Sec. 17b-262-791. Documentation

(a) The chronic disease hospital shall maintain all documentation required for rate setting purposes in accordance with section 17-311-56 of the Regulations of Connecticut State Agencies. This documentation is subject to review and audit by the department.

(b) The chronic disease hospital shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the chronic disease hospital shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation may result in the disallowance and recovery by the department of any amounts paid to the chronic disease hospital for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the provider agreement and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) The department requires that each chronic disease hospital maintain fiscal and medical records to fully disclose services and goods rendered to residents. Records shall be maintained in accordance with the department's Provider Enrollment Agreement as signed by the chronic disease hospital.

(e) Required documentation includes:

(1) certification for chronic disease hospital admission as required by the department. The form shall be signed by a licensed practitioner;

(2) the department's written authorization of the client's need for chronic disease hospital care;

(3) all admission and discharge forms supporting the claim;

(4) medical records in accordance with section 19-13-D5(d) of the Regulations of Connecticut State Agencies and 42 CFR 482.24 that contains all pertinent diagnostic information and documentation of each service provided;

(5) the initial and all subsequent treatment plans of care signed and dated by a licensed practitioner; and

(6) For clients in the rehabilitation level of care, a record that includes:

(A) each team member's goals for the client and progress notes from each team conference;

(B) all decisions reached; and

(C) the reason for any lack of progress in reaching a specific goal.

(Adopted effective October 6, 2009)