of the Department's Manual, as may be amended from time to time.

(12) General Hospital for purposes of this regulation means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries. It shall also include a border hospital as defined in Section 150.1 of the Department's Manual, as may be amended from time to time.

(13) Inpatient means a recipient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental or other health related services and is present at midnight for the census count.

(14) Medical Appropriateness means medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting.

(15) Medical Necessity means medical care provided to:

(A) Correct or diminish the adverse effects of a medical condition;

(B) Assist an individual in attaining or maintaining an optimal level of well being;

(C) Diagnose a condition; or

(D) Prevent a medical condition from occurring.

(16) Override Option means a decision, used in utilization review, when "overriding" circumstances of clinical significance justify changing the conclusion of the objective criteria.

(17) Patient means an individual who receives a health care service from a provider and is also a Medicaid recipient.

(18) Preadmission Review means a review prior to or in the case of an emergency admission, immediately thereafter, a patient's admission to a hospital to determine the medical necessity, appropriateness, and quality of the health care services proposed to be delivered, or in the case of an emergency, delivered in the hospital.

(19) Principal Procedure means the procedure most closely related to the principal diagnosis, that is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes and/or was necessary to care for a complication, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(20) Prior Authorization means approval for a service from the Department or the

Department's agent before the provider actually provides the service. In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

In the case of an emergency admission to a general hospital, prior authorization means approval obtained within two business days of admission.

(21) Quality of Care means the evaluation of medical care to determine if it meets the professionally recognized standard(s) of acceptable medical care for the condition and the patient under treatment.

(22) Recipient means an individual who has been determined eligible for Medicaid.

(23) Reliability means a measure of the consistency of a method in producing results. A reliable test gives the same results when applied more than once under the same conditions.

(24) Retrospective Review means the review conducted after services are provided to a patient, to determine the medical necessity, appropriateness, and quality of the services provided.

(25) Utilization Review means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures and facilities. Utilization review evaluates the medical necessity, and medical appropriateness of admissions, the services performed or to be performed, the length of stay and the discharge practices. It is conducted on a prospective and/or retrospective basis.

(26) Validity means a measure of the extent to which an observed situation reflects the true situation or an indication of medical quality measures what it purports to measure.

(b) **Utilization Review Program in General Hospitals**

(1) The Department's Utilization Review Program conducts utilization review activities for services delivered to general hospital inpatients, where Medicaid has been determined to be the appropriate payer.

(2) The Department's objectives for performing utilization review include:

(A) To determine the medical necessity and appropriateness of general hospital inpatient services;

(B) To assure that the quality of service meets accepted and established standards;

(C) To safeguard against unnecessary and inappropriate utilization;

(D) To effectively monitor provider patterns of utilization; and

(E) To identify inappropriate patterns and services.

(3) To evaluate services the Department through its staff or its agent, uses utilization review techniques that have withstood tests for validity and reliability. For example: Professional Activity Study (PAS) Norms, Appropriateness Evaluation Protocol (AEP), InterQual ISD Review System (Intensity of service, severity of illness discharge screens).

(4) As part of the Utilization Review process, reviewers may use an override option. The purpose of the override option is to:

(A) Allow the reviewer to indicate that the criteria are not sufficiently comprehensive to meet non-criteria circumstances or factors necessitating admission and/or hospitalization;

or

(B) Conversely, to judge that the service which meets the criteria are not justified on clinical grounds.

(5) When the Hospital Utilization Review Program makes an adverse determination on a preadmission review, the provider is notified by telephone and in writing and is given the opportunity to request a second review. The second review to present additional information, can be requested by telephone or in writing within ten (10) calendar days of the adverse determination, unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider by telephone and in writing.

(6) When the Hospital Utilization Review Program makes an adverse determination on a retrospective review providers are sent a written summary of findings by the Department. The provider is given an opportunity to request a second review and present additional information in writing, provided said request is submitted in writing to the Department within twenty (20) calendar days of the date of receipt of notice of adverse determination unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The date of receipt is presumed to be five (5) days after the date on the notice, unless there is a reasonable showing to the contrary. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider in writing.

(c) **Payment for Medicaid Services**

(1) Payment by Connecticut Medicaid is only for definitive medical care, treatment and services that are judged to be medically necessary. The Department will not pay for any principal procedure or other procedures or service of an unproven, experimental, social, educational or research nature or for service(s) in excess of those deemed medically necessary by the Department to treat the patient's condition or for services not directly related to the patient's diagnosis, symptoms or medical history.

(2) Medical care, treatment and services must be provided to eligible Medicaid recipients in accordance with the Department's policies, procedures, conditions and limitations and billed for in accordance with the billing section of the Department's Manual.

(3) Payment will be denied for hospital inpatient services, and also for physicians (including physicians in free-standing clinics), dentists, and podiatrists services provided to hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions, and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial

was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided which the Department finds not to meet the medically necessary or utilization review standard.

(d) **Requirements for Establishment of Medical Necessity**

(1) To determine that inpatient general hospital services or admissions are medically necessary, the Department or its agent:

(A) Shall require prior authorization of each general hospital inpatient admission including emergency admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such prior authorization. In addition the Department, in its discretion, may perform preadmission review and/or reviews of any or all general hospital inpatient admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such review.

(B) Shall perform retrospective reviews in the Department's discretion which may be of a random or targeted sample of general hospital admissions and services delivered. The review may be focused on the appropriateness, necessity, and quality of the health care services provided.

(2) If the Department decides to reimpose prior authorization or preadmission review requirements which it has previously notified providers it will no longer require, the Department shall notify all affected providers at least thirty (30) days in advance of the imposition of preadmission review or prior authorization requirements.

(3) All claims for payment for admission and all days of stay and services provided must be documented with the medical records required by section 150.1F.V. of the Department's Manual. Lack of said documentation itself may be adequate ground for the Department, in its discretion, to deny payment for the admission of some or all of the days of stay or services provided.

(e) **Special Requirements for Retrospective Review of Emergency Admissions When Prior Authorization Had Not Been Obtained On A Timely Basis.**

Payment for an emergency admission where prior authorization was not obtained may be made pursuant to the following:

(1) The hospital shall request retrospective review within thirty (30) calendar days of the date the patient was admitted to the hospital. The hospital may request that the Department waive the thirty (30) calendar day time limit if the hospital proves to the satisfaction of the Department that: (a) the failure to make the request within the thirty (30) day time limit was caused by reasons beyond the control of the hospital; and (b) the hospital neither knew nor had any reason to check the eligibility of the individual within the thirty (30) day time period or checked with the Department's eligibility verification unit and was given erroneous information (the "Good Cause Exception"). The total number of Good Cause Exceptions, per hospital fiscal year, shall not exceed the greater of one, or.125% (.00125) of such hospital's Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's

possession on July 1, from the Department's Medicaid Management and Information System (MMIS);

(2) The retrospective review will be done at the hospital's expense at the standard charge of the department's contractor to hospitals;

(3) For each fiscal year commencing October 1, the hospital may request, in total, retrospective reviews up to the maximum number for which it has received authorization pursuant to subsection six (6) below;

(4) The patient for whom the retrospective review is requested was an emergency admission (i.e. admitted through the emergency room or transferred from another hospital on an emergency basis due to the original hospital's inability to treat the patient due to the severity or complexity of the illness or injury). No request may be made for consideration of patients admitted directly or via transfer if the admission was not an emergency admission;

(5) The retrospective review reveals that all requirements for payment are met except for the failure to obtain prior authorization.

(6) In July of each year, the Department shall notify each hospital of the maximum number of retrospective reviews. Said number shall be one percent (1%) of its Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS).

(Effective February 24, 1993)

Sec. 17-134d-81. Policy and procedures governing the billing and payment for prescription drugs on behalf of title XIX medicaid recipients

(a) **Scope**

This regulation governs the billing and payment for prescription drugs and Pharmaceutical Services provided to persons determined eligible for such goods and services under provisions of Connecticut's Medical Assistance Program in accordance with Section 17-134d of the General Statutes of Connecticut.

(b) **Definitions**

For the purpose of Regulation Section 17-134d-81, the following definitions apply:

(1) "Average Wholesale Price" (A.W.P.) means the published wholesale price as determined by the Department from the price listed by one or more national publications recognized by the Department.

(2) "Brand Name/Trade Name" means the name assigned to a drug by the pharmaceutical innovator, i.e., manufacturer and/or distributor for the purpose of distribution to wholesalers or retailer, whether or not this name is registered in the United States Patent Office.

(3) A "Compounded Prescription" means two or more drugs mixed together and at least one ingredient must be a legend drug. A compounded prescription must include name, strength, and amount of each prescribed ingredient.

(4) "Connecticut Over-the-Counter Formulary" means the formulary of O.T.C.

(nonlegend) drugs which are reimbursable by the Department.

(5) "Department" means the Connecticut Department of Income Maintenance.

(6) "Dispensing Fee" means an amount of money paid to a pharmacist for rendering a professional service involving the preparation and dispensing of a prescribed drug order by a licensed authorized practitioner.

(7) "Documented in Writing" means that the prescription has been handwritten, typed or computer printed. Computerized systems must meet all of the requirements of the Commission of Pharmacy Regulations Chapter 382 Sections 20-164b-1 through 20-164b-11 for non-controlled drugs and Sections 21a-244-1 through 21a-244-6 for controlled drugs and as they may be amended from time to time. (Note: Record retention for all Medicaid claims extends to a five (5) year period per (g)(2) of this regulation.)

(8) "Drug Efficacy Study Implementation (DESI) Program" means the program through which the Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved indication(s).

(9) "Estimated Acquisition Cost" (E.A.C.) means the Department's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

(10) "Federal Acquisition Cost/Federal Upper Limit" (F.A.C.) means the upper limit allowable cost established and published by HCFA for those multiple source drugs which appear on HCFA's list of multiple source drugs for which upper limits have been established and as revised from time to time.

(11) "HCFA" means the Health Care Financing Administration of the United States Department of Health and Human Services.

(12) "Legend Drugs" means any article, substance, preparation or device which bears the legend: "Caution Federal Law prohibits dispensing without a prescription."

(13) "Licensed Authorized Practitioner" means any physician or other licensed practitioner who is authorized to prescribe drugs within the scope of his or her professional practice as defined and limited by Federal and State law.

(14) "Multiple-source Drug" means a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names, or both under a proprietary name and without such a name.

(15) "Nutritional Supplements" means commercially prepared products, the primary purpose of which is to treat a diagnosed deficiency or potential deficiency in the patient's diet or nutrition.

(16) "Over-the-Counter/Nonlegend Drugs" (O.T.C.) means drugs which do not require a prescription by Federal or State law (O.T.C. items are available for purchase by the general public with or without a prescription) and generally are used for persons residing in the community and is usually administered or used by the patient on the basis of self-diagnosis.

(17) "Pharmacy" means a facility licensed by the Commission of Pharmacy in the Department of Consumer Protection under Section 20-168 of the Connecticut General

Statutes, or by the appropriate regulatory body of the state in which it is located.

(18) "Prescribed Drug" means a single drug or compound or mixtures or substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that is:

(A) Prescribed by a licensed authorized practitioner within the scope of his or her professional practice as defined and limited by Federal and State law; and

(B) Dispensed by the licensed pharmacist on a written or oral prescription issued in accordance with the State Medical Practice Act and that is recorded and maintained in the pharmacist's records.

(19) "Prescription" means an order issued by a licensed authorized practitioner and documented in writing by either the practitioner or the pharmacist. In nursing homes the signed order of a licensed authorized practitioner will be accepted in lieu of a written or oral prescription. The written prescription includes:

(A) the name and address of the patient; and

(B) whether the patient is an adult or a child, or the patient's specific age; and

(C) the compound or preparation ordered; and

(D) its strength when applicable and the specific amount thereof, to be dispensed at one time; and

(E) directions for the use of the medication and any cautionary statements required; and

(F) the number of times that the prescription may be refilled, if applicable; and

(G) date of issuance; and

(H) name and address of the prescribing practitioner and his/her Drug Enforcement Act number when appropriate.

(20) "Prior Authorization" (P.A.) means approval for a service from the Department before the provider actually provides the services. In order to receive approval from the Department a provider must comply with all prior authorization requirements found in regulation. P.A. does not, however, guarantee payment unless all other eligibility requirements are met.

(21) "Usual and Customary Charge to the General Public" means a charge which will be made for the particular prescription by the provider to the patient group accounting for the largest number of non-Medicaid prescriptions. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

(c) **Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department all pharmaceutical providers must:

(1) be licensed by the appropriate regulatory body of the state in which it is located to operate a pharmacy and provide the Department with a copy of the license; and

(2) meet and maintain all applicable license requirements of Federal and State statutes and regulations; and

(3) meet and maintain all applicable Departmental enrollment requirements; and

(4) have a valid provider agreement on file which is signed by the provider and the Department upon application for enrollment into the Medicaid program and periodically thereafter as required by the Department and which is in effect for the period as stated in the agreement. The provider agreement specifies conditions and terms (Federal and State statutes, regulations and standards) which govern the program and to which the provider is mandated to adhere to in order to participate in the program.

(d) **Eligibility**

Payment for Pharmaceutical Services is available for all Medicaid eligible recipients subject to the conditions and limitation which apply to these services.

(e) **Services Covered and Limitations**

(1) Services Covered

Except for the limitations and exclusions listed below, the Department will pay for drugs which are prescribed by a licensed authorized practitioner as a result of accepted methods of diagnosis and treatment.

(2) Service Limitations

(A) Maximum Allowable Supply

The Department will not reimburse for an original prescription or refill that exceeds the supply requirement for a period of thirty (30) days not to exceed two hundred and forty (240) units except in the following instances:

(i) Prescriptions for chronic conditions or maintenance drugs shall be for at least a thirty (30) day supply not to exceed two hundred and forty (240) units unless a lesser amount is prescribed.

(ii) For prescriptions for oral contraceptives, a supply sufficient for a maximum period of three (3) months may be dispensed at any time.

(B) Refills

Payment will be made for a refill of a prescription as authorized by the licensed authorized practitioner for an acute, or chronic illness, or condition as follows:

(i) Payment will be made for the original prescription and as many refills as ordered by the licensed authorized practitioner covering a maximum period of six (6) months. This does not apply to those items which fall within the "Controlled Substance Act," that being five (5) refills or six (6) months whichever comes first as is governed by 21 U.S.C. Section 829 (b) and Section 21a-249 (h) of the Connecticut General Statutes and as they may be amended from time to time.

(ii) Payment shall be made for a refill of a prescription for oral contraceptives which may cover a maximum period of twelve (12) months, including the original filling.

(C) The Department will not pay for any nonlegend drugs for nursing home patients when these items are used in usual and customary amount of routine care and treatment; the cost of such items is included in the nursing home's daily rate as set by the Department.

(D) The Department will not pay for any nutritional supplements for nursing home patients; the cost of such items is included in the nursing home's daily rate as set by the Department.

(E) A licensed authorized practitioner may telephone prescription orders to a pharmacist. These orders must be documented in writing and countersigned or initialed by the pharmacist and must include the date of the telephone call.

(3) Services Not Covered

The Department will not pay for:

(A) Any vaccines and/or biologicals which can be obtained free of charge from the Connecticut State Department of Health Services. The Department will notify pharmacists of such vaccines and biologicals.

(B) Any drugs used in the treatment of obesity.

(C) Drugs included in the DESI program. The Department will notify providers of such drugs.

(D) Controlled Substance dispensed to Medicaid recipients which are in excess of the product manufacturer's recommendation for safe and effective use for which there is no documentation of medical justification in the pharmacy's file.

(E) Drugs for a Lock-In recipient who is not locked into the billing pharmacy.

(F) Alcoholic liquors.

(G) O.T.C.s except those on the State of Connecticut's "O.T.C. Formulary" or as otherwise provided in these regulations.

(H) Anything of an unproven, experimental or research nature.

(I) Items used for personal care and hygiene or for cosmetic purposes.

(J) Drugs not directly related to the patient's diagnosis, when diagnosis is required by the Department to be written on the prescription.

(K) Drugs solely used to promote fertility.

(L) Drugs used to promote smoking cessation.

(f) **Need for Service and Authorization Process**

(1) Need for Service

A patient's need for pharmaceutical service is indicated when a licensed authorized practitioner prescribes a legend or nonlegend drug for treatment of or prevention of an illness or condition as documented in the patient's medical record.

(2) Prior Authorization

(A) The Department will not require P.A. for certain prescribed drugs which otherwise would require P.A. when prescribed by a licensed authorized practitioner for certain specified diagnoses The diagnoses must be written on the prescription either by the authorized practitioner, or the pharmacist, after verification with the prescriber. The Department will notify providers of such medications with the corresponding diagnosis and diagnosis indicator.

The following drugs require prior authorization for all patients:

(B) Any prescribed nonlegend (O.T.C.) medication or its equivalent used in the treatment of specific condition and which does not appear on the Connecticut's "O.T.C. Formulary," or on the NDC/Diagnosis cross reference list with an appropriate diagnosis indicator (see (f) (2) (A)).

(C) All Vitamins, except pediatric vitamins for children prior to the child's seventh birthday, vitamins with fluoride and Legend Hematinic alone or in combination with vitamins, or any product so specified by the manufacturer as a hematinic.

(D) Nutritional supplements (not covered under (f) (2) (A)).

(E) Amphetamines, amphetamine-like drugs (not covered under (f) (2) (A)).

(3) Authorization Procedures

(A) Prior authorization for prescribed drugs is obtained by submitting the Department's P.A. form, "Authorization Request and Bill for Prescription Drugs" to:

Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
Attention: Medical Unit

(B) Prior authorization will be approved covering a maximum of a three (3) month period. The effective starting date will be the date service is initially rendered and approved. If the need for service exceeds the authorization period, a request for an extension must be submitted on a form provided by the Department and approved prior to the onset of the period of extension. The request is sent to the Department with documentation by the physician that the medication continues to be medically necessary.

(C) A pharmacist receiving a prescription for medication requiring prior authorization must complete the pharmacy section of the P.A. form. The licensed authorized practitioner (prescriber) must complete all relevant portions of the P.A. form. The pharmacist will then submit the request to the Department for consideration.

(D) In emergency situations, the pharmacist may telephone the Department to obtain verbal authorization. The written request for authorization must be submitted to the Department within fifteen (15) working days following verbal authorization.

(E) In emergency situations, which occur after normal working hours, the pharmacist must call the Department for verbal approval on the following work day. The written request for authorization must be submitted to the Department within fifteen (15) working days following the date the medication was dispensed.

(g) **Other**

(1) Information Required on Prescriptions

All prescriptions must be processed in accordance with the regulations of the Commission of Pharmacy.

(2) Retention of Prescriptions

All claims for covered drugs must be substantiated by a prescription from a licensed authorized practitioner on file in the pharmacy supplying the service, in accordance with Section 20-184c of the Connecticut General Statutes. In addition, documentation of prescriptions and/or medication orders must be retained by the pharmacy for a period of five (5) years or if any dispute arises concerning a prescription, until such dispute has been finally resolved.

(3) Patient Profile

A patient profile record listing prescriptions must be maintained by the pharmacy for Title XIX patients.

(4) Oral Prescriptions

An oral prescription which is telephoned by a licensed authorized practitioner to a pharmacist must be documented in writing by the pharmacist for his records. These orders must be countersigned or initialed by the pharmacist and must meet the requirements as contained in Section 20-184b of the General Statutes and as it may be amended from time to time.

(h) **Billing**

Bills for covered drugs from pharmacy providers, are submitted on the Pharmacy Claim form or electronically transmitted to the Department's billing fiscal agent and must include all information required by the Department to process the claim for payment.

(i) **Payment**

(1) Payment for Legend Drugs

Except for vaccine(s) utilized in mass inoculation, payment for legend drugs shall be based on the quantities set forth in A.W.P. for one hundred units, a pint if liquid or pound if powder, or as determined by the Department. Reimbursement will be made under E.A.C. or F.A.C., whichever is applicable to the particular drug dispensed plus the dispensing fee, or the usual and customary charge to the general public, whichever is lower.

The Department will pay for mass inoculation of Influenza, Pneumovax or Hepatitis-B vaccine(s) provided they are prescribed by a licensed authorized practitioner and documented in the patient's medical record. The reimbursable amount and reimbursement procedures will be determined by the Department and supplied to providers via a fee schedule.

(A) Estimated Acquisition Cost

The Department of Income Maintenance must determine an E.A.C. for all legend drugs not covered by the F.A.C.

(i) The Department's E.A.C. will be the Department's best estimate of the price generally and currently paid by providers for a drug marketed and sold by a particular manufacturer or labeler in the package size of drugs most frequently purchased by providers. E.A.C. will be set at a percentage of A.W.P. The Department will notify providers in the event that the Department's best estimate of the appropriate percentage changes.

(ii) The Department shall reimburse providers at the lower of the following:

a. The Department's E.A.C. plus the applicable dispensing fee; or

b. The provider's usual and customary charge to the general public; or

c. The amount billed by the provider.

(B) Multiple-source Drugs

For each multiple-source drug for which HCFA has identified and designated a F.A.C., reimbursement shall be the lower of the following:

(i) The F.A.C. as established by HCFA plus the applicable dispensing fee; or

(ii) The provider's usual and customary charge to the general public; or

(iii) The amount billed by the provider.

(C) Certification of Brand Name Drugs

Reimbursement for multiple-source drugs for which HCFA has designated a F.A.C. is not limited to the F.A.C. if a licensed authorized practitioner determines that a specific brand is medically necessary for a particular patient, provided the following requirements are met:

(i) A licensed authorized practitioner may certify in writing that there shall be no substitution for a specified brand name drug product prescribed for a particular patient, by writing the phrase "Brand Medically Necessary," on the prescription form. The phrase shall be in the practitioner's handwriting and shall not be preprinted, stamped, initialed, or checked off in a box on such form.

(ii) If the licensed authorized practitioner specifies by telephone that there shall be no substitution, handwritten certification bearing the phrase "Brand Medically Necessary," must be mailed to the pharmacy within ten days. The written certification must be kept by the pharmacist as part of his or her permanent records.

(D) Compounded Prescriptions

The Department will pay for compounded prescriptions at the lower of:

(i) The E.A.C. or F.A.C., whichever is applicable to the given drug, for each ingredient plus an applicable dispensing fee; or

(ii) The provider's usual and customary charge to the general public; or

(iii) The amount billed by the provider.

(E) Unit Dose Packaging

The Department will not pay providers for unit dose packaging or any other specially packaged drugs when standard packages are available and/or where the special packaging is strictly for convenience and does not contribute to the therapeutic benefit of the drug.

(2) Payment for Nonlegend Drugs

(A) The Department of Income Maintenance will pay for all O.T.C. drugs listed on the Connecticut O.T.C. Formulary, provided they are prescribed for a specific illness and/or condition by a licensed authorized practitioner.

(i) The reimbursable amount shall be established by the Commissioner. The Department will publish the reimbursable amounts via a fee schedule.

(ii) The Commissioner shall appoint a committee to periodically review the drugs listed on the Connecticut O.T.C. Formulary. Periodically a report of the committee's recommendations will be submitted to the Commissioner for consideration. The committee may include one or more of the following; a physician, a pharmacist and a nurse consultant.

(iii) For any non-legend drug prescribed in less than the standard packaged amount, the Department will pay for the contents of the full package size which is closest to the amount ordered and still be sufficient to supply the amount prescribed.

(3) Dispensing Fees

Dispensing fees will be established by the Department after periodic review of pharmacy operational cost. Pharmacy providers will be advised of such fees and any changes.

(4) Substitution of generically Equivalent Drugs

(A) The Department will pay a pharmacist a professional dispensing fee of fifty cents ($.50) per prescription in accordance with Section 17-134q of the Connecticut General Statutes in addition to any other dispensing fee, for substituting a generically equivalent drug product, in accordance with Section 20-185b of the Connecticut General Statutes, for the drug prescribed by the licensed authorized practitioner for a Medicaid recipient, except in the following instances:

(i) When a drug product is dispensed for which HCFA has designated a F.A.C.; or

(ii) When a compounded prescription is dispensed; or

(iii) When a nonlegend drug is dispensed; or

(iv) When the substitution is required by Federal law or regulation.

(Effective July 29, 1992)

Sec. 17-134d-82. Requirements for payment of case management services

(a) **Scope**

These regulations set forth the requirements for payment of Case Management Services provided by the State of Connecticut Department of Mental Retardation to persons determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17-134d of the General Statutes of Connecticut.

(b) **Definitions**

For the purposes of Regulation Section 17-134d-82, the following definitions shall apply:

(1) "Case manager" means the person responsible for assisting an eligible person to gain access to needed services, managing the development of a plan of services, securing and coordinating needed services, monitoring an eligible person's progress, maintaining family contact, collecting or disseminating data and information.

(2) "Case management services" means a continuum of supportive activities systematically carried out by an individual case manager that are available to assist and enable an eligible person to gain access to needed medical, social, educational, or other services.

(3) "Calendar quarter" means the periods of time in any state fiscal year inclusive of July 1 through September 30; October 1 through December 31; January 1 through March 30; and April 1 through June 30.

(4) "Department" means the State of Connecticut Department of Income Maintenance.

(5) "Eligible person" means a person who qualifies to receive services under the Connecticut Medical Assistance Program pursuant to Section 17-134b of the General Statutes of Connecticut, as amended from time to time, and regulations promulgated pursuant to Section 17-134d of the General Statutes of Connecticut.

(6) "Needed services" means any medical, social, educational, or other services identified as required by an eligible person in a plan of services.

(7) "Plan of services" means a written document which is developed by a team on an annual basis that identifies an eligible person's unique characteristics, needs, needed services, and public agencies or private entities that will provide or may provide the needed

services.

(8) "Representative" means any person, organization, or entity authorized to act on the behalf of an eligible person through an agreement, or a family member, or a court appointed delegate of the eligible person pursuant to provisions in the General Statutes of Connecticut, as amended from time to time.

(9) "Target group" means those eligible persons specified by the Department to receive case management services by age, type or degree of disability, illness or condition, or any other identifiable characteristics, or geographic areas or political subdivisions, or combination thereof.

(10) "Team" means a group of persons which consists of the case manager and shall include one or more of the following: the eligible person or his representative; actual or potential providers of needed services; pertinent professionals from various disciplines; and any other persons whose participation is relevant who convene to develop or review a plan of services.

(c) **Provider Participation**

In order to participate in the Connecticut Medical Assistance Program and receive payment from the Department for the case management services rendered, the Department of Mental Retardation shall:

(1) Provide case management services pursuant to all applicable provisions under federal and state statutes and regulations promulgated thereunder;

(2) Meet and maintain all Department provider enrollment requirements;

(3) Have a valid Connecticut Medical Assistance Program provider agreement on file with the Department which is signed by the Department of Mental Retardation Commissioner or the Commissioner's designee. The provider agreement will be effective upon the Department approved date of enrollment. The provider agreement specifies conditions and terms (Federal and State regulations, standards and statutes) which govern the Connecticut Medical Assistance program and to which the Department of Mental Retardation is mandated to adhere to in order to participate in the program; and

(4) Assign an individual case manager to serve as the primary person responsible for case management services.

(5) Pursuant to subsection (f) (2) below a case manager is limited to qualified case managers designated by the Department of Mental Retardation.

(d) **Eligibility**

Payment for case management services is available only on behalf of all persons specified as members of a target group pursuant to subsection (f) (1) below who are eligible to receive services pursuant to the Connecticut Medical Assistance Program subject to conditions and limitations which apply to such case management services.

(e) **Services Covered**

Covered case management services may include a continuum of supportive activities performed by an individual case manager which enable an eligible person to gain access to needed services. At a minimum, such case management services shall include one or more

of the following types of case management activities in a calendar quarter:

(1) Case advocacy to enable an eligible person to make his preferences known, to ensure the smooth flow of information and minimize conflict between service delivery systems and to mobilize resources to obtain or access needed services;

(2) Collaboration through direct or collateral contacts with an eligible person or his representative to support a person-or family-centered planning process for development and maintenance of a plan of services;

(3) Coordinating or attending team meetings to develop or revise a plan of services;

(4) Liaison activities to arrange for assessments that may be necessary to determine an eligible person's needed services;

(5) Coordination of a plan of services through direct or collateral contacts with the eligible person or his representative, members of their informal support networks, and public or private entities that provide or may provide needed services;

(6) Monitoring the quality and quantity of needed services that are being provided as they relate to an eligible person's needs, plan of services, and safety;

(7) Providing information and referral; and

(8) Review and maintenance of an eligible person's plan of services.

(f) **Limitations**

(1) Target Group Limitations

Payment for case management services is limited to case management services provided to eligible persons with mental retardation as defined in the General Statutes of Connecticut Section 1-1g and to eligible persons with conditions related to mental retardation as defined in subsection (e) (7) (G) (ii) of section 1919 of the Social Security Act and implementing federal regulations, as amended from time to time, who receive case management services from the Department of Mental Retardation pursuant to subsection (f) (2) below.

(2) Provider Limitations

(A) For eligible persons with mental retardation or with conditions related to mental retardation the Department of Mental Retardation shall be the sole entity enrolled with the Department to provide case management services to eligible persons and to enter into a provider agreement with the Department for the provision of such services.

(B) For eligible persons with mental retardation or with conditions related to mental retardation qualified case managers are limited to case managers designated to render services to said persons by the Department of Mental Retardation in accordance with the General Statutes of Connecticut and rules regarding provision of services adopted by said agency, as amended from time to time.

(3) Payment Limitations

(A) Payment for case management services will be made only when the eligible person or his representative has requested or applied to receive services from the Department of Mental Retardation.

(B) Payment for case management services may not duplicate payments made under the Connecticut Medical Assistance Program for other services that are covered under the

program. Specifically, separate payment for case management services is not available when the same case management service is provided as an integral and inseparable part of another Connecticut Medical Assistance program covered service, including as part of intermediate care facility services for the mentally retarded (ICF/MR).

(C) Payment for case management services by the Department will not be made unless one or more of the case management activities pursuant to subsection (e) above are rendered in a calendar quarter.

(g) **Need for Services**

Payment for case management services will be made by the Department only if the eligible person evidences a need for case management services. If the eligible person meets the requirements to receive services from the Department of Mental Retardation in accordance with the General Statutes of Connecticut and rules regarding provision of services adopted by said agency, as amended from time to time, the eligible person evidences a need for case management services.

(h) **Documentation Requirements**

Case management services will be reimbursed by the Department only when the following requirements are documented and are on file with the Department of Mental Retardation:

(1) Plan of Services Requirement

Case management services are provided in accordance with the eligible person's plan of services. At a minimum, the plan shall:

(A) Be developed by a team based upon the outcome of a team meeting conducted at least annually or more frequently if needed; and

(B) Be based on a uniform assessment, in accordance with the Department of Mental Retardation's regulations or policies as amended from time to time, of an eligible person's needs which may include: assessments of medical, social, educational and other needs;

(C) Be reviewed and followed by the case manager;

(D) Indicate that the eligible person or his representative has participated in, or has been given the opportunity to participate in, the development of the eligible person's plan of services;

(E) Identify issues, needs, and goals relevant for the eligible person for the coming year;

(F) Identify the needed services required by an eligible person and the anticipated frequency, duration, and limitations of needed services;

(G) Indicate the case management services needed, and the anticipated frequency, duration, and limitations of case management services; and

(H) Indicate the various public agencies or private entities that will or may provide the needed services as identified by the team.

(2) Permanent Service Record

An individualized permanent service record for an eligible person must be maintained. At a minimum, the record shall contain the following:

(A) The eligible person's name, address, and other relevant historical and financial

information;

(B) Assessments of the eligible person performed as necessary, to determine needed services;

(C) A plan of services pursuant to subsection (h) (1) above;

(D) Signed monthly service entries indicating the date, place of service, and type of case management services rendered; and

(E) A quarterly summary progress note reviewing the eligible person's needs and the plan of services which is dated and signed by the case manager.

(3) Other Documentation Requirements

All documentation shall be incorporated into the eligible person's permanent service record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by federal statute.

(i) **Billing Requirements**

All bills submitted to the Department for payment of case management services must be substantiated by documentation in the eligible person's permanent service record pursuant to subsection (h) above.

(j) **Payment**

Payment by the Department for case management services rendered to eligible persons shall be based on the Department of Mental Retardation's actual direct and indirect costs to provide case management services. Said costs shall be filed at the end of each state fiscal year with the Department by the Department of Mental Retardation.

For each state fiscal year the Department shall establish a payment rate based upon the said costs for the previous state fiscal year which shall be updated for inflation, using the most recent estimates of the price deflator for the gross national product as published in February of said state fiscal year in the "Economic Report of the Governor" of the State of Connecticut.

(k) **Audit**

All supporting accounting and business records, statistical data, and all other records relating to the provision of case management services paid for by the Department shall be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowableness of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the Department of Mental Retardation, the Department's payment rate for the said rate period shall be subject to adjustment.

(Effective August 31, 1990)

Sec. 17-134d-83. Policy and procedures governing oxygen therapy on behalf of Title XIX medicaid recipients

(a) **Scope**

Section 17-134d-83 through Section 17-134d-85 of the regulations of Connecticut State Agencies governs the billing and payment for Oxygen Therapy provided to persons determined eligible for such goods and services under the provisions of Connecticut's

Medical Assistance Program in accordance with Chapter 302 of the General Statutes of Connecticut.

(b) **Definitions**

For the purpose of Regulation Section 17-134d-83 through Section 17-134d-85, the following definitions apply:

"Ambulatory" means an individual who is independently mobile or wheelchair mobile and is able to participate in the active daily living available to them in their living environment.

"Chronic Disease Hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases as licensed by the Department of Health Services.

"Department" means State of Connecticut Department of Income Maintenance.

"Home" means the recipient's place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital or long-term care facility.

"Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions licensed by the Department of Health Services and includes inpatient psychiatric services in general hospitals.

"Long-Term Care Facilities" (LTC) are institutions licensed and certified under State law which have a provider agreement with the Department of Income Maintenance to provide a variety of medical, personal care, rehabilitative, and social services for recipients of Medical Assistance who are afflicted with acute, chronic or convalescent diseases or injuries or who because of their mental or physical condition require health-related care and services above the level of room and board which can be provided only through an institutional setting. These facilities include nursing facilities licensed as chronic and convalescent nursing homes, rest homes with nursing supervision and intermediate care facilities for the mentally retarded (ICFs/MR).

"Medical Equipment, Devices and Supplies" (MEDS) means Durable Medical Equipment, Medical Surgical Supplies, Orthotic and Prosthetic Devices and Oxygen Therapy.

"Oxygen Concentrator" means an electrically operated device that draws room air, separates the oxygen from the other gases in the air, and delivers the oxygen at high concentrations to the patient.

"Oxygen Therapy" means oxygen, equipment, supplies and services related to the delivery of oxygen.

"Oxygen Therapy Supplies" means all supplies needed for an oxygen system to function; such as cannula or mask, tubing, regulator with flow gauge and container.

"Portable Oxygen System" means oxygen in a portable unit which weighs less than 12 lbs. allowing the user greater ambulatory capability.

"Prescription" — The Certification of Medical Necessity form (Medicare Form HCFA-484) shall be the prescription form used for all oxygen therapy orders. This fully completed

form signed by the prescribing physician will be the only acceptable initial certification form for oxygen services.

"Prior Authorization" (P.A.) means approval for a service from the Department of Income Maintenance *before* the provider actually provides the service. In order to receive approval from the Department a provider must comply with all prior authorization requirements found in Section 17-134d-84 (b) and (c). P.A. does not guarantee payment unless all other eligibility requirements are met. Payment may not be made, however, if P.A. is required and not obtained.

"Provider" means the vendor/supplier of oxygen therapy who is enrolled with the Department as a MEDS supplier or supplier of oxygen therapy.

"Pro Re Nata" (P.R.N.) means as the situation demands.

"Psychiatric Hospital" means a facility that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons and which has been accredited by the Joint Commission on Accreditation of Hospitals.

"Usual and Customary Charge to the General Public" means a charge which will be made for the particular service by the provider to the patient group accounting for the largest number of non-Medicaid services. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

(c) **Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department all MEDS providers must:

(1) meet and maintain all applicable licensing and certification requirements of Federal and State statutes and regulations; and

(2) meet and maintain all Departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the Department upon application for enrollment into the Medicaid program and periodically thereafter as required by the Department and which is in effect for the period as stated in the agreement. The provider agreement specifies conditions and terms (Federal and State statutes, regulations and standards) which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(d) **Eligibility**

Payment for oxygen therapy is available for all Medicaid eligible recipients who have a documented medical need, when it is prescribed by a physician subject to the conditions and limitations which apply to these services.

(e) **Services Covered**

(1) Except for the limitations and exclusions for oxygen therapy listed below, the Department will pay in accordance with Regulation Sections 17-134d-83 through Section 17-134d-85 for oxygen therapy in accordance with sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual Chapter

II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual, and as these may be amended from time to time.

(2) Payment for oxygen products and services via oxygen concentrators in LTC facilities shall be included in the per diem reimbursement rate established by the Commissioner of Income Maintenance. (LTC facilities must purchase oxygen concentrators in sufficient numbers to meet the needs of their residents and may have up to one reserve unit for each nursing station. These requirements supplement the emergency system required in the Public Health Code, as applicable.)

(f) **Service Limitations**

Services covered are limited to those listed in the Department's fee schedule.

(g) **Oxygen Therapy Services Not Covered**

The Department will not pay for:

(1) Anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms or medical history.

(2) Oxygen therapy supplied to hospital inpatients including Chronic Disease and Psychiatric Hospitals are routine services and are included in the hospital daily rate.

(3) The P.R.N. use of oxygen therapy.

(4) Oxygen concentrators in long-term care facilities.

(A) The purchase of oxygen concentrators are included in the LTC facilities' per diem rate and thereby are available to nursing facility residents.

(B) LTC facilities with built in wall oxygen systems are exempt from the requirements pertaining to purchase of oxygen concentrators. Concentrators may not be used for P.R.N. oxygen therapy in a facility with this type of oxygen system.

(5) Information furnished to the recipient over the telephone by the provider or prescribing physician.

(6) Demurrage, delivery, or set up charges.

(Effective May 27, 1992)

Sec. 17-134d-84. Policy and procedures governing the need for service for oxygen therapy on behalf of Title XIX medicaid recipients

(a) **Need for Services**

The Department will pay for oxygen therapy for any recipient who meets the criteria established by Medicare pursuant to sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual, Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual, and as they may be amended from time to time. This includes all medical criteria including medical documentation, laboratory and health conditions, with the exception of (a) (1) and (2) of this section.

(1) A measure of arterial oxygen saturation obtained by ear or pulse oximetry, will also

be acceptable when ordered and evaluated by the attending physician *and* performed under his/her supervision or when performed by a Licensed Nurse, Physician, a licensed supplier of Laboratory services, a Registered Respiratory Therapist or a Certified Respiratory Therapy Technician as recognized by the National Board Of Respiratory Care.

(2) Those recipients residing in the home and receiving oxygen therapy prior to the effective date of this regulation may continue to do so as long as the oxygen therapy is continuous. For the purpose of this provision continuous means that oxygen therapy remains necessary and is actively being used by the recipient at the beginning of every rental month. If at anytime the service is discontinued and is prescribed again at a later time the requirements set forth under Sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual, Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual and as they may be amended from time to time must be met. All residents of longterm care facilities must meet the requirements as set forth in the Medicare Carrier's Manual, Chapter II, Coverage and Limitations, section 2100.5; and as they may be amended from time to time; effective upon passage of these regulations in order to receive oxygen therapy services from a MEDS provider. Oxygen concentrators owned by nursing facilities may be used at the discretion of the nursing facility.

(3) Prescription Requirements

The Certification of Medical Necessity form (Medicare Form HCFA-484) shall be used for all orders of oxygen therapy. This fully completed form must be signed by the prescribing physician. The form shall be completed (1) annually for patients who require oxygen on a lifetime basis, and (2) every six (6) months for all other patients requiring oxygen.

(b) **Prior Authorization**

Prior authorization is required only for the rental of stationary gaseous or liquid oxygen systems in LTC facilities. However, if LTC facilities choose to purchase the stationary systems and include the cost in the per diem rate calculation, prior authorization is not required.

(c) **Prior Authorization Procedure**

Provision of service must be initiated within six (6) months of the date of authorization.

(1) Form W-619 "Authorization Request for Professional Services" is used to obtain prior authorization. The form must be completed and signed by the prescribing physician and the supplier and is submitted to the Department.

(2) Authorization Period

The initial authorization period for oxygen therapy can be up to 6 months. If the medical need continues beyond the initial authorization period, a request for the extension of the authorization using Form W-619 must be submitted to the Department with documentation by the attending physician, prior to expiration of the authorized period, that service continues to be medically necessary.

(3) The provider of service may request verbal approval from the Department during

normal working hours, when such authorization may be given for initial service coverage. Authorization will be based on the Need for Service criteria as described in Section 17-134d-84 subsection (a). A completed prior authorization form must then be submitted to the Department within fifteen (15) working days stating the name of the consultant giving verbal approval and date approval was given.

(d) **Other**

(1) It will be the Department's decision to rent or purchase oxygen equipment and supplies except in cases where Medicare is the primary insurance carrier.

(2) All equipment purchased by the Department shall be new.

(3) All equipment purchased by the Department for a recipient will be the property of the recipient upon receipt by the recipient or her/his representative.

(4) The provider will furnish technical assistance to the recipient to teach the recipient and/or his or her family in the proper use and care of the equipment.

(5) Used equipment, when rented, must be completely refurbished and in proper condition to meet the recipient's specific medical need.

(6) Subject to the aforementioned limitations, exclusions, and definitions, oxygen therapy may be provided to eligible recipients in:

(A) Recipient's home;

(B) Long-term care facilities (LTC facilities will provide oxygen concentrator services to the fullest extent, possible after considering the patient's medical need and capability to ambulate. Only after these considerations have been satisfied and the need for alternative system has been documented will the Department pay a MEDS provider for oxygen services provided to LTC facility residents.)

(7) All required documentation must be maintained for at least five (5) years in the provider's file subject to review by the authorized Department personnel. This requirement survives any intervening change of ownership. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or 5 years whichever is greater.

(8) For residents of long term care facilities proper documentation for the coverage of a portable oxygen system for a particular ambulatory patient must be maintained by both the facility and the provider. The supplier should secure from the LTC facility such documentation for their records.

(9) Failure to maintain all required documentation may result in the disallowance and recovery by the Department of any amounts paid out for which the required documentation is not maintained and provided to the Department upon request.

(Effective May 27, 1992)

Sec. 17-134d-85. Policy and procedures governing the billing and payment for oxygen therapy on behalf of title XIX medicaid recipients

(a) **Billing Procedure**

(1) Form H.C.F.A. 1500 "Health Insurance Claim Form" is used to bill for oxygen

therapy. The bill is mailed to the Department's claims processing agent.

(2) All claims submitted for payment which include prior authorized items must include the authorization number from the current authorization.

(3) All claims submitted for services not requiring prior authorization must include the name of the prescribing physician.

(4) The provider shall enter its usual and customary charge on the claim form.

(b) **Payment**

Payment for oxygen therapy will be made at the lower of:

(1) the usual and customary charge to the public, or

(2) the amount as contained in the fee schedule as published by the Department, or

(3) the amount billed by the provider.

(c) **Payment Rate for Oxygen Therapy**

The Commissioner of Income Maintenance establishes the oxygen therapy rate as contained in the Department's fee schedule.

(d) **Payment Limitations**

(1) All prices quoted for equipment and services include delivery costs fully prepaid by the provider, F.O.B. destination; no additional charges are to be made for packing, shipping, or delivery to the recipient.

(2) If the estimated cost of repairs to any equipment exceeds replacement cost, the item will be replaced.

(3) Payment for repairs or replacement of equipment which is purchased by the Department is contingent upon any unexpired manufacturers or dealer warranties. The supplier must first utilize existing warranties covering such servicing, repairs, and replacement.

(4) The cost of oxygen therapy includes all services and supplies necessary including, but not limited to: (1) installation and/or set up of prescribed equipment; (2) teaching and training the recipient, recipient's family, and long-term care facility professional staff in the use and care of the equipment as shall be necessary; (3) oximetry test.

(5) The rental fee for the delivery of oxygen therapy includes a nasal cannula, mask, and disposable humidifier as needed.

(Effective May 27, 1992)

Sec. 17-134d-86. Medicaid payment for general hospital outpatient emergency and non-emergency visits to a hospital emergency room and outpatient clinic visits

(a) **Definitions**

(1) "Department" means The State of Connecticut Department of Income Maintenance or its agent.

(2) "Emergency room" means that part of a general hospital that is designed, organized, equipped, and staffed to provide initial diagnosis and treatment of patients requiring immediate physician, dental, or allied services.

(3) "Emergency visit" means an urgent encounter requiring the immediate decision-

making and medically necessary action to prevent death or any further disability for patients in health crises (including labor and delivery). Such medical conditions are manifested 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 patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In order to be considered urgent, the encounter must occur within seventy-two (72) hours from the onset of the presenting medical condition.

(4) "General hospital" means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries.

(5) "Medically necessary" means medical care provided to:

(A) Correct or diminish the adverse effects of a medical condition;

(B) Assist an individual in attaining or maintaining an optimal level of well being;

(C) Diagnose a condition; or

(D) Prevent a medical condition from occurring.

(6) "Non-emergency visit" means a medically necessary non-urgent encounter presenting a medical condition which does not meet the requirements for an emergency visit as defined in this section but, rather, requires a routine level of ambulatory health care. Such conditions may be characterized by the fact that they may also be treated in an alternate health care setting, such as: community-based physician's office, walk-in clinic, comprehensive health center, neighborhood health center and other free-standing primary health care clinics because such medical conditions do not require the skills, resources and equipment of a hospital emergency room. Such visits may include primary health care or the initial diagnosis and treatment of routine acute or chronic illnesses whether on a scheduled or unscheduled basis.

(7) "Outpatient" means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does not receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

(8) "Outpatient clinic visit rate" means the rate set by the Department using the methodology as required by subsection 17-312 (d) of the General Statutes of the State of Connecticut.

(b) **Payment**

(1) The Department shall pay general hospitals for each outpatient clinic visit at the outpatient clinic visit rate not to exceed the charges made by such hospital for comparable services to the general public.

(2) The Department shall pay all non-emergency visits to a general hospital emergency room at the hospital's outpatient clinic visit rate but not to exceed the charges made by such

hospital for comparable services to the general public.

(3) There is no payment for emergency room services provided on the same day as an inpatient admission for the same recipient.

(4) Emergency Room Visit Rate

(A) The rate for an emergency room visit is calculated by the Department effective July 1st of each year.

(B) Payment for emergency visits to the emergency room shall be calculated as follows: Hospital emergency room costs must be submitted in writing under oath by each hospital by June 1st annually on forms acceptable to the Department. Each hospital's cost is adjusted by the lesser of: (i) the percent of change in its own emergency room costs over the last four years; or (ii) the percent of change in the emergency room costs for all hospitals for the same period. The rate authorized by the Department shall be the lower of the hospital's adjusted cost, as set forth above, or the rate calculated at the 66⅔ percentile of the statewide adjusted cost for all hospitals, ranked in ascending order.

(C) A hospital emergency room visit includes a facility cost component and a professional cost component.

(D) Each hospital may annually elect to have the rate for its facility component and professional component determined separately or with the components combined. Said election shall be made at the time the emergency room costs are filed with the Department in accordance with subsection (b) (4) (A) and (B) of this regulation.

(5) The Department shall pay general hospitals for each emergency room visit at the rate authorized herein not to exceed the charges made by such hospital for comparable services to the general public.

(Effective September 25, 1990)

Sec. 17-134d-87—17-134d-90. Reserved

Sec. 17-134d-91. Repealed

Repealed May 10, 2000.

Title XIX Inpatient Psychiatric Hospital Services

Sec. 17-134d-92—17-134d-102. Repealed

Repealed March 6, 1998.

Sec. 17-134d-103—17-134d-138. Reserved

Requirements for Payment of Case Management Services for Persons with Chronic Mental Illness

Sec. 17-134d-139. Scope

Sections 17-134d-140 to 17-134d-149 inclusive set forth the requirements for payment

of Case Management Services provided by the State of Connecticut Department of Mental Health to persons determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17-134d of the General Statutes of Connecticut.

(Effective February 23, 1993)

Sec. 17-134d-140. Definitions

For the purposes of Regulation Sections 17-134d-139 through 17-134d-149, the following definitions shall apply:

(a) "Case Manager" means the person employed by the Department of Mental Health or performing provider responsible for assessing the eligible person's needs, developing a plan of services with the eligible person and others to meet those needs, linking the eligible person to the services identified in the plan of services, supporting and monitoring the eligible person in the utilization of the identified services, advocating on the eligible person's behalf and maintaining client files and recording services provided.

(b) "Case Management Services" means the continuum of assessment, planning, linkage, support and advocacy activities systematically carried out by an individual case manager that are available to assist and enable an eligible person to gain access to needed medical, clinical, social, educational or other services.

(c) "Collateral Contact" means a contact with other individuals/agencies within the person's natural support networks.

(d) "Department" means the State of Connecticut Department of Income Maintenance.

(e) "Eligible Person" means a person who qualifies to receive services under the Connecticut Medical Assistance Program pursuant to Section 17-134b of the General Statutes of Connecticut, as amended from time to time, and regulations promulgated pursuant to Section 17-134d of the General Statutes of Connecticut.

(f) "Needed Services" means any medical, clinical, social, educational or other services identified as required by an eligible person in a plan of services.

(g) "Performing Provider" means any designated grantee agency, or other entity employed by the Department of Mental Health in the delivery of case management services to eligible persons.

(h) "Plan of Services" means a written document which is developed on an annual basis identifying an eligible person's unique set of needed services and the public or private entities that will or may provide those services.

(i) "Representative" means any person, organization or entity authorized to act on behalf of an eligible person through an agreement, or, a family member of court appointed delegate of the eligible person pursuant to provisions in the General Statutes of Connecticut, as amended from time to time.

(j) "Target Group" means those eligible persons who are part of the target population of the Department of Mental Health as defined in Department of Mental Health policy and amended from time to time.

(Effective February 23, 1993)

Sec. 17-134d-141. Provider participation

In order to participate in the Connecticut Medical Assistance Program and receive payment from the Department for the case management services rendered, the Department of Mental Health shall:

(1) provide case management services directly or via its performing providers pursuant to all applicable provisions of federal and state statutes and regulations promulgated thereunder;

(2) meet and maintain all Department provider enrollment requirements;

(3) have a valid Connecticut Medical Assistance Program provider agreement on file with the Department which is signed by the Department of Mental Health Commissioner or the Commissioner's designee. The provider agreement will be effective upon the Department approved date of enrollment. The provider agreement specifies conditions and terms (federal and state regulations, standards and statutes) which govern the Connecticut Medical Assistance Program and to which the Department of Mental Health is mandated to adhere in order to participate in the program;

(4) assign an individual case manager to serve as the person primarily responsible for case management services or assure that an individual case manager is assigned by one of its performing providers; and

(5) insure that, pursuant to subsection 17-134d-144 (b) below, a case manager is an individual employed by the Department of Mental Health or one of its performing providers.

(Effective February 23, 1993)

Sec. 17-134d-142. Eligibility

Payment for case management services is available only on behalf of all persons specified as members of the target group, pursuant to subsection (a) of 17-134d-144, who are eligible to receive services pursuant to the Connecticut Medical Assistance Program subject to conditions and limitations which apply to such case management services.

(Effective February 23, 1993)

Sec. 17-134d-143. Services covered

Case management services may include the continuum of activities systematically carried out by an individual case manager that are available to assist and enable an eligible person to gain access to needed medical, clinical, social, educational or other services. At a minimum, such case management services shall include the provision of one or more of the following types of case management activities, through either direct or collateral contact, in a calendar month:

(1) assessing the eligible person's needs;

(2) developing a plan of services with the eligible person and others to meet those needs;

(3) linking the eligible person to the services identified in the plan of services;

(4) supporting and monitoring the eligible person in the utilization of the identified services; and

(5) advocating on the eligible person's behalf.

(Effective February 23, 1993)

Sec. 17-134d-144. Limitations

(a) **Target Group Limitations**

(1) Payment for case management services is limited to case management services provided to eligible persons with chronic mental illness as defined in the Department of Mental Health target population definition, as amended from time to time.

(b) **Provider Limitations**

(1) For eligible persons with mental illness, the Department of Mental Health shall be the sole entity enrolled with the Department to provide case management services to eligible persons and to enter into a provider agreement with the Department for the provision of such services.

(2) For eligible persons with mental illness, qualified case managers are limited to case managers designated to render services to said persons by the Department of Mental Health. Such providers are limited to programs operated by the Department of Mental Health or its performing providers.

(c) **Payment Limitations**

(1) Payment for case management services will be made only when the receipt of said services occurs at the option of the eligible person or their representative.

(2) Payment for case management services may not duplicate payments made under the Connecticut Medical Assistance Program for other services which are covered under the program. Specifically, separate payment for case management services is not available when the same case management service is provided as an integral and inseparable part of another Connecticut Medical Assistance Program covered service or included as part of a Medicaid funded service, including but not limited to the following: outpatient clinic services; partial hospital services; emergency crisis intervention services; inpatient services; substance abuse treatment services; psychiatric/psychological evaluation; individual therapy; group therapy; or; family therapy.

(3) Payment for case management services by the Department will not be made unless one or more of the case management activities pursuant to Section 17-134d-143 above are rendered in a calendar month.

(Effective February 23, 1993)

Sec. 17-134d-145. Need for services

Payment for case management services will be made by the Department only if the eligible person evidences a need for case management services, and if they meet the requirements to receive services from the Department of Mental Health in accordance with its target population definition and rules regarding provision of services, as amended from time to time.

(Effective February 23, 1993)

Sec. 17-134d-146. Documentation requirements

Case management services will be reimbursed by the Department only when documentation of compliance with the following requirements is on file with the Department of Mental Health or its performing providers:

(a) **Plan of Services Requirement**

Case management services are provided in accordance with the eligible person's plan of services. At a minimum, the plan shall:

(1) be developed by the case manager at least annually or more frequently if needed, and indicate that the eligible person or their representative has participated in, or has been given the opportunity to participate in, the development of the eligible person's plan of services;

(2) be based on an assessment of an eligible person's needs which may include: assessments of medical, clinical, social, educational and other needs;

(3) be reviewed and monitored by the case manager;

(4) identify issues, needs and goals relevant to the eligible person from the date of admission to the date of plan review;

(5) identify the needed services required by an eligible person and the anticipated frequency, duration and limitations of needed services;

(6) indicate the case management services needed, and the anticipated frequency, duration and limitations of case management services; and

(7) indicate the various public agencies or private entities that will or may provide the needed services.

(b) **Permanent Service Record**

An individualized permanent service record for an eligible person must be maintained. At a minimum, the record shall contain the following:

(1) The eligible person's name, address and other relevant historical and financial information;

(2) Assessments of the eligible person, performed as necessary, to determine needed services;

(3) A plan of services pursuant to subsection (a) of Section 17-134d-146;

(4) Signed monthly service entries indicating the date(s), place of service and type of case management services rendered.

(c) **Other Documentation Requirements**

All documentation shall be incorporated into the eligible person's permanent service record in a complete, prompt and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by federal statute.

(Effective February 23, 1993)

Sec. 17-134d-147. Billing requirements

All bills submitted to the Department for payment of case management services must be substantiated by documentation in the eligible person's permanent service record pursuant

to Section 17-134d-146.

(Effective February 23, 1993)

Sec. 17-134d-148. Payment

Payment by the Department for case management services rendered to eligible persons shall be based on the providers' actual direct and indirect costs to provide case management services. Said costs shall be filed at the end of each state fiscal year with the Department by the Department of Mental Health.

For each state fiscal year the Department shall establish a payment rate based upon the said costs for the previous state fiscal year which shall be updated for inflation, using the most recent estimates of the price deflator for the gross national product as published in February of said state fiscal year in the "Economic Report of the Governor" of the State of Connecticut.

(Effective February 23, 1993)

Sec. 17-134d-149. Audit

All supporting accounting and business records, statistical data, and all other records relating to the provision of case management services paid for by the Department shall be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowability of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the Department of Mental Health and its grantee agencies, the Department's payment rate for the said rate period shall be subject to adjustment.

(Effective February 23, 1993)