Agency
Department of Social Services

Subject
Requirements for Payment of Home Health Agencies

Inclusive Sections
§§ 17b-262-1—17b-262-966

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Requirements for Payment of Home Health Agencies

Sec. 17b-262-1. Scope

Sections 17b-262-2 to 17b-262-9 inclusive set forth the requirements for payment of Home Health services provided to individuals who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17b-262 of the Connecticut General Statutes.

(Effective June 4, 1996)

Sec. 17b-262-2. Definitions

For the purpose of Sections 17b-262-1 through 17b-262-9 the following definitions apply:

(1) **"Commissioner"** means the Commissioner of the department of social services, or his representative.

(2) **"Department"** means the State of Connecticut department of social services, or its agent.

(3) **"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.

(4) **"Home Health Care Agency"** means the definition contained in subsection (d) of section 19a-490 of the Connecticut General Statutes (CGS).

(5) **"Home Health Provider"** means any home health care agency licensed by the Department of Public Health and who also meets the requirements for participation in Medicare. Providers shall also meet all departmental enrollment requirements.

(6) **"Refusal to Serve"** shall mean a refusal to accept a new client, a termination of service to an existing client, or an interruption of service to an existing client which lasts longer than 48 hours.

(7) **"Service Area"** means those cities or towns designated by zip codes on forms provided by the department.

(8) **"Suspension of Service"** shall mean an interruption of service to an existing client which lasts 48 hours or less.

(Effective June 4, 1996)

Sec. 17b-262-3. Provider participation

In order to receive payment from the department for home health services, all Home Health Care Agencies shall be licensed by the Department of Public Health and shall meet the requirements for participation in Medicare. [Home Health Care Agency Licensure Regulations: Public Health Code Sections 19-13-D66 to D79 Inclusive and Federal Regulation: Sections 42 (Code of Federal Regulations) 440.70 and 42 (Code of Federal Regulations) 441.15]. Providers shall also meet all departmental enrollment requirements.

(Effective June 4, 1996)

Sec. 17b-262-4. Eligibility

Payment for home health services is available to all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

(Effective June 4, 1996)

Sec. 17b-262-5. Policy

No home health care agency enrolled as a Medicaid provider shall select a service area, or refuse to serve any person, based on the geographical location of the service to be provided unless the home health care agency has a legitimate, nondiscriminatory reason for its choice of service area or its refusal to serve. Referrals for service made to Medicaid enrolled home health care agencies shall not be refused if the patient's home is located within the home health care agency's designated service area. Any and all home health care agency refusals to serve shall be documented and based upon objective, legitimate, non-discriminatory reason(s). Upon receipt of a complaint of discriminatory action by a home health care agency, the home health care agency's proof of legitimate non-discriminatory purpose shall be evaluated to determine that it is not pretextual.

(Effective June 4, 1996)

Sec. 17b-262-6. Designation of service area

(a) All home health care agencies shall designate their service area by identifying the zip codes of the areas which they serve on a form to be provided by the department. All changes in that service area shall be reported to the department on an annual basis. The designated service area shall not be smaller than that reported to the Department of Public Health. If an agency serves any zip code within a town or municipality, the agency shall serve all zip codes within such town.

(b) The department shall timely evaluate all such designations, and changes in designations, to determine that the service area has not been chosen in a pattern which suggests an intent to avoid, or has the effect of avoiding, areas with a high concentration of minority residents, based on census data and other objective information. If the department determines that the choice of service area is designed to or has the effect of avoiding areas with a high concentration of minority residents, the agency shall be notified in writing of such determination and shall be required, within ten days, to provide written justification of its choice of service area based upon legitimate non-discriminatory reasons in accordance with subsection 17b-262-8, Legitimate Non-Discriminatory Reason.

(Effective June 4, 1996)

Sec. 17b-262-7. Refusal to serve

(a) All home health care agencies shall record each and every written or oral refusal to serve and suspension of service, including but not limited to discharges, including the date, the name and address of the patient or the reason why the name and address is unavailable, the reason for the refusal to serve, and identifying the support for this reason.

(b) If the stated reason for the refusal to serve is that there is an immediate danger to the health and safety of the home health care agency's personnel, the home health care agency shall, within 48 hours of the refusal to serve or discharge:

(1) Complete a form to be provided by the department detailing the timely, objective and substantial evidence on which the refusal to serve is based, the reasonable efforts taken to protect the home health care agency personnel, the geographic area covered by the refusal to serve, and the actual or expected duration of the refusal to serve;

(2) If the name and address of the client are known, send the client written notice of the refusal to serve in a form prescribed by the department, which notice shall include the reason for the refusal to serve, the timely, objective and substantial evidence on which the refusal to serve is based, the length of time during which service shall be refused, the right of the client to file a complaint with the department; and informing the client of his or her right to seek legal advice if he or she feels his or her rights have been violated; and

(3) Send the department a copy of the form with a copy of the notice to the client attached.

If the department determines that the agency has failed to comply with these requirements, the home health care agency shall be notified in writing of such determination, and shall be required, within ten days of receipt of the notice, to submit, in writing, justification for its failure to comply based on legitimate nondiscriminatory reasons in accordance with section 17b-262-8.

(c) The department shall review and monitor all forms prepared by home health care agencies pursuant to subsection (b) of section 17b-262-7, Refusal to Serve, to determine that the refusal to serve does not evidence a pattern which suggests an intent to avoid, or have the effect of avoiding, areas with a high concentration of minority residents, based on census data and other objective information. If the department determines that such a pattern exists, the home health care agency shall be notified of such determination, and shall be required, within ten days, to submit, in writing, justification for his refusals to serve based on legitimate non-discriminatory reasons in accordance with section 17b-262-8.

(d) The department shall conduct random inspections to ensure compliance with record-keeping requirements.

(e) The department shall respond to all complaints of refusal to serve by conducting a full investigation into the circumstances of the particular case, including but not limited to inspection of the home health care agency's records regarding refusals to serve.

(f) The department shall, in its discretion, conduct investigations into any refusals to serve or discharges which it determines warrant investigation, even in the absence of a specific complaint.

(g) If the department determines that a home health care agency has refused to serve a person located within its designated service areas, the agency shall be notified in writing of such determination and shall be required, within ten days, to submit, in writing, justification for its refusal to serve based upon legitimate non-discriminatory reasons in accordance with section 17b-262-8.

(h) All suspensions of service shall be justified by timely, objective and substantial evidence, and oral or written notice of the suspension shall be given to the client.

(Effective June 4, 1996)

Sec. 17b-262-8. Legitimate non-discriminatory reason

(a) In any case in which a home health care agency is required to provide written justification based upon legitimate non-discriminatory reasons in accordance with this section, the home health care agency shall be afforded an opportunity to demonstrate, and shall have the burden of demonstrating, that it had a legitimate, nondiscriminatory reason for its actions, including but not limited to:

(1) The patient's non-compliance with the plan of care;

(2) Lack of staff qualified for the client's particular medical needs; and

(3) Immediate danger to the health or safety of home health care agency personnel.

(b) Immediate danger to the health or safety of home health care agency personnel shall not constitute a legitimate, non-discriminatory reason unless:

(1) There is timely, substantial and objective evidence demonstrating that the provider has a well-founded belief that there is an immediate danger to the health or safety of home health care agency personnel in providing services at the particular time and location at which the home health care services were requested, or in accessing such location, which prevents the agency from delivering services;

(2) All reasonable efforts to protect the home health care agency personnel have been made prior to refusing service, including but not limited to the use of escorts, coordination with community patrols, and coordination with public and housing authority law enforcement;

(3) The refusal to serve covers an area no larger than necessary to avoid the immediate danger to the health and safety of the home health care agency personnel; and

(4) The refusal to serve is limited in duration so as to be no longer than necessary to avoid the immediate danger to the health or safety of the home health care agency personnel.

(c) Proof of a legitimate non-discriminatory reason, including immediate danger to the health and safety of home health care agency personnel, shall be documented in writing and be based on timely, objective and substantial evidence. Such proof may include, but not be limited to, records maintained pursuant to Department of Public Health's regulations. Proof of immediate danger to the health and safety of home health care agency personnel, such as documented observation of significant drug dealing, criminal gang activity or threatening use of weapons or police department reports of ongoing criminal activity, shall relate to the particular location in question, or the means of access to that location.

(d) All proof of legitimate non-discriminatory purpose submitted pursuant to subsection (c) of section 17b-262-8, Legitimate Non-Discriminatory Reason, shall be investigated and evaluated by the department to ensure that they are not pretextual. For purposes of this section, an allegedly legitimate non-discriminatory purpose is pretextual when:

(1) The home health care agency is unable to offer timely, substantial and objective proof

of its alleged legitimate non-discriminatory purpose; or

(2) Timely, substantial and objective evidence exists which demonstrates that there were alternative, neutral means of accomplishing the alleged purpose and that the home health care agency knew or should have known of the existence of such alternative, neutral means.

The department shall issue its findings and recommendations in writing at the conclusion of its investigation.

(e) If the home health care agency is unable to demonstrate a legitimate nondiscriminatory purpose, or if the department finds an alleged legitimate non-discriminatory purpose to be pretextual, the department shall issue a notice of violation and refer the case to the U.S. Department of Health and Human Services Office of Civil Rights.

(Effective June 4, 1996)

Sec. 17b-262-9. Sanctions

If the department determines, in accordance with sections 17b-262-1 through 17b-262-9, that these regulations have been violated, the department shall provide the home health care agency a written notice of violation stating the basis of the department's determination and the sanctions to be imposed. Such sanctions may include any of the following, alone or in combination:

(a) Termination of provider agreement;
(b) Monitoring and/or reporting requirements;
(c) Public Notice; and
(d) Such other and further sanctions as the department deems appropriate.

(Effective June 4, 1996)

Sec. 17b-262-10—17b-262-201. Reserved

Requirements for the Reimbursement of Early Intervention Services to Children Age Birth to Three Years with Developmental Delays

Sec. 17b-262-202—17b-262-211. Repealed

Repealed August 28, 1998.

Sec. 17b-262-212. Reserved

Requirements for Payment of School Based Child Health Services

Sec. 17b-262-213. Scope

Sections 17b-262-213 to 17b-262-224 inclusive set forth the requirements for payment of school based child health services provided by or on behalf of Local Educational Agencies (LEAs) under section 10-76d of the Connecticut General Statutes (CGS), and Part B of the Individuals with Disabilities Education Act (IDEA) 20 U.S.C section 1411 et seq., to children determined eligible to receive such services under Connecticut's Medical

Assistance Program pursuant to section 17b-262 of the CGS.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-214. Definitions

For purposes of section 17b-262-213 through 17b-262-224 the following definitions shall apply:

(1) **"Allied Health Professional"** means an individual who is licensed or certified by the Department of Public Health (DPH) or the SDE to provide school based child health services as defined within the context of this regulation.

(2) **"Child"** means an individual as defined in subsection (e) of section 10-76a of the Connecticut General Statutes (CGS).

(3) **"Children Requiring Special Education"** means an individual as defined in subsection (e) of section 10-76a of the CGS.

(4) **"Department"** means the State of Connecticut Department of Social Services (DSS) or its designated agent.

(5) **"Diagnostic Services"** means those services as defined in the Code of Federal Regulations (CFR) under 42 CFR, Part 440, subsection (a) of section 440.130, as amended from time to time.

(6) **"Individualized Education Program (IEP)"** means the ongoing plan of treatment services as defined in section 10-76d-11 of the Regulations of Connecticut State Agencies, and Part B of IDEA, as amended from time to time.

(7) **"Evaluation"** is the process defined under section 10-76d-9 of the Regulations of Connecticut State Agencies.

(8) **"Licensed Practitioner of the Healing Arts"** means those practitioners as defined in section 20-1 of the CGS.

(9) **"Local Educational Agencies" or "Board of Education"** means local or regional boards of education as defined in subsection (b) of section 10-76a-1 of the Regulations of Connecticut State Agencies and in Part B of IDEA, as amended from time to time.

(10) **"Medical Appropriateness/Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally- effective, alternative treatments or diagnostic modalities.

(11) **"Medically Necessary"** means medical care provided to correct or diminish the adverse affects of a medical condition, assist an individual in attaining or maintaining an optimal level of well being, diagnose a condition or prevent a medical condition from occurring.

(12) **"Planning and Placement Team"** means the definition contained in subsection (p) of section 10-76a-1 of the Regulations of Connecticut State Agencies.

(13) **"Provider"** means the local educational agencies or boards of education that participate in the medicaid program as providers of school based child health ("SBCH") services.

(14) **"Qualified SBCH Service Providers"** include but, are not limited to: licensed physician, licensed osteopath, licensed optometrist, licensed chiropractor, licensed naturopath, licensed audiologist, speech therapy assistants working under the direction of licensed speech pathologists, licensed speech pathologist, licensed advanced practice registered nurse (APRN), licensed registered nurse (RN), licensed physician assistant, licensed practical nurse (LPN), licensed psychologist, certified family and marital counselors, SDE certified school psychologist, SDE certified school social worker, DPH certified independent social worker, DPH certified substance abuse counselor, DPH certified marital and family therapist, SDE certified school counselor, SDE certified guidance counselor, licensed occupational therapist, licensed occupational therapy assistant, licensed physical therapist, physical therapist assistant meeting requirements of section 20-66 of the CGS, licensed respiratory care practitioner and licensed optometrist.

(15) **"Rehabilitative Services"** are those services as defined under 42 CFR, Part 440, subsection (d) of section 440.130, as amended from time to time.

(16) **"School Based Child Health Services"** are those diagnostic and rehabilitative treatment services which are medically necessary and appropriate and which meet the needs of children as provided in accordance with Part B of IDEA, as amended from time to time, and section 10-76d of the CGS and supporting regulations, and are recommended in writing by a licensed practitioner of the healing arts within each respective practitioner's scope of practice as defined under state law in accordance with 42 CFR, Part 440, subsections (a) and (d) of section 440.130, as amended from time to time.

(17) **"Triennial Reevaluation"** is the process of reevaluation at least once every three years as described under section 10-76d-9 of the Regulations of Connecticut State Agencies.

(18) **"Type of Placement"** means, for the purposes of this regulation, the type of setting in which the child receives special education services. These settings include, but are not limited to: in-district, out-of-district public residential, out-of-district private residential, out-of-district public day and out-of-district private day.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-215. Provider participation

In order to participate in the Connecticut Medical Assistance Program and provide SBCH Services eligible for Medicaid reimbursement from the Department, the provider shall meet the following requirements:

(1) Enroll with the Department, and have on file, a valid provider agreement. This agreement shall be updated annually in order to continue billing the Department for services.

(2) Ensure that all professionals employed by or under contract arrangements with a LEA to provide school based child health services meet all applicable federal and state licensing and certification requirements.

(3) Comply with all Medicaid documentation and other requirements, including, but not limited to those delineated in the provider agreement.

(4) Follow all laws, rules, regulations, policies and amendments which govern Medicaid

reimbursement for services provided pursuant to Part B of IDEA, as amended from time to time, and section 10-76 of the CGS, and which are specified by the federal government and the State of Connecticut.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-216. Eligibility

Medicaid funding is available for SBCH Services under section 17b-262-218 below on behalf of all children who are Medicaid recipients.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-217. Need for services

Medicaid shall reimburse for SBCH Services provided the following requirements are met:

(a) The diagnostic and evaluation services recommended by the PPT and a licensed practitioner of the healing arts in the initial evaluation or triennial reevaluation of the child are supported by reports containing recommendations by licensed or certified practitioners within the scope of their practice as defined by state law.

(b) The ongoing treatment services, as recommended by the PPT and a licensed practitioner of the healing arts, are specified in the child's IEP on file with the respective LEA. The IEP shall include, either in the IEP document itself or in an attachment to the IEP, but is not limited to:

(1) applicable medical diagnoses in a format acceptable to the department;

(2) anticipated treatment goals;

(3) a description of the type, amount, frequency and duration of the services to be furnished;

(4) identification of the type(s) of service providers(s); and

(5) signature(s) of licensed practitioner(s) of the healing arts, within their scope of practice as defined by state law, recommending the plan of medical services.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-218. Services covered

The Department shall pay for the following services:

(a) **Audiology**

Audiology services include, but are not limited to: (1) identification of children with hearing loss; (2) determination of the range, nature and degree of hearing loss, including referral for medical or other professional attention for the treatment of hearing; (3) provision of treatment activities, such as language habilitation, auditory training, speech reading (lip reading), hearing evaluation and speech conservation; (4) creation and administration of programs for the prevention of hearing loss; (5) counseling and guidance of children, parents and teachers regarding hearing loss; and (6) determination of the child's need for individual or group amplification, selecting and fitting an appropriate aid and evaluating the

effectiveness of amplification, provided that these services are within the scope of practice set forth in subsection (3) of section 20-408 of the CGS.

(b) **Clinical Diagnostic Laboratory Services**

Clinical diagnostic laboratory services means services recommended by the PPT such as simple diagnostic tests and procedures performed in the school. These services include, but are not limited to: (1) blood sugar by a finger stick, (2) urine dipstick and (3) hematocrit.

(c) **Durable Medical Equipment, Other Medical Supplies and Devices**

Durable medical equipment means the purchase or rental of medically necessary and appropriate assistive devices such as: (1) augmentative communication device; (2) crouch screen voice synthesizer; (3) prone stander; (4) corner chair; (5) wheelchair; (6) crutches; (7) walkers; (8) auditory trainers; and (9) suctioning machines. Other medical supplies and devices means supplies and devices necessary, and incidental to, IEP related services.

(d) **Medical Services**

Medical services means medical diagnostic and evaluative services recommended by the PPT to determine the child's medically related disability as approved by the licensed practitioner of the healing arts as defined in section 20-1 of the CGS and provided by the qualified SBCH service provider.

(e) **Medical Transportation**

Medical transportation means the transportation of a child identified as requiring special education and related services to sites of medically appropriate and necessary services. This includes the cost of staff required to accompany the child, as prescribed in the IEP, in order to transport the child to and from school and other sites of medically appropriate and necessary services.

(f) **Mental Health Services (Psychological & Counseling Services)**

Mental health services means diagnostic and treatment services involving mental, emotional or behavioral problems and disturbances and dysfunctions, or the diagnosis and treatment of substance abuse. These services include, but are not limited to: (1) mental health evaluations; (2) psychological testing such as the (A) administering of psychological tests and other assessment procedures; (B) interpreting of assessment results; (C) obtaining, integrating and interpreting of information about child behavior and conditions related to learning; (D) planning and managing of a program of psychological services including psychological counseling for children and parents; and (3) counseling services such as individual, group or marital and family counseling or psychotherapy for the treatment of a mental, emotional, behavioral or substance abuse condition to alleviate the condition and encourage growth and development, as performed by qualified SBCH providers, provided these services are within the scope of practice set forth in subsection (a) of section 20-74o, section 20-187a, subsections (a) and (b) of section 20-195, subsection (a) of section 20-195a, subsection (a) of section 20-195m, and subsection (b) of section 20-195q of the CGS, and sections 10-145d-555 through 10-145d-566, inclusive, of the Regulations of Connecticut State Agencies.

(g) **Nursing Services**

Nursing services include, but are not limited to: (1) health assessment and development of individualized health care plans; (2) nursing procedures including suctioning, tracheostomy care, catherterization, toileting, ostomy management and care; (3) monitoring of health status, for example, monitoring of shunt functioning or respiratory status; and individual health counseling and instruction and emergency interventions, provided that these services are within the scope of practice set forth in subsections (a), (b) and (c) of section 20-87a of the CGS.

(h) **Occupational Therapy**

Occupational therapy services means those services as defined in subsection (1) of section 20-74a of the CGS.

(i) **Physical Therapy**

Physical therapy services means those services as defined in subsection (2) of section 20-66 of the CGS.

(j) **Respiratory Care Services**

Respiratory care services means those services as defined in subsection (b) of section 20-162n of the CGS.

(k) **Speech/Language**

Speech pathology services include, but are not limited to: (1) identification of children with speech and language impairments; (2) diagnosis and appraisal of specific speech and language impairments; (3) referrals for medical or other professional attention necessary for the treatment of speech or language impairments; (4) provision of speech or language services for the treatment or prevention of communicated impairments; and (5) counseling or guidance of parents, children and teachers regarding speech and language impairments, provided that these services are within the scope of practice set forth in subsection (1) of section 20-408 of the CGS and sections 10-145d-543 through 10-145d-546, inclusive, of the Regulations of Connecticut State Agencies.

(*l*) **Optometric Services**

Optometric services include, but are not limited to: (1) assessment for visual acuity, color blindness, near vision and strabismus; and (2) diagnosis of abnormalities related to the eye and optic nerves, provided that these services are within the scope of practice set forth in subsection (2) of section 20-127 of the CGS.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-219. Limitations

(a) No payments shall be made by Medicaid:

(1) directly to health professionals or organizations under contract to a LEA for medically appropriate and necessary services covered under section 17b-262-218 above;

(2) for services of an unproven, experimental, cosmetic or research nature or for any diagnostic, therapeutic or treatment procedures in excess of those deemed medically appropriate and necessary by the Department to treat the child's condition;

(3) for any immunizations, biological products and other products or examinations and

laboratory tests for preventable diseases available free of charge from the Department of Public Health;

(4) for speech services involving non-diagnostic, non-therapeutic, routine, repetitive and reinforced procedures or services for the child's general good and welfare (e.g., the practicing of word drills which are not planned and performed or supervised by a licensed speech pathologist);

(5) for services which are provided free of charge to all students such as routine screenings; or

(6) for cancelled visits or appointments not kept.

(b) Services may be provided to an individual until the end of the school year in which a student reaches twenty-one (21) years of age.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-220. Documentation and record retention requirements

(a) A permanent service record documenting each SBCH Service provided to each medicaid eligible child shall be maintained by the LEA at which the child is enrolled at the time of service. The permanent service record shall include, but is not limited to:

(1) the written evaluation and the results of any diagnostic tests;

(2) the diagnosis(ses), in a manner acceptable to the Department;

(3) the IEP signed by a licensed practitioner of the healing arts in a manner acceptable to the Department; and

(4) the actual service delivery record including: the type of service; the date of the service; the units of service; the name and discipline of the person performing services and, for persons affiliated with an organization under contract to the LEA, the name of the organization; the signature of the individual performing the service; and progress notes signed by a licensed or certified allied health professional who performed or supervised the services within the scope of his or her practice under state law.

(b) The Local Educational Agency (LEA) shall maintain a current record of the applicable licenses or certificates of practice of all licensed or certified persons performing SBCH Services.

(c) The Local Educational Agency (LEA) shall maintain all supporting records of costs reported for SBCH Services.

(d) All records shall be maintained for at least six (6) years.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-221. Billing requirements

(a) All SBCH Services performed on behalf of Medicaid-eligible children shall be recorded on the required claim forms for the SBCH provider and submitted to the Department in accordance with the billing instructions provided by the Department.

(b) All claims submitted to the Department for payment of services covered under section 17b-262-218 above shall be substantiated by documentation in the eligible child's permanent

service record pursuant to section 17b-262-220 above.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-222. Establishment of rates

(a) The Department shall establish payment rates for three (3) types of service specific to type of placement for SBCH Services:

(1) a per month per child unit rate for SBCH treatment services, specific to type of placement;

(2) a rate for initial evaluations and triennial reevaluations, specific to type of placement; and

(3) a rate for Durable Medical Equipment, Other Medical Supplies and Devices. Rates shall be determined based upon annual cost and utilization filings made on forms prescribed by the Commissioner of the Department, except that for the July 1, 1999 through June 30, 2000 rate period, such rates shall be determined based upon the July 1, 1996 through June 30, 1997 cost reports inflated by the increase in the consumer price index (urban-all items). Rates shall be based on cost and utilization data for all children referred for special educational services. The Commissioner may establish interim rates for the billing periods.

(b) On an annual basis, except for the July 1, 1999 through June 30, 2000 period, the participating local educational agencies (LEA), shall provide to the Commissioner of the Department of Social Services, for all Medicaid eligible and non-Medicaid eligible children receiving SBCH services through such agencies, the following information and supporting documentation including, but not limited to:

(1) the average monthly unduplicated count of children receiving initial evaluations for special education services by type of placement;

(2) the costs of providing initial evaluations for special education services by type of placement;

(3) the average monthly unduplicated count of children receiving triennial reevaluations and diagnostic testing for special education services by type of placement;

(4) the costs of providing triennial reevaluations and diagnostic testing for special education services by type of placement;

(5) the average monthly unduplicated count of children receiving ongoing special education-related health treatment services independent of initial evaluations and triennial reevaluations by type of placement; and

(6) the costs of providing ongoing special education-related health treatment services independent of initial evaluations and triennial reevaluations by type of placement.

(c) Cost and utilization data provided to the Department by the State Department of Education shall be audited in accordance with Generally Accepted Government Auditing Standards (GAGAS).

Cost and utilization data shall be maintained for a minimum of six (6) years from the billing period by the LEA.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-223. Audit/compliance review

All supporting accounting and business records, statistical data, the child's permanent service record and all other records relating to the provision of SBCH Services paid for by the Department shall be subject to audit or compliance review by authorized personnel. If an audit discloses discrepancies in the accuracy or allowability of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the Department of Education and its LEAs, the Department's rates for said period shall be subject to adjustment. All documentation shall be made available to authorized personnel upon request in accordance with 42 CFR, Part 431. SDE shall take full responsibility for any Medicaid claims disallowed due to inadequate documentation by any LEA or failure to comply with requirements set forth in statute or regulations.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-224—17b-262-298. Reserved

Requirements for Payment of Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Sec. 17b-262-299. Scope

Sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies set forth the requirements for payment of services provided by Intermediate Care Facilities for the Mentally Retarded to clients eligible to receive such services under Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective October 1, 2001)

Sec. 17b-262-300. Definitions

As used in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Active treatment" means the treatment as described in 42 CFR 483.440(a), as amended from time to time;

(2) "Applied income" means the amount of income that each client receiving ICF/MR services is expected to pay each month toward the cost of his or her care, calculated according to the DSS Uniform Policy Manual, section 5045.20;

(3) "Client" means a person eligible for services under the Connecticut Medicaid program;

(4) "DMR" means the Department of Mental Retardation or its agent;

(5) "DPH" means the Department of Public Health or its agent;

(6) "Department" or "DSS" means the Department of Social Services or its agent;

(7) "Discharge" means the movement of a client out of an ICF/MR;

(8) "Home leave" means an overnight absence from the ICF/MR for any reason other than admission to a hospital. It is taken at the discretion of the client;

(9) "Hospital" means a general hospital, special hospital or chronic disease hospital as

defined in section 19-13-D1(b) of the Regulations of Connecticut State Agencies;

(10) "Interdisciplinary team" or "IDT" means a group of persons, as described in 42 CFR 483.440(c)(2), as amended from time to time;

(11) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified and enrolled to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist a client in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) "Objective information" means an estimate of the client's projected length of hospital stay obtained by the ICF/MR from a hospital staff person. This prognosis may be obtained from the client's record or the overall plan of service (OPS) or given by a physician or other health professional under his or her direction or by another qualified professional such as a social worker or discharge planner;

(16) "Overall plan of services" or "OPS" means a document that specifies a strategy to guide the delivery of services to a client for up to one year. It is the document required for a client that meets the federal requirements for a plan of care as outlined in 42 CFR 456.380, as amended from time to time, and an individual program plan as outlined in 42 CFR 483.440, as amended from time to time; and

(17) "Provider" means an ICF/MR that is enrolled in the Medicaid program.

(Adopted effective October 1, 2001)

Sec. 17b-262-301. Provider participation

In order to enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies and be certified, in accordance with federal regulations, to participate in the Medicaid program.

(Adopted effective October 1, 2001)

Sec. 17b-262-302. Eligibility

Payment to Intermediate Care Facilities for the Mentally Retarded is available on behalf

of all clients who are determined to be in need of ICF/MR care by the Department of Mental Retardation and the Department of Social Services, subject to the conditions and limitations set forth in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies. Clients shall be receiving active treatment as described in 42 CFR 483.440(a), as amended from time to time.

(Adopted effective October 1, 2001)

Sec. 17b-262-303. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay an all-inclusive per diem rate, computed in accordance with section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, of the Regulations of Connecticut State Agencies, to the ICF/MR for each client. This rate represents an inclusive payment for all services and items that are required to be provided by the facility as a condition for participation as an ICF/MR, including but not necessarily limited to the following:

(A) services provided by qualified staff engaged by the ICF/MR, as described in 42 CFR 483.430, as amended from time to time;

(B) active treatment services as described in 42 CFR 483.440, as amended from time to time;

(C) client behavior and facility practice as described in 42 CFR 483.450, as amended from time to time;

(D) health care services as described in 42 CFR 483.460, as amended from time to time;

(E) physical environment management as described in 42 CFR 483.470, as amended from time to time;

(F) dietetic services as described in 42 CFR 483.480, as amended from time to time;

(G) routine personal hygiene items as defined in 42 CFR 483.10(c)(8)(i)(E), as amended from time to time;

(H) over the counter medications except insulin;

(I) durable medical equipment, except for those items listed in section 17b-262-676(a)(2) of the Regulations of Connecticut State Agencies where Medicaid payment is available directly to the supplier of durable medical equipment if the item is medically necessary;

(J) supplies used in the routine care of the client that are included on the department's medical and surgical fee schedule including:

(i) antiseptics and solutions;

(ii) bandages and dressing supplies;

(iii) catheters and urinary incontinent supplies;

(iv) diabetic supplies;

(v) diapers and underpads;

(vi) compression, burns and specialized medical garments;

(vii) ostomy supplies;

(viii) respiratory and tracheotomy supplies;

(ix) enteral and parenteral supplies; and

(x) miscellaneous supplies;

(K) services related to the provision or arrangement for provision of customized wheelchairs that are the responsibility of the ICF/MR as described in subsections 17-134d-46(m) and (n) of the Regulations of Connecticut State Agencies; and

(L) transportation services necessary to transport a client to and from any service included in the per diem rate as described in this section.

(2) The department shall pay to reserve a bed in an ICF/MR for a client during a temporary absence in a hospital as described in section 17b-262-306 of the Regulations of Connecticut State Agencies.

(3) The department shall pay to reserve a bed in an ICF/MR for home leave in accordance with section 17b-262-307 of the Regulations of Connecticut State Agencies.

(b) **Limitations**

(1) The department shall not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.

(2) The department shall pay for the date of admission and not for the date of discharge. Exceptions to this are:

(A) the department shall pay for the date of death when the client dies in the ICF/MR. If the client dies while in the hospital or on home leave, the date of death is paid as a reserve bed day, provided all other bed reservation requirements as described in sections 17b-262-306 and 17b-262-307 of the Regulations of Connecticut State Agencies are met; and

(B) in the case of a client admitted and discharged on the same day, payment is authorized for one day of care.

(Adopted effective October 1, 2001)

Sec. 17b-262-304. Need for services and authorization process

(a) The decision to admit and the subsequent admission to a facility must be made by the Department of Mental Retardation or the admitting ICF/MR in conjunction with the client's interdisciplinary team, subject to review by DSS.

(b) DSS shall evaluate and approve in writing the client's need for ICF/MR services ordered by the physician, as described in 42 CFR 456.372, as amended from time to time.

(c) In order for DSS to pay for ICF/MR services, the ICF/MR shall document the need for the admission by all of the following:

(1) certification of the need for care by a physician as described in 42 CFR 456.360(a), as amended from time to time;

(2) medical, psychological and social evaluations as described in 42 CFR 456.370, as amended from time to time;

(3) an admissions review as described in 42 CFR 483.440(b), as amended from time to time;

(4) exploration of alternative services as described in 42 CFR 456.371, as amended from time to time;

(5) an OPS; and

(6) a written report of each evaluation and OPS entered in the client's record, as described in 42 CFR 456.381, as amended from time to time.

(7) DSS written approval of the client's need for ICF/MR services in accordance with 42 CFR 456.372, as amended from time to time.

(d) Beginning no later than six months after admission, or earlier if indicated at the time of admission, the ICF/MR shall document the need for continued stay by all of the following:

(1) recertification of need for care as described in 42 CFR 456.360(b), as amended from to time, on forms prescribed by DSS;

(2) exploration of alternative services as described in 42 CFR 456.371, as amended from time to time;

(3) a continued stay review process in accordance with 42 CFR 456.431 to 42 CFR 456.438, inclusive, as amended from time to time;

(4) a review of the OPS as described in 42 CFR 456.380(c), as amended from time to time; and

(5) monitoring of the program plan as described in 42 CFR 483.440(f), as amended from time to time.

(Adopted effective October 1, 2001)

Sec. 17b-262-305. Client's bill of rights

(a) An ICF/MR shall protect and promote the rights of each client as described in 42 CFR 483.420, as amended from time to time.

(b) Requirements for the administration of the patient's personal allowance shall be in accordance with sections 17-2-140 to 17-2-145, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective October 1, 2001)

Sec. 17b-262-306. Bed reserve for hospitalization

(a) DSS shall pay to reserve a bed in an ICF/MR for a client during a temporary absence in a hospital for up to fifteen (15) days in accordance with subsection (e) of this section.

(b) The ICF/MR shall inform the client and guardian or other responsible person, upon admission to the ICF/MR and upon transfer of a client to the hospital, that the bed of a client shall be reserved if the conditions outlined in this section are met.

(c) The ICF/MR shall reserve the bed of any client who is absent from the ICF/MR due to hospitalization unless the ICF/MR has obtained objective information from the hospital that the client shall not return to the ICF/MR within the fifteen day period, including the day of admission, to the hospital.

(d) The ICF/MR shall not make the reserved bed available for use by any other person.

(e) DSS shall reimburse an ICF/MR at the per diem Connecticut Medicaid program rate of the ICF/MR for each day that the ICF/MR reserves the bed of a client in accordance with the following conditions:

(1) an ICF/MR shall be reimbursed for reserving the bed of a client who is hospitalized for a maximum of seven (7) days including the admission date of hospitalization, if on the date of admission the ICF/MR documents that it contacted the hospital and the hospital failed to provide objective information confirming that the person would be unable to return to the ICF/MR within fifteen (15) days of the date of hospitalization;

(2) the ICF/MR shall be reimbursed for a maximum of eight (8) additional days provided on or before the seventh day, but not before the third day of the hospitalization of a client, the ICF/MR contacts the hospital for an update on the client's status and the ICF/MR documents in the client's file that the information obtained through the contact does not indicate that the client shall be unable to return to the ICF/MR within fifteen (15) days of the hospital admission;

(3) documentation of the hospital contact described in subdivisions (1) and (2) of this subsection shall include the date of the contact, the hospital representative's name, the source of the information and the estimated length of stay;

(4) if at any time the ICF/MR is provided with information from the hospital that the client shall not return to the ICF/MR within fifteen (15) days of the hospital admission, the ICF/MR is not eligible to receive reimbursement for reserving the client's bed for any days after such information is received, including the day the information is received; and

(5) for the purposes of determining the beginning of the bed reservation period, admission to the hospital shall mean the time at which the client, on recommendation of a physician, is formally admitted as an inpatient to the hospital. When a client is transferred to the hospital and is not formally admitted, it shall not be considered a discharge, regardless of the length of the stay. It shall be considered a discharge from the ICF/MR only when the client is formally admitted by the hospital. Any other hospital stay, whether in the emergency room or otherwise shall be considered an outpatient visit.

(f) If the client's hospitalization exceeds the period of time that an ICF/MR is required to reserve the client's bed, the ICF/MR:

(1) shall provide the client the first available bed at the time notice is received of the client's discharge from the hospital;

(2) shall grant the client priority admission over applicants for new admission to the ICF/MR; and

(3) may charge a fee to reserve the bed if the client, his or her family or responsible party wishes to pay to reserve the bed. For hospital leave beyond fifteen (15) days per hospital admission, the facility shall reserve the bed as long as payment is available. The fee shall not exceed the per diem Connecticut Medicaid program rate for that bed.

(Adopted effective October 1, 2001)

Sec. 17b-262-307. Bed reserve for home leave

(a) DSS shall pay to reserve a bed in an ICF/MR for a client during a temporary absence for home leave for up to thirty-six (36) days per calendar year. The ICF/MR shall not make the reserved bed available for use by any other person.

(b) The ICF/MR shall inform the client and guardian or other responsible person upon admission to the facility, that a bed shall be reserved for home leave if the conditions outlined in subsection (d) of this section are met.

(c) The ICF/MR shall reserve a client's bed for up to thirty-six (36) days per calendar year. No facility shall require, or request, a client to provide payment for authorized home leave.

(d) DSS shall reimburse an ICF/MR at the per diem Connecticut Medicaid program rate of the facility for each day that the facility reserves the bed in accordance with the following conditions:

(1) the client has not used more than thirty-six (36) days of home leave during the calendar year;

(2) the facility has not refused to take the client back during or upon completion of the authorized home leave. If so, no payment shall be made for the entire home leave; and

(3) the client has not failed to return to the ICF/MR. If the client has not returned, the liability for payment to the ICF/MR shall terminate on the date the ICF/MR is notified that the client will not be returning.

(e) If the client has used more than thirty-six (36) days of home leave in a calendar year the facility shall not be required to reserve the bed; however, the ICF/MR:

(1) shall provide the client the first bed available after notice is received that the client wishes to return;

(2) shall grant the client priority admission over applicants for new admission to the ICF/MR; and

(3) may charge a fee to reserve the bed if the client, his or her family or responsible party wishes to pay to reserve the bed. For home leave beyond thirty-six (36) days per calendar year, the facility shall reserve the bed as long as payment is available. The fee shall not exceed the per diem Connecticut Medicaid program rate for that bed.

(f) The ICF/MR shall document in the client's medical record:

(1) the contact person;

(2) the duration of the absence;

(3) the client's condition before leaving, and upon returning, to the facility; and

(4) the dates of home leave.

(g) The medical record does not need to be closed nor does the client need to be readmitted after home leave.

(Adopted effective October 1, 2001)

Sec. 17b-262-308. Applied income

(a) DSS is responsible for calculating the applied income. DSS shall notify the ICF/MR

of the amount of any applied income that the facility is responsible for collecting. Applied income shall be deducted from what otherwise would have been the DSS monthly payment to the ICF/MR on behalf of the client.

(b) The ICF/MR shall notify DSS of any errors in the amount of applied income processed against the claim using the form specified by DSS. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(c) In any month that a client returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the client was in the ICF/MR multiplied by the per diem rate.

(d) Applied income shall not be pro rated. It shall be used to cover the cost of care until it is expended.

(Adopted effective October 1, 2001)

Sec. 17b-262-309. Billing and payment procedures

(a) The ICF/MR shall submit claims to the department as described in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to ICFs/MR.

(b) The ICF/MR shall:

(1) complete the daily admission and discharge forms in accordance with DSS instructions;

(2) notify the DSS caseworker if the ICF/MR is aware that the ICF/MR client's asset level exceeds the established resource limit. The report shall be made on the form specified by DSS.

(3) notify the convalescent payment unit of DSS of any and all credits due DSS on the form specified by DSS.

(Adopted effective October 1, 2001)

Sec. 17b-262-310. Rates

The per diem rates for an ICF/MR shall be determined annually, pursuant to section 17b-340 of the Connecticut general statutes and sections 17-311-1 to 17-311-120, inclusive, of the Regulations of Connecticut State Agencies. DSS shall reimburse the ICF/MR at the per diem rate minus the applied income.

(Adopted effective October 1, 2001)

Sec. 17b-262-311. Documentation

(a) The ICF/MR shall maintain all documentation required for rate setting purposes for a minimum of 10 years pursuant to section 17-311-56 of the Regulations of Connecticut State Agencies, including all documentation required to support the billing for bed reserve days described in subsection (e)(4) of this section. This documentation shall be subject to review by the department.

(b) The ICF/MR shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, and shall be subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the ICF/MR 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 shall result in the disallowance and recovery by the department of any amounts paid to the ICF/MR 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 for ICFs/MR and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) An ICF/MR shall maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid residents. Records shall be maintained in accordance with the department's Provider Agreement for ICFs/MR.

(e) Required documentation shall include:

(1) all reports, evaluations, certifications, reviews and approvals documenting the need for admission as described in subsection 17b-262-304(b) of the Regulations of Connecticut State Agencies;

(2) all certifications and reviews documenting the need for continued stay as described in subsection 17b-262-304(c) of the Regulations of Connecticut State Agencies;

(3) all admission and discharge forms required by DSS; and

(4) all documentation required to support the ICF's/MR billing for and the DSS payment of bed reserve days as described in sections 17b-262-306 and 17b-262-307 of the Regulations of Connecticut State Agencies.

(f) Providers shall maintain all medical records pursuant to sections 17a-227-17 and 17a-227-18 of the Regulations of Connecticut State Agencies.

(Adopted effective October 1, 2001)

Sec. 17b-262-312—17b-262-336. Reserved

Requirements for Payment of Physicians' Services

Sec. 17b-262-337. Scope

Sections 17b-262-337 through 17b-262-349, inclusive, set forth the Department of Social Services requirements for payment of accepted methods of treatment performed by or under the supervision of licensed physicians for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective May 11, 1998; Amended January 31, 2008)

Sec. 17b-262-338. Definitions

As used in sections 17b-262-337 through 17b-262-349, inclusive, of the Regulations of

Connecticut State Agencies:

(1) "Acute" means symptoms that are severe and have rapid onset and a short course;

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

(3) "Allied Health Professional" or "AHP" means a licensed individual who is qualified by special training, education, skills, and experience in health care and treatment and shall include: psychologists, social workers, nurses, nurse midwives, physician assistants, professional counselors, marital and family therapists, alcohol and drug counselors, physical therapists, occupational therapists, speech therapists, audiologists and respiratory care practitioners as defined in title 20 of the Connecticut General Statutes;

(4) "Border provider" means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and that is enrolled as and treated as a Connecticut Medical Assistance Program provider. Such providers are certified, accredited, or licensed by the applicable agency in their state and are deemed border providers by the department on a case-by-case basis;

(5) "Child" means a person who is under twenty-one years of age;

(6) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(7) "Client" means a person eligible for goods or services under the department's Medicaid program;

(8) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes;

(9) "Consultation" means those services rendered by a physician whose opinion or advice is requested by the client's physician or agency in the evaluation or treatment of the client's illness;

(10) "Department" means the Department of Social Services or its agent;

(11) "Early and Periodic Screening, Diagnostic and Treatment services" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(12) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(13) "Family planning services" means any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely plan the number and spacing of their children;

(14) "Fees" means the payments for services, treatments, and drugs administered by physicians which shall be established by the commissioner and contained in the

department's fee schedules;

(15) "General hospital" means "general hospital" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(16) "Home" means the client's place of residence, which includes a boarding home, community living arrangement, or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), or other facilities that are paid an all inclusive rate directly by Medicaid for the care of the client;

(17) "Hysterectomy "means "hysterectomy" as defined in 42 CFR 441.251;

(18) "Informed consent" means "informed consent" as defined in 42 CFR 441.257;

(19) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded;

(20) "Institutionalized individual" means an "institutionalized individual" as defined in 42 CFR 441.251;

(21) "Legend Device" means "legend device" as defined in section 20-571 of the Connecticut General Statutes;

(22) "Legend Drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(23) "Medical appropriateness" or "Medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(24) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(25) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(26) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(27) "Mentally incompetent individual" means a "mentally incompetent individual" as defined in 42 CFR 441.251;

(28) "Nursing facility" means a "nursing facility" as defined in 42 USC 1396r(a);

(29) "Out of state provider" means a provider that is located outside Connecticut and is not a border provider;

(30) "Panel or Profile Tests" means certain multiple tests performed on a single specimen or material derived from the human body which are related to a condition, disorder or family of disorders, which when combined mathematically or otherwise, comprise a finished

identifiable laboratory study or studies;

(31) "Physician" means a person licensed pursuant to section 20-10 of the Connecticut General Statutes;

(32) "Physicians' services" means services provided:

(A) by a physician within the scope of practice as defined by state law; or

(B) by an AHP within the scope of practice of the AHP as defined by state law;

(33) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(34) "Provider" means a licensed physician or physician group enrolled in the Medicaid program, or an AHP acting within their scope of practice;

(35) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;

(36) "Sterilization" means "sterilization" as defined in 42 CFR 441.251;

(37) "Under the supervision" means that the physician shall assume professional responsibility for the service performed by the AHP;

(38) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary charge" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

(39) "Utilization review" means "utilization review" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 1998; Amended January 31, 2008)

Sec. 17b-262-339. Provider participation

In order to enroll in Medicaid and receive payment from the department, providers shall meet and maintain all departmental enrollment requirements as described in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 1998; Amended January 31, 2008)

Sec. 17b-262-340. Eligibility

Payment for provider's services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(Adopted effective January 31, 2008)

Sec. 17b-262-341. Services covered and limitations

The department shall pay providers:

(1) only for those procedures listed in the department's fee schedule for providers that are medically necessary and medically appropriate to treat the client's condition;

(2) for provider services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, icf/mr or other medical care facility;

(3) for laboratory services provided by a provider in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

(4) for medical and surgical supplies used by a provider in the course of treatment of a client;

(5) for drugs and devices administered by a provider;

(6) for a second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation;

(7) for family planning, abortion and hysterectomy services as described in section 17b-262-348(s) of the Regulations of Connecticut State Agencies;

(8) for Early and Periodic Screening, Diagnostic and Treatment services, including treatment services which are indicated following screening not otherwise covered, provided that prior authorization is obtained;

(9) for surgical services necessary to treat morbid obesity when another medical illness is caused by, or is aggravated by, the obesity. Such illnesses shall include illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system. For the purposes of this section, "morbid obesity" means "morbid obesity" as defined by the International Classification of Diseases (ICD), as amended from time to time;

(10) for family planning services for clients of childbearing age, including minors who can be considered sexually active, and who desire the services;

(11) for sterilization for clients who are at least 21 years of age at the time of informed consent; and

(12) for a hysterectomy performed during a period of retroactive eligibility as described in 42 CFR 441.255(e).

(Adopted effective January 31, 2008)

Sec. 17b-262-342. Services not covered

The department shall not pay for the following:

(1) transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis;

(2) immunizations, biological products and other products available to providers free of charge;

(3) examinations and laboratory tests for preventable diseases which are furnished free of charge;

(4) information or services provided to a client by a provider over the telephone;

(5) cosmetic surgery;

(6) an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;

(7) cancelled services and appointments not kept;

(8) services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements as set forth in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(9) infertility treatment;

(10) sterilizations performed on mentally incompetent individuals or institutionalized individuals;

(11) more than one visit per day to the same physician by a client; and

(12) services to treat obesity other than those described in section 17b-262-341(9) of the Regulations of Connecticut State Agencies; and

(13) any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

(Adopted effective January 31, 2008)

Sec. 17b-262-343. Need for service

Payment for an initial office visit and continuing services which the department deems medically necessary, in relation to the diagnosis for which care is required, is available provided that:

(a) the services are within the scope of the provider's practice, and

(b) the services are made part of the client's medical record.

(Adopted effective January 31, 2008)

Sec. 17b-262-344. Prior authorization

(a) Prior authorization, on forms and in the manner specified by the department, is required in order for payment to be available for the following provider services:

(1) electrolysis epilation;

(2) physical therapy services in excess of two visits per calendar week per client per provider;

(3) physical therapy services in excess of nine visits per calendar year per client per provider, when the therapy being prescribed is for the treatment of:

(A) all mental disorders, including diagnoses related to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;

(B) musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; and

(C) symptoms related to nutrition, metabolism, and development covered by the ICD, as amended from time to time;

(4) reconstructive surgery, including breast reconstruction following mastectomy;

(5) plastic surgery;

(6) transplant procedures; and

(7) Early and Periodic Screening, Diagnostic and Treatment services that are identified during a periodic screening as medically necessary and which are not payable pursuant to the existing physician fee schedule.

(b) Prior authorization is required for payment of all hospital admissions as required and described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(c) The department shall make payment available only if the procedure or course of treatment authorized shall be initiated not later than six months of the date of authorization.

(d) The initial authorization period shall be for a period not to exceed six months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered for up to an additional six-month period per request.

(f) Except in emergency situations, prior authorization shall be received before services are rendered.

(g) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services that normally require prior authorization.

(h) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective January 31, 2008)

Sec. 17b-262-345. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

(c) When a client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's name.

(d) When billing for anesthesia services, anesthesiologists shall include the name of the primary surgeon on the bill.

(e) Laboratory services performed in the provider's office shall be payable to the provider and shall be billed as separate line items. When a provider refers a client to a private laboratory for services, the laboratory shall bill directly and no laboratory charge shall be paid to the provider.

(f) when services are provided by more than one member of a group, the authorization request shall be submitted prior to billing as described in the billing instructions in the

provider manual.

(Adopted effective January 31, 2008)

Sec. 17b-262-346. Payment

(a) Fees shall be the same for in state, border and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the provider.

(c) Notwithstanding the provisions of the regulations of connecticut state agencies or any provisions of the department's Medical Services Policy, the department shall not pay any provider under sections 17b-262-337 through 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies for a client seen at a freestanding clinic enrolled in Medicaid. Only the clinic may bill for such services. As an exception to the foregoing, a provider may bill for covered services for a client seen at an outpatient dialysis clinic or at an outpatient surgical facility. A provider who is enrolled with medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.

(d) The department shall not pay interns or residents for their services nor shall the department pay for assistant surgeons in general or chronic disease hospitals staffed by interns and residents, unless the procedure is significantly complicated, open heart surgery for example, so as to justify a full surgeon acting as an assistant. If the surgery is performed by a resident or intern and the supervising surgeon assists, only the assistant's fee shall be paid to the surgeon. The regular surgical fee shall not be paid.

(e) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, no fee shall be paid to the surgeon even when the surgeon is on call.

(Adopted effective January 31, 2008)

Sec. 17b-262-347. Payment rate

The department shall establish and may periodically update the fees for covered physician services as promulgated in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective January 31, 2008)

Sec. 17b-262-348. Payment limitations

(a) The fees listed in the department's fee schedule shall be payable only when the services are performed by or under the supervision of a provider.

(b) The department shall pay the fee for an initial visit by a provider in an office, home,

ICF/MR or nursing facility only once per client. Initial visits refer to the provider's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the provider-client relationship has been discontinued for three or more years and is then reinstated.

(c) The department shall pay non-hospital based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.

(d) Payment for physician fees are available only when the opinions and advice of a physician consultant are requested by another physician or other appropriate source. The consultant's opinion and any services that were ordered or performed must be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source. In a consultation, the referring provider carries out the plan of care. In a referral, a second provider provides direct service to the client.

(e) If a client is referred to a provider for treatment of a condition that the referring provider does not usually treat, the department shall pay the treating provider the fee for an office visit rather than the fee for a consultation.

(f) When the consultant provider assumes the continuing care of the client, any subsequent service shall be paid according to the fee listed for the procedure.

(g) If a client's medical condition necessitates the concurrent services and skills of two or more providers, each provider shall be entitled to the listed fee for the service that he or she provides.

(h) When a provider examines a Medicaid applicant for the purpose of substantiating whether a medical condition exists that would enable the department to determine eligibility for Medicaid disability, the department shall pay only for the tests required to establish eligibility as requested by the department. No other procedures shall be paid.

(i) **Surgery**

(1) When a claim is submitted by a provider for multiple surgical procedures performed on the same date of service, the department shall pay for the primary surgical procedure the full Medicaid allowed amount. the department shall pay for additional surgical procedures performed on that day at 50% of the Medicaid allowed amount.

(2) When an assistant surgeon, in addition to staff provided by the general or chronic disease hospital, is required, the amount payable by the department to the assistant surgeon shall be 20% of the listed fee for surgery.

(3) Fees for related evaluation and management encounters on the same day of surgery are not payable.

(4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care while in the general or chronic disease hospital. Followup visits after a client is discharged from the general or chronic disease hospital shall be payable as office visits.

(5) The listed fees for surgery on the musculoskeletal system shall include payment for the application of the first cast or traction device.

(j) **Anesthesia**

(1) The listed fees for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and blood incident to the anesthesia or surgery.

(2) The listed fees for anesthesia services shall be used only when the anesthesia is administered by or under the supervision of a licensed provider who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia services.

(3) No payment shall be made for local infiltration or digital block administered by the operating surgeon.

(k) **Radiology**

(1) The listed fees for all diagnostic radiology procedures, including nuclear medicine, magnetic resonance imaging, computerized axial tomography and diagnostic ultrasound, shall include consultation and a written report to the referring provider.

(2) The listed fees for all diagnostic radiology procedures shall apply only when the provider's own equipment is being used. If the equipment used to perform the procedure is owned directly or indirectly by the general or chronic disease hospital or a related entity, or if a hospital includes the operating expenses of the equipment in its cost reports, the provider shall not be paid for the technical component of the listed fee.

(*l*) **Radiotherapy**

(1) The provider fee for radiological treatment of malignancies shall include one-year follow-up care unless otherwise specified.

(2) The provider fee for treatment of nonmalignant conditions shall include followup care ninety days from the end of treatment unless otherwise specified.

(3) The provider fee for treatment shall include the concomitant office visits, but does not include surgical, radiological or laboratory procedures performed on the same day.

(4) The fees listed for therapeutic procedures involving the use of radium and radioisotopes shall not include the radioactive drug used or preliminary and followup diagnostic tests. Radioactive drugs may be billed separately.

(5) The fees listed for diagnostic procedures involving the use of radium and radioisotopes shall not include the radioactive drugs used. Radioactive drugs may be billed separately.

(m) **Laboratory**

(1) The following routine laboratory tests shall be included in the physician fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination and urine glucose determination.

(2) No payment shall be made for tests which are provided free of charge.

(3) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not according to the fee for each separate test included in the panel or profile.

(n) **Drugs**

(1) The department shall pay the actual acquisition costs for oral medications incident

to an office visit as billed by the provider.

(2) The department shall pay for legend drugs and legend devices administered by the provider based on a fee schedule determined by the department.

(3) No payment shall be made for drugs provided free of charge.

(o) **Newborn Care**

(1) The provider fee for routine care of a normal newborn infant in the general hospital includes history and examination of the infant, initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(2) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care and the routine or subsequent newborn care for the same child.

(3) Newborn resuscitation may be billed in addition to billing for routine care of a newborn or billing for critical care.

(p) **Payment for assessments and subsequent care for clients in a nursing facility, ICF/MR and chronic disease hospital**

(1) The department shall make payments available to providers for evaluation and management only when performed in the facility.

(2) The annual assessment is limited to one per client per year.

(q) **Allergy Procedures**

Providers shall bill for follow-up visits which include intracutaneous tests only if subsequent visits require testing. If follow-up visits do not include testing, regular office visit codes for established clients shall be billed.

(r) **Admission to a General Hospital**

Payment for services provided by the admitting provider in a general hospital shall not be made available if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting or quality of care. Specific requirements are described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(s) **Family planning, abortion and hysterectomy**

(1) The department shall pay the provider for sterilization only if the client has given his or her informed consent in accordance with the requirements in 42 CFR 441.250 through 441.259, inclusive, as amended from time to time.

(2) The department shall pay for hysterectomies and related laboratory and hospital services that are medically necessary and medically appropriate only if the physician or physician's representative has obtained:

(A) a consent form in accordance with 42 CFR 441.251 through cfr 441.259 inclusive, as amended from time to time, or

(B) a physician's certification in accordance with 42 CFR 441.255(d), as amended from

time to time.

(3) The department shall pay physicians for all abortions that a physician certifies as medically necessary and medically appropriate whether or not the woman's life would be endangered by carrying the fetus to term and whether or not the pregnancy is the result of rape or incest. For the purposes of abortion coverage and payment, a physician determines medical necessity.

(4) the provider shall maintain all forms required by section 19a-116-1 of the Regulations of Connecticut State Agencies and section 19a-601 of the Connecticut General Statutes.

(Adopted effective January 31, 2008)

Sec. 17b-262-349. Documentation and audit requirements

(a) Providers shall maintain a specific record for all services received for each client eligible for Medicaid payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the provider, documentation of services provided and the dates the services were provided.

(b) All required documentation shall be maintained in its original form for at least five years or longer by the provider in accordance with statute or regulation subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation whichever is longest.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(d) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(Adopted effective January 31, 2008)

Sec. 17b-262-350—17b-262-439. Reserved

Sec. 17b-262-440—17b-262-449. Repealed

Repealed January 31, 2008.

Sec. 17b-262-450—17b-262-451. Reserved

Requirements for Payment of Psychiatrists' Services

Sec. 17b-262-452. Scope

Sections 17b-262-452 through 17b-262-463 inclusive set forth the Department of Social Services requirements for payment of: (a) medical and clinical services provided by licensed psychiatrists in private or group practice, and (b) clinical procedures performed by allied

health professionals in the employ of the psychiatrist in private or group practice for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective May 11, 1998)

Sec. 17b-262-453. Definitions

For the purposes of sections 17b-262-452 through 17b-262-463 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

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

(3) "Allied Health Professional (AHP)" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in mental health care and treatment and shall include, but is not limited to: psychologists, social workers, psychiatric nurses, and other qualified therapists.

(4) "By or Under the Supervision" means the psychiatrist shall assume professional responsibility for the service performed by the allied health professional, overseeing or participating in the work of the allied health professional including, but not limited to:

(A) availability of the psychiatrist to the allied health professional in person and within five minutes;

(B) availability of the psychiatrist on a regularly scheduled basis to review the practice, charts, and records of the allied health professional and to support the allied health professional in the performance of services; and

(C) a predetermined plan for emergency situations, including the designation of an alternate psychiatrist in the absence of the regular psychiatrist.

(5) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(6) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(7) "Consultation" means those services rendered by a psychiatrist whose opinion or advice is requested by another physician or an agency in the evaluation and treatment of a client's illness.

(8) "Department" means the Department of Social Services or its agent.

(9) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(10) "Estimated Acquisition Cost (EAC)" 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.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(13) "Home" means the client'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; long-term care facility includes a nursing facility, chronic disease hospital, and intermediate care facility for the mentally retarded (ICF/MR).

(14) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(15) "Legend Drug" means the definition contained in section 20-571 of the Connecticut General Statutes.

(16) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(17) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities,

(B) chronic disease hospitals—inpatient, and

(C) intermediate care facilities for the mentally retarded (ICFs/MR).

(18) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(19) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(20) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition;

or to prevent a medical condition from occurring.

(21) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(22) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(23) "Provider" means a psychiatrist.

(24) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(25) "Psychiatric Services" means services provided to individuals, groups, and families, by or under the supervision of a licensed psychiatrist in private or group practice. In such a setting the psychiatrist retains the primary medical and clinical responsibility for work up of the initial evaluation, diagnosis, and prescription of the treatment plan, rehabilitation, and discharge of the client. Such services include the diagnosis of specific mental and social problems which disrupt an individual's daily functioning and provide treatment to reduce the symptoms and signs associated with these disturbances.

(26) "Psychiatrist" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who specializes in the study, diagnosis, treatment, and prevention of mental and social disorders.

(27) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Adopted effective May 11, 1998)

Sec. 17b-262-454. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective May 11, 1998)

Sec. 17b-262-455. Eligibility

Payment for psychiatrists' services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to

these services.

(Adopted effective May 11, 1998)

Sec. 17b-262-456. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed psychiatrist which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for:

(1) psychiatric evaluation;

(2) psychotherapy, including: individual, group, family, hypnosis, and electroshock;

(3) psychiatric consultation;

(4) drugs, as limited in subsection (b) of section 17b-262-456;

(5) all admitting and inpatient services performed by the admitting psychiatrist in an acute care hospital after the psychiatrist has received prior authorization for the admission pursuant to the department's utilization review program as delineated in section 17-134d-80 of the Regulations of Connecticut State Agencies; and

(6) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) a psychiatric evaluation shall be limited to one evaluation in any twelve month period per client per provider;

(2) only one unit of therapy of the same type shall be paid for on the same day:

(3) group psychiatric sessions shall be limited in size to a maximum of eight persons per group session regardless of the payment source of each participant;

(4) services covered shall be limited to those listed in the department's applicable fee schedule; and

(5) hypnosis and electroshock therapy shall be personally provided by a psychiatrist.

(c) **Services Not Covered**

The department shall not pay for the following psychiatric services:

(1) information or services furnished by the provider to the client over the telephone;

(2) concurrent services for the same client involving the same services or procedure;

(3) office visits to obtain a prescription, the need for which has already been ascertained;

(4) procedures performed in the process of preparing an individual for transsexual surgery; and

(5) cancelled office visits or appointments not kept.

(Adopted effective May 11, 1998)

Sec. 17b-262-457. Need for service

The department shall pay for medically necessary and medically appropriate psychiatric

services for Medical Assistance Program eligible clients which are provided by a licensed physician who specializes in the study, diagnosis, treatment, and prevention of mental and social diseases.

(Adopted effective May 11, 1998)

Sec. 17b-262-458. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for all clients, including clients originally referred by another state agency for:

(1) treatment services in excess of thirteen visits in a calendar quarter;

(2) treatment services to hospitalized clients from the date of admission; and

(3) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization. The form shall include the progress made to date and the future gains expected through additional treatment.

(c) Initial authorization for outpatient services shall be up to six months.

(d) Initial authorization for hospital inpatient services shall be authorized for up to forty-two days from the date of initial admission for a specific episode of illness.

(e) Requests for continued treatment beyond the initial authorized period shall be submitted prior to the onset of services for which authorization is requested. The form shall include the progress made to date and the future gains expected through additional treatment.

(f) Outpatient services beyond the initial authorized period shall be extended up to six months.

(g) One extension of hospital inpatient services for the same episode of illness shall be allowed up to an additional twenty one days unless the client requires hospitalization for a concurrent medical problem.

(h) Clients who require hospitalization for a concurrent medical problem shall receive hospital inpatient psychiatric services until hospital inpatient treatment for the concurrent medical problem is no longer necessary.

(i) The authorization request form shall include the name of the physician, person, or agency making the referral.

(j) In emergency or urgent situations involving services which require prior authorization, the provider of the service may request verbal approval by the department during normal working hours, or no later than the next business day if the emergency or urgent situation

occurs outside of the department's normal working hours, when such authorization may be given. However, approval in such a manner shall be limited to psychiatric services that are immediately necessary and vital to the health and safety of the client.

(k) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective May 11, 1998)

Sec. 17b-262-459. Billing procedures

(a) Claims from psychiatrists shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the psychiatrist's usual and customary charge for the services delivered.

(c) When a Medical Assistance Program client is referred to a psychiatrist for consultation, the consultant psychiatrist shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant psychiatrist shall enter the entire name as well as the state license number of the referring physician on the billing form.

(d) Psychiatric consultations in the hospital, home, or long-term care facility shall be billed as a comprehensive consultation.

(e) All charges billed for supplies and materials provided by a psychiatrist, except glasses, shall be reviewed by the department.

(Adopted effective May 11, 1998)

Sec. 17b-262-460. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same of substantially similar goods or services by the provider from any person or entity.

(b) A psychiatrist who is fully or partially salaried by a general hospital, public or private institution, physicians' group, or clinic shall not receive payment from the department unless the psychiatrist maintains an office for private practice at a location separate from the hospital, institution, physicians' group, or clinic in which the psychiatrist is employed. Psychiatrists who are solely hospital, institution, physicians' group, or clinic-based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(c) A psychiatrist who maintains an office for private practice separate from the hospital, institution, physicians' group, or clinic shall be able to bill for services provided at the private practice location or for services provided to the psychiatrist's private practice clients in the hospital, institution, physicians' group, or clinic only if the client is not a patient of the hospital, institution, physicians' group, or clinic.

(Adopted effective May 11, 1998)

Sec. 17b-262-461. Payment rate

The commissioner establishes the fees contained in the psychiatrists' and allied health professionals' fee schedules pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective May 11, 1998)

Sec. 17b-262-462. Payment limitations

(a) Psychiatrists' services shall be performed at the psychiatrist's private or group practice location, hospital, long-term care facility, clinic, or the client's home.

(b) The psychiatrist who employs allied health professionals shall personally conduct the evaluation and, accordingly, develop the treatment plan in all cases.

(c) In situations where the psychiatrist employs allied health professionals on a salary or fee-for-service basis, the psychiatrist shall be paid at the psychiatrists' rate only under the following conditions:

(1) for clients personally being treated by the psychiatrist; and

(2) when the psychiatrist personally interviews the client as part of the psychiatrist's supervisory responsibilities, but only at that rate which corresponds to the time or service he or she actually provides to the client.

(d) Services provided by allied health professionals shall be billed at the rate for allied health professionals established by the department and not at the scheduled rate for psychiatrists.

(e) Fees for psychiatric evaluations include an allowance for the preparation of a full written report.

(f) When a psychiatrist renders consultation services and thereafter assumes the continuing care of the client, any subsequent services rendered by the psychiatrist or the psychiatrist's staff shall no longer be considered as a consultation and shall be billed at the rate applicable for the ongoing service.

(g) The fee for any procedure, as stipulated in the fee schedule for psychiatric services published by the department, represents the maximum amount payable per day regardless of the time it takes to complete the procedure.

(h) Payment for hospital inpatient services shall be limited to admissions to acute care hospitals.

(i) Payment for services provided by the admitting psychiatrist in an acute care hospital shall not be made, or shall be recouped, if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill

the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting, or quality of care.

(j) The department shall pay psychiatrists for drugs which are administered or dispensed directly to a client under the following conditions:

(1) excluding oral medications, payment shall be made to a psychiatrist for the estimated acquisition cost as determined by the department for drugs which are administered directly to the client; and

(2) for legend drugs which must be administered by a psychiatrist, the department shall reimburse the psychiatrist for the estimated acquisition cost as determined by the department for the amount of the drug which is administered.

(Adopted effective May 11, 1998)

Sec. 17b-262-463. Documentation

(a) Psychiatrists shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the psychiatrist, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the psychiatrist's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the psychiatrist for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective May 11, 1998)

Sec. 17b-262-464—17b-262-466. Reserved

Requirements for Payment of Psychologists' Services

Sec. 17b-262-467. Scope

Psychologists' services provide professional therapeutic intervention relating to mental, emotional, and social problems involving individuals or groups, taking into consideration the sum of actions, traits, attitudes, thoughts, and mental state of an individual. Sections 17b-262-467 through 17b-262-478 inclusive set forth the Department of Social Services requirements for payment of accepted methods of treatment by licensed psychologists for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Effective June 8, 1998)

Sec. 17b-262-468. Definitions

For the purposes of sections 17b-262-467 through 17b-262-478 the following definitions shall apply:

(1) **"Client"** means a person eligible for goods or services under the department's Medical Assistance Program.

(2) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(3) **"Department"** means the Department of Social Services or its agent.

(4) **"HealthTrack Services"** means the services described in subsection (r) of section 1905 of the Social Security Act.

(5) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(6) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(7) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(8) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(9) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(10) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(11) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(12) **"Provider"** means a psychologist.

(13) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(14) **"Psychologist"** means a health professional, licensed by the Board of Examiners of Psychologists of Connecticut pursuant to section 20-186 and under Chapter 383 of the Connecticut General Statutes, who is engaged in private practice and has clinical training and experience approved by the department to provide psychological services to clients eligible under Connecticut's Medical Assistance Program.

(15) **"Psychologists' Services"** that are permitted means clinical, diagnostic, and remedial services personally performed by a psychologist. Services include:

(A) counseling and psychotherapy to individuals who are experiencing problems of a mental or behavioral nature; and

(B) measuring and testing of personality, aptitudes, emotions, and attitudes.

(16) **"Qualified Neuropsychologist"** means a psychologist who:

(A) documents completion of a Ph.D. or Psy.D. degree in clinical psychology from a program approved by the American Psychological Association with extensive pre- or post-doctoral coursework in basic neurosciences, neuroanatomy, neuropathol-ogy, clinical neurology, psychological assessment, clinical neuropsychological assessment, psychopathology and psychological intervention; and either

(B) has completed one year of full-time supervised clinical neuropsychological experience at the post-doctoral level and at least one year of independent professional experience as a clinical neuropsychologist, or, in lieu of (B), has

(C) the equivalent of three years of unsupervised post-doctoral experience as a clinical neuropsychologist within the past ten years.

(17) **"Neuropsychological Evaluation"** means a full battery of tests used to develop a diagnosis. The evaluation is the sum of all the testing and diagnostic interview sessions. The components of the neuropsychological evaluation are: patient history; assessment of perceptual motor functions; language functions; attention; memory, learning, intellectual processes and level; and emotional, behavioral, and personality functioning. The evaluation must be accomplished by means of appropriate psychological procedures administered by a qualified neuropsychologist.

(18) **"State Plan"** means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Effective June 8, 1998)

Sec. 17b-262-469. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Effective June 8, 1998)

Sec. 17b-262-470. Eligibility

Payment for psychologists' services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Effective June 8, 1998)

Sec. 17b-262-471. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed psychologist which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following psychological services:

(1) Psychodiagnostic Evaluations

(A) Intellectual Evaluation - Individual

Evaluation of intellectual functioning by means of appropriate psychological procedures, such as the Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children, and Stanford-Binet Intelligence Scale;

(B) Scholastic Achievement or Group Intelligence

(i) Scholastic Achievement: Determination of acquired abilities in areas of educational achievement through the administration and evaluation of tests, California Reading Test, and Wide Range Achievement Test; and

(ii) Group Intellectual Evaluation: Determination of intellectual functioning by means of group intelligence tests such as the Lorge-Thorndike Intelligence Test, Otis Quick-Scoring Mental Ability Test, and California Short-Form Test of Mental Maturity;

(C) Personality Diagnosis and Evaluation

Study of personality dynamics, interpersonal relations, emotional adjustment, and stability, through the utilization of psychological procedures such as Rorschach, MMPI, Thematic Apperception Test, Children's Apperception Test, and Figure-Drawing;

(D) Evaluation of Organic Brain Involvement: Organicity

Assessment of functions requiring memory, concept formation, visual motor skills, by

means of psychological procedures such as the Wechsler Memory Scale, Goldstein-Scheerer Battery Graham-Kendall Memory for Designs, and Bender Visual Motor Gestalt Test;

(E) Evaluation of Aptitudes, Interests, and Educational Adjustment

Assessment of vocational aptitudes and interests and educational achievement by means of such procedures as manipulation tests of dexterity and coordination, vocational aptitude tests, interest tests, and achievement tests; and

(F) Neuropsychological Evaluation

Assessment of perceptual or motor functions; attention; memory; and learning; intellectual processes; and emotion, behavior, and personality by means of appropriate psychological procedures administered by a qualified neuropsychologist, such as the Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, and the Halstead-Reitan Neuropsychological Battery.

(2) Counseling and Psychotherapy

(A) Diagnostic Interview

Initial contact, review of available records, and personal interview with subject. Applicable only when formal testing is not possible;

(B) Individual Counseling or Psychotherapy; and

(C) Group Counseling or Psychotherapy.

(3) Staff Consultation

Attendance at staff conferences to present and to discuss psychological findings in planning for the individual; and

(4) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) a diagnostic interview or psychodiagnostic evaluation procedure is limited to one of each in any twelve month period per psychologist for the same client;

(2) only one unit of individual counseling or psychotherapy and one unit of group counseling or psychotherapy shall be paid for on the same day;

(3) the department shall not pay for more than one psychodiagnostic evaluation in any twelve month period when performed by the same psychologist for the same client;

(4) group psychotherapy sessions shall be limited in size to a maximum of eight persons per group session regardless of the payment source of each participant;

(5) only two staff consultations, as described in subdivision (3) of subsection (a) of section 17b-262-471, shall be allowed per year per client per psychologist; and

(6) services covered are limited to those listed in the department's published fee schedule.

(Effective June 8, 1998)

Sec. 17b-262-472. Services not covered

The department shall not pay for the following psychological services:

(a) information or services furnished by the psychologist to the client over the telephone;

(b) all evaluations, diagnostic interviews, and therapy services performed in hospital

inpatient or outpatient settings;

(c) concurrent services involving similar treatment modalities for the same client by different health professionals;

(d) cancelled office visits or for appointments not kept; and

(e) psychological services which are primarily for vocational or educational guidance.

(Effective June 8, 1998)

Sec. 17b-262-473. Need for service and authorization process

(a) **Need for Service**

The department shall pay for psychological services which are provided by a licensed psychologist and are medically necessary and medically appropriate for the prevention, diagnosis, and treatment of intellectual functioning and mental illness.

(b) **Prior Authorization**

(1) Prior authorization, on forms and in a manner as specified by the department, is required for:

(A) all clients for all counseling and psychotherapy interviews in excess of thirteen visits in a calendar quarter, per type of treatment for the same provider and client; and

(B) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(2) For services requiring prior authorization, the procedure or course of treatment shall be initiated within six months of the date of authorization.

(3) The initial authorization period shall be up to three months.

(4) All authorization request forms shall include an explanation of the need for additional treatment for services in excess of the limitations described in subparagraph (A) of subdivision (1) of subsection (b) of section 17b-262-473, and the future gains expected.

(5) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorized period shall be considered for up to six months per request.

(6) The provider shall determine as soon as possible whether the number of service visits necessary shall exceed thirteen visits in a calendar quarter. If the number of visits shall exceed the limit, authorization shall be obtained from the department prior to the onset of the service visits for which authorization is needed.

(7) The authorization request form shall include the name of the physician, person, or agency making the referral.

(8) In urgent situations involving services which require prior authorization, the provider of service may request verbal approval by the department during normal working hours, or no later than the next business day if the urgent situation occurs outside of the department's normal working hours, when such authorization may be given. However, approval in such a manner shall be limited to psychological services that are immediately necessary and vital to the health and safety of the client.

(9) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Effective June 8, 1998)

Sec. 17b-262-474. Billing procedures

(a) Claims from psychologists shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the psychologist's usual and customary charge for the services delivered.

(c) Claims submitted for services not requiring prior authorization shall include the name of the physician, person, or agency making the referral—if there was a referral.

(d) When a psychologist is requested to attend a staff conference for a Medical Assistance Program client, the name of the referring practitioner, clinic, or agency shall be entered in the appropriate section of the claim form.

(e) Neuropsychological evaluations shall be billed as one unit regardless of the number of sessions.

(Effective June 8, 1998)

Sec. 17b-262-475. Payment

(a) Psychologists who are fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department unless the psychologist maintains an office for private practice at a separate location from the hospital, institution, or clinic in which the psychologist is employed and bills for a service provided to the psychologist's private practice client at the psychologist's private practice location only.

(b) Payment for services directly performed by a psychologist in private practice shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or

services by the provider from any person or entity.

(Effective June 8, 1998)

Sec. 17b-262-476. Payment rate

The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Effective June 8, 1998)

Sec. 17b-262-477. Payment limitations

(a) The psychologist's interview of the client's family during the course of treatment in the psychologist's office shall be paid at the rate for individual therapy regardless of the number of persons in attendance.

(b) The fees for evaluative and treatment services, as stipulated in the psychologist's fee schedule, represent one unit of service, and only one unit shall be billed per day per service regardless of the number of days to complete the unit billed.

(c) The department shall not reimburse the psychologist for services performed by allied health professionals or paraprofessionals who are in the employ of the psychologist. The psychologist shall be paid for services only to the clients personally being treated by the psychologist.

(Effective June 8, 1998)

Sec. 17b-262-478. Documentation

(a) Psychologists shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the psychologist, documentation of services provided, and the dates the services were provided.

(b) The evaluation report for psychodiagnostic tests, including the Aptitudes, Interests, and Education Adjustment Evaluation, shall be on file with the psychologist to justify medical necessity and medical appropriateness of treatment.

(c) All required documentation shall be maintained for at least five years in the psychologist's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(d) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the psychologist for which the required documentation is not maintained and provided to the department upon request.

(Effective June 8, 1998)

Sec. 17b-262-479—17b-262-492. Reserved

Requirements for Client Copayment on Prescription Drugs, Over-The-Counter Drugs, and Refills Under the Medical Assistance Program

Sec. 17b-262-493. Scope

Sections 17b-262-493 to 17b-262-498 inclusive, set forth the copayment requirements for clients who are eligible to receive prescription drugs, over-the-counter drugs, or refills covered under the Medicaid, General Assistance and State Administered General Assistance Programs and furnished by a pharmacy provider enrolled in the Connecticut Medical Assistance Program pursuant to section 17b-259a and section 17b-262 of the Connecticut General Statutes and subject to the exclusions as set forth in section 17b-262-496.

(Adopted effective November 13, 1997)

Sec. 17b-262-494. Definitions

For the purposes of sections 17b-262-493 to 17b-262-498 inclusive, the following definitions shall apply:

(1) "Client" means a person eligible for services under the department's Medical Assistance Program.

(2) "Compounded Prescriptions" means two or more drugs mixed together in which at least one ingredient is a legend drug. A compounded prescription shall include the name, strength, and amount of each prescribed ingredient.

(3) "Copayment" means the set portion of the department's fee for prescription drugs, over-the-counter drugs, or refills which shall be the responsibility of the client to pay to the pharmacy provider for such services furnished to the client.

(4) "Department" means the department of social services.

(5) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319V of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(6) "Pharmacy" means a facility licensed by the Commission of Pharmacy in the Department of Consumer Protection under Section 20-594 of the Connecticut General Statutes or by the appropriate regulatory body of the state in which it is located.

(7) "Provider" means any individual or entity enrolled in the department's Medical Assistance Program and performing within the scope of his or her practice under state law and capable of furnishing services or goods to Medical Assistance clients under the terms of a provider agreement with the department.

(8) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(Adopted effective November 13, 1997)

Sec. 17b-262-495. Services requiring a copayment

Except for the exclusions specified in section 17b-262-496 below, a copayment shall be

imposed on each prescription, over-the-counter drug, or refill which is furnished to a client and covered in the department's fee schedule for pharmacy providers.

(Adopted effective November 13, 1997)

Sec. 17b-262-496. Copayment exclusions

The following list contains those clients and services not subject to a copayment:

(a) The categories of clients and services described in subsection (b) of section 1916 of the Social Security Act and Part 447, section 447.53, of Title 42 of the Code of Federal Regulations (CFR), are specifically excluded from the copayment requirement;

(b) Children who are at least 18 years of age but under 21 years of age; and

(c) Compounded prescriptions.

(Adopted effective November 13, 1997)

Sec. 17b-262-497. Copayment responsibilities

(a) Each pharmacy provider shall collect the copayment amount from the client at the time of the service unless the pharmacy provider, in dispensing a prescription, over-the-counter drug, or refill, does not have face-to-face contact with the client, in which case, the pharmacy shall bill the client for the amount of the copayment;

(b) The copayment shall be automatically deducted from the maximum allowable amount paid by the department to the pharmacy provider for each prescription drug, over-the-counter drug, or refill;

(c) A pharmacy provider participating in the Connecticut Medical Assistance Program may not deny prescription drugs, over-the-counter drugs, or refills to any client because of the client's inability to pay the copayment amount. The client's inability to pay does not eliminate the client's liability for the copayment charge or prevent the provider from attempting to collect the copayment amount from the client at a later time;

(d) The client's own declaration that he or she is unable to pay the copayment amount at the time of the service is the basis for determining when a client is unable to pay; and

(e) No pharmacy provider may waive the copayment requirement or in any way compensate the client for the copayment amount.

(Adopted effective November 13, 1997)

Sec. 17b-262-498. Copayment rate

The copayment amount shall be $1.00 for each prescription drug, over-the-counter drug or refill.

(Adopted effective November 13, 1997)

Requirements for Payment of Inpatient Psychiatric Hospital Services

Sec. 17b-262-499. Scope

Sections 17b-262-499 through 17b-262-510 inclusive set forth the Department of Social

Services requirements for payment for Connecticut's Medical Assistance Program, when clients under age twenty-one and age sixty-five or over receive inpatient psychiatric hospital services in accordance with section 17b-262-499 through section 17b-262-510.

(Adopted effective March 6, 1998)

Sec. 17b-262-500. Definitions

For the purposes of sections 17b-262-499 through 17b-262-510 the following definitions shall apply:

(1) "Active Treatment" means the definition contained in 42 Code of Federal Regulations (CFR), Part 441, section 441.154.

(2) "Acute" means having rapid onset, severe symptoms, and a short course.

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

(4) "Allied Health Professional (AHP)" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in mental health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, and other qualified therapists.

(5) "Certification of Need Review" means an evaluation process for clients under the age of twenty-one who are requesting inpatient admission to a psychiatric hospital. This evaluation is conducted by the department acting as the independent team.

(6) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(7) "Client Age Sixty-Five or Over" means the definition contained in 42 CFR, Part 441, section 441.100.

(8) "Client Under Age Twenty-One" means the definition contained in 42 CFR, Part 441, section 441.151.

(9) "Department" means the Department of Social Services or its agent.

(10) "Elective Admission" means any psychiatric admission to a psychiatric hospital or psychiatric facility that is nonemergency, including urgent admissions and transfers from one facility to another.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by

the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(13) "Independent Team" means the definition contained in 42 CFR, Part 441, section 441.153. In addition, the independent team may not include anyone who is related, in any way, to the admitting facility, or who is directly responsible for the care of patients whose care is being reviewed, or has a financial interest in the admitting facility. The department performs the functions of the independent team.

(14) "Inpatient" means the definition contained in 42 CFR, Part 440, section 440.2. The client must also be present in the hospital at midnight for the census count.

(15) "Interdisciplinary Team" for review of clients under the age of twenty-one, means the definition contained in 42 CFR, Part 441, section 441.156.

(16) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(17) "Joint Commission on Accreditation of Healthcare Organizations (JCAHO)" means a national, private, not-for-profit organization founded in 1951, which offers accreditation to health care organizations throughout the United States.

(18) "Leave of Absence" means a conditional release which is a period of time after admission and prior to the day of discharge, in which the client has been permitted by the attending physician to be absent from the facility premises.

(19) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(20) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(21) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(22) "Medical Record" means the definitions contained in 42 CFR, Part 482, section 482.6l, and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(23) "Plan of Care" means the definitions contained in 42 CFR, Part 441, Subpart D, and Part 456, sections 456.180 through 456.181.

(24) "Preadmission Review" means a review prior to, or, in the case of an emergency admission, within fourteen days after a client's admission to an inpatient psychiatric facility with the purpose of determining the medical necessity, appropriateness, and quality of the health care services to be delivered, or in the case of an emergency, delivered in the hospital.

(25) "Prior Authorization" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

(26) "Provider" means a psychiatric hospital or psychiatric facility.

(27) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(28) "Psychiatric Emergency" means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability, or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a Physician Emergency Certificate are not automatically deemed to qualify as a psychiatric emergency.

(29) "Psychiatric Facility" means an institution which is not a hospital and is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHO), to provide inpatient psychiatric services under the direction of a physician to clients who are under the age of twenty-one or age sixty-five or over, and meets specific conditions contained at 42 CFR, Part 435, section 435.1009.

(30) "Psychiatric Hospital" means an accredited or state licensed institution which is engaged in providing hospital level psychiatric services, under the supervision of a physician, for the diagnosis and treatment of mentally ill persons. Specific conditions for psychiatric hospital contained at 42 CFR, Part 482, sections 482.60 through 482.62, and at 42 CFR, Part 435, section 435.1009, shall be implemented. Psychiatric units or beds in a general, acute care hospital are not included in this definition.

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

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

(33) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations.

(34) "Transfer" means that an individual is discharged from the hospital or facility and directly admitted to another.

(35) "Under the Direction of a Physician" means that health services may be provided by allied health professionals whether or not the physician is physically present at the time that the services are provided. The physician shall:

(A) assume professional responsibility for the services provided;

(B) assure that the services are medically appropriate; and

(C) be readily available within five minutes but not necessarily on the premises.

(36) "Urgent Admission" means an elective, nonemergency admission.

(37) "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 concurrent, prospective, or retrospective basis.

(Adopted effective March 6, 1998)

Sec. 17b-262-501. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall meet the following requirements:

(a) **General:**

(1) meet and maintain all applicable licensing, accreditation, and certification requirements;

(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 Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) **Specific:**

(1) providers of inpatient psychiatric services shall be licensed, when appropriate, by the state and accredited as a psychiatric hospital by the Joint Commission on Accreditation of Healthcare Organizations, and

(2) psychiatric hospitals outside of Connecticut shall meet all of the above provider requirements. They shall also be an enrolled Medical Assistance Program provider in their state of residence, when that state participates in the optional program of Medical Assistance Program psychiatric inpatient services provided to clients age twenty-one and under and age sixty-five and over.

(Adopted effective March 6, 1998)

Sec. 17b-262-502. Eligibility

Payment for inpatient psychiatric hospital services shall be available on behalf of Medical Assistance Program clients under age twenty-one and age sixty-five or over under the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-503. Services covered

The department shall pay for the following:

(a) medically necessary and medically appropriate inpatient psychiatric services for

clients under age twenty-one or age sixty-five or over when the need for services as stated in section 17b-262-499 through section 17b-262-511 are met and provided by an enrolled Medical Assistance Program provider;

(b) inpatient hospital tests when the tests are specifically ordered by the attending physician or other licensed practitioner who is responsible for the diagnosis and treatment of the client, and who is acting within the scope of practice as defined under state law;

(c) HealthTrack Services; and

(d) HealthTrack Special Services. HealthTrack Special Services require prior authorization on a case-by-case basis to determine that the services are medically necessary and medically appropriate.

(Adopted effective March 6, 1998)

Sec. 17b-262-504. Services not covered

The department shall not pay for the following inpatient psychiatric hospital services which are not covered under the Medical Assistance Program:

(a) procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature or for any diagnostic, therapeutic, or treatment procedures in excess of those deemed medically necessary and appropriate by the department to treat the client's condition;

(b) services that do not directly relate to the client's diagnosis, symptoms, or medical history;

(c) services or items furnished for which the provider does not usually charge;

(d) the day of discharge or transfer;

(e) an inpatient psychiatric hospital admission or a day of care that does not meet all the department's requirements for inpatient services;

(f) an inpatient psychiatric hospital admission or a day of care that is denied by the hospital's Utilization Review Committee;

(g) a day when the client, who is age sixty-five or over, is absent from the psychiatric hospital at the midnight census, even though the leave or transfer is medically authorized and part of the treatment plan;

(h) a day when the client, who is under age twenty-one, is absent from the psychiatric hospital at the midnight census, even though the leave or transfer is medically authorized and part of the treatment plan; or

(i) costs associated with the education or vocational training of the client which shall be excluded from Medical Assistance Program payments.

(Adopted effective March 6, 1998)

Sec. 17b-262-505. Certification of need review requirements for inpatient psychiatric services for a client under age twenty-one in a psychiatric hospital

(a) In order to receive payment for inpatient psychiatric hospital services for individuals under age twenty-one, each individual admission, including elective and emergency

admissions, shall have a certification of need review.

(b) The certification of need review shall be a part of the client's medical record, with written documentation certifying that:

(1) ambulatory care resources available in the community do not meet the treatment needs of the client;

(2) proper treatment of the client's psychiatric condition requires inpatient care under the direction of a physician; and

(3) the services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.

(c) When the admission of a Medical Assistance Program client is elective, an independent team is responsible to perform the certification of need review. The department shall act as the independent team.

(d) When the admission is an individual who is not Medical Assistance Program eligible and who applies for the Medical Assistance Program while in the hospital, the certification of need review shall be conducted at the time of application for Medical Assistance Program coverage or by the first day of Medical Assistance Program coverage. An interdisciplinary team conducts the certification of need review which shall cover any period prior to application for which Medical Assistance Program claims are made. In addition, this certification of need review shall be validated by the independent team.

(e) For emergency admissions, the certification of need review shall be completed by an interdisciplinary team within fourteen days after the emergency admission and validated by the independent team.

(f) When the client is transferred from a psychiatric hospital to an acute care hospital and upon discharge readmitted to the psychiatric hospital, a new certification of need review by the independent team is required.

(Adopted effective March 6, 1998)

Sec. 17b-262-506. Individual plan of care requirements for inpatient psychiatric services for a client under age twenty-one in a psychiatric hospital

(a) Inpatient psychiatric services for clients under age twenty-one shall constitute active treatment, as documented in the professionally developed and supervised individual plan of care.

(b) Before admission or before authorization for payment, the interdisciplinary team shall establish a written plan of care for each applicant or client, designed to achieve the client's discharge from inpatient status at the earliest possible time. This plan shall:

(1) be based on a diagnostic evaluation that includes examinations of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and thereby reflect the need for inpatient psychiatric care;

(2) be developed by the interdisciplinary team of professionals in consultation with the client, and his or her parents, legal guardian, or others into whose care he or she will be released after discharge;

(3) state the treatment objective;

(4) prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives;

(5) include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the client's family, school, and community upon discharge; and

(6) be a recorded document which is maintained in the client's medical record.

(c) In addition, the individual plan of care shall be reviewed every thirty days by the interdisciplinary team, starting at the date of admission. The purpose of the review is to determine that services being provided are currently required or were required on an inpatient basis, and to recommend any changes to the plan that are indicated by the client's overall progress towards the treatment goals.

(d) The development and review of the plan of care shall satisfy the utilization control requirements for recertification and the establishment and periodic review of the plan of care.

(Adopted effective March 6, 1998)

Sec. 17b-262-507. Individual plan of care for a client age sixty-five or over in a psychiatric hospital

(a) A written, individual plan of care shall be developed to ensure that institutional care maintains the client at, or restores them to, the greatest possible degree of health and independent functioning. The plan of care for an elective admission shall be completed by the attending or staff physician prior to admission. The plan of care for clients age sixty-five or over, in addition to the requirements specified in the definitions, shall also include:

(1) an initial review of the client's medical, psychiatric, and social needs;

(2) periodic review of the client's medical, psychiatric, and social needs;

(3) a determination, at least every ninety days, of the client's need for continuing institutional care and for alternative care arrangements;

(4) appropriate medical treatment in the institution; and

(5) appropriate social services.

(b) In the situation where an individual applies for Medical Assistance Program eligibility after an elective or emergency admission to the psychiatric hospital, the plan of care shall be completed at the same time that the Medical Assistance Program application is submitted to the department or by the first day of Medical Assistance Program coverage. It shall cover both the period prior to and after application for which Medical Assistance Program claims are made.

(Adopted effective March 6, 1998)

Sec. 17b-262-508. Utilization review program for inpatient psychiatric services for clients under age twenty-one or age sixty-five or over

(a) The department's Utilization Review Program conducts utilization review activities

for services delivered by the inpatient psychiatric hospital to clients where the Medical Assistance Program has been determined to be the appropriate payer.

(b) To determine that inpatient psychiatric services or admissions are medically necessary and medically appropriate, the department may:

(1) require preadmission review or prior authorization of each inpatient psychiatric hospital admission, including a certificate of need review, for clients under age twenty-one, unless the department notifies the providers that a specific admission, diagnosis, or procedure does not require such authorization; and

(2) perform retrospective reviews at the department's discretion which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the appropriateness, necessity, or quality of the health care services provided.

(c) If the department decides to impose prior authorization or preadmission review requirements, all effected providers shall be notified at least thirty days in advance of date of implementation.

(d) All claims for payment for admission and all days of stay and services that are provided shall be documented. Lack of said documentation itself may be adequate ground for the department, in its discretion, to deny or recoup payment for the admission for some or all of the days of stay or services provided.

(e) The department shall conduct medical review and inspections of care in psychiatric hospitals.

(Adopted effective March 6, 1998)

Sec. 17b-262-509. Billing procedures

Claims from inpatient psychiatric providers shall be submitted on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(Adopted effective March 6, 1998)

Sec. 17b-262-510. Documentation and record retention

(a) A provider shall meet the special medical record requirements for a psychiatric hospital and shall maintain records to support claims made for payment. All documentation shall be made available upon request by and to authorized department, state, or federal personnel in accordance with state and federal laws. Documentation shall be retained by the provider for a period of five years, or if any dispute arises concerning a service, until such dispute has been finally resolved.

(b) Failure to maintain all required documentation or to provide it to the department upon request, may result in the disallowance and recovery by the department of any amounts paid out for which the required documentation is not maintained or provided.

(Adopted effective March 6, 1998)

Sec. 17b-262-511. Reserved

Requirements for Payment to Independent Radiology and Ultrasound Centers

Sec. 17b-262-512. Scope

Sections 17b-262-512 through 17b-262-520 inclusive set forth the Department of Social Services requirements for the payment of radiology services performed by an independent radiology or ultrasound center provided in a freestanding center, which is not part of a physician's office nor a hospital outpatient department or clinic, for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-513. Definitions

For the purposes of sections 17b-262-512 through 17b-262-520 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Electrocardiogram (EKG) Services" means diagnostic services derived from an electrocardiogram device which measures the electrical variations in heart muscles.

(6) "Electroencephalogram (EEG) Services" means diagnostic services derived from an electroencephalogram instrument which records the electrical activity of the brain.

(7) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(8) "Freestanding Radiology or Ultrasound Center" means those centers which offer radiology or ultrasound services but which are not part of a physician's office nor an inpatient or outpatient hospital service.

(9) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(10) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(11) "Interperiodic Encounter" means any medically necessary visit to a Connect-icut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(12) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(13) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities.

(14) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(15) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(16) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(17) "Provider" means a radiology or ultrasound center which provides professional and technical services and which is independent of a physician's office or an inpatient or outpatient hospital department or clinic.

(18) "Provider Agreement" means the signed, written, contractual, agreement between the department and the provider of services or goods.

(19) "Radiology" means any diagnostic and treatment service administered through the use of radiant energy.

(20) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(21) "Ultrasound Services" means diagnostic and therapeutic services administered by ultrasound equipment—equipment emitting inaudible sound frequencies in the approximately 20,000 to 10,000,000,000 cycles per second range.

(Adopted effective March 6, 1998)

Sec. 17b-262-514. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-515. Eligibility

Payment for radiology or ultrasound center services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-516. Services covered

The department shall pay for:

(a) medically appropriate and medically necessary radiology or ultrasound center services as published in the department's fee schedule when ordered by a licensed physician or other licensed practitioner of the healing arts; and

(b) HealthTrack Services and HealthTrack Special Services.

(Adopted effective March 6, 1998)

Sec. 17b-262-517. Need for service and authorization process

(a) **Need for Service**

The department shall pay for independent radiology and ultrasound center services which are ordered by a duly licensed physician or other licensed practitioner of the healing arts and which the department deems to be medically necessary and medically appropriate.

(b) **Prior Authorization**

Prior authorization, on forms and in a manner as specified by the department, shall be required for HealthTrack Special Services:

(1) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(2) the request for HealthTrack Special Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as

defined under state law, justifying the need for the item or service requested;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(c) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-518. Billing procedures

(a) Claims from independent radiology or ultrasound center providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The payment for radiology or ultrasound center services includes all consultation services as well as the written report to the referring physician.

(Adopted effective March 6, 1998)

Sec. 17b-262-519. Payment rate and limitations

(a) The commissioner shall establish the fees contained in the department's published fee schedule for independent radiology and ultrasound centers pursuant to section 4-67c of the Connecticut General Statutes.

(b) The payment rate shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(c) When emergency services are rendered after normal posted business hours, a fee as indicated on the provider's fee schedule shall be reimbursed to the provider per patient.

(d) Actual allowable procedures billable to the Medical Assistance Program are negotiated individually by provider.

(Adopted effective March 6, 1998)

Sec. 17b-262-520. Documentation

(a) Independent radiology or ultrasound center providers shall maintain a specific record for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, documentation of the services provided, and the dates the services

were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and provided to the department by request.

(Adopted effective March 6, 1998)

Sec. 17b-262-521. Reserved

Requirements for Provider Participation in the Connecticut Medical Assistance Program

Sec. 17b-262-522. Scope

Sections 17b-262-522 through 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services general requirements to which providers of Medical Assistance Program goods and services shall adhere in order to participate in, and receive payment from, the Connecticut Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

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

Sec. 17b-262-523. Definitions

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

(1) **"Acute"** means symptoms that are severe and have a rapid onset and a short course;

(2) **"Border provider"** means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and that is enrolled as and treated as a Connecticut Medical Assistance Program provider. Such providers are certified, accredited, or licensed by the applicable agency in their state and are deemed border providers by the department on a case by case basis;

(3) **"Claim"** means a request for payment submitted by a provider to the department, or its fiscal agent, in accordance with the billing requirements set forth by the department;

(4) **"Client"** means a person eligible for goods or services under the department's Medical Assistance Program;

(5) **"Commissioner"** means the commissioner of the Connecticut Department of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes;

(6) **"Copayment"** means a nominal fee, chargeable to the client and not payable from the department, for specified goods or services and which meets the requirements of section 1916 of the Social Security Act and 42 CFR 447.15 and 42 CFR 447.50 to 42 CFR 447.58,

inclusive;

(7) **"Coverable Medical Assistance Program good or service"** means any good or service which is payable by the Medical Assistance Program under its regulations;

(8) **"Department"** means the Connecticut Department of Social Services or its agent;

(9) **"Emergency"** means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(10) **"Free of charge"** means a good or service for which no individual client has an obligation to pay and for which no third party payment is ever sought;

(11) **"Lock-in"** means the department's restriction of a client to a specific provider for certain Medical Assistance Program goods or services under the authority of section 17-134d-11 of the Regulations of Connecticut State Agencies;

(12) **"Medical appropriateness or medically appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate [medical]setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(13) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid;

(14) **"Medical Assistance Program goods or services"** means medical care or items that are furnished to a client to meet a medical necessity in accordance with applicable statutes or regulations that govern the Medical Assistance Program;

(15) **"Medical necessity or medically necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring;

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

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

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

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

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

the goods;

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

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

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

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

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

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

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

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

(29) **"Type and specialty"** means the department's categorization of Medical Assistance Program providers according to the type and specialty of the goods or services furnished by the provider.

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

Sec. 17b-262-524. Provider participation

(a) To enroll in the Medical Assistance Program and receive payment from the department for the provision of goods or services to Medical Assistance Program clients, providers shall:

(1) Meet and maintain all applicable licensing, accreditation and certification requirements;

(2) meet and maintain all departmental enrollment requirements including the timely submission of a completed provider enrollment or reenrollment form and submission of all enrollment information and such affidavits as the department may require; and

(3) have a valid provider agreement on file which is signed by the provider and the

department. This agreement, which shall be periodically updated, shall continue to be in effect for the duration specified in the agreement. The provider agreement specifies conditions and terms that govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) Additionally, the department shall at its discretion:

(1) Require documentation or other information necessary to ensure that requirements for enrollment in a type of service and specialty have been met pursuant to all applicable statutes and regulations;

(2) require that an out-of-state or border provider submit such supplemental documentation as it requires in the event their licenses, certificates, permits or other credentials do not disclose the required information, or if the criteria for attainment of such credentials is different from similarly situated in-state providers;

(3) require submission of a schedule of charges to the general public or any other pertinent data or information necessary to facilitate review of new or existing services;

(4) approve or disapprove enrollment or reenrollment of any provider based upon the department's requirements. The department in its sole discretion shall determine whether the provider meets the requirements for enrollment;

(5) deny initial enrollment or reenrollment of any provider when such enrollment or reenrollment is determined not to be in the best interests of the Medical Assistance Program;

(6) deny enrollment or reenrollment of any provider who does not offer coverable Medical Assistance Program goods or services regardless of whether the provider meets all other enrollment requirements; and

(7) enroll out-of-state providers if they provide services to clients who are out-of-state in accordance with section 17b-262-532 of the Regulations of Connecticut State Agencies.

(c) At the discretion of the department, out-of-state providers shall be eligible for enrollment or reenrollment into the Medical Assistance Program based on documentation of current enrollment in the Medical Assistance Program in another state.

(d) Failure by the provider to submit any required documents or information for reenrollment, at such times and in such a manner as the department shall require, may result in the loss of the provider's eligibility to participate in the Medical Assistance Program.

(e) Specific enrollment requirements for provider types and specialties are set forth in the Regulations of Connecticut State Agencies dealing with the specific provider type and specialty. The department in accordance with the governing Regulations of Connecticut State Agencies shall, in its sole discretion, determine the category of provider type and specialty into which a provider falls.

(f) For purposes of this section, the terms "institution" or "general hospital" include (1) any wholly or partially owned subsidiary of the institution or general hospital; (2) any entity that is related to the institution or general hospital, including, but not limited to, a parent company, or wholly or partially owned subsidiary of the institution or general hospital; and (3) any other entity, such as a partnership, that is established by (A) the institution or general hospital or (B) any entity related to the institution or general hospital, including a parent

company and its wholly or partially owned subsidiaries.

(g) Notwithstanding any provisions of the Regulations of Connecticut State Agencies or any medical services policy, any provider who is (1) compensated directly or indirectly by an institution or general hospital or (2) located within an institution or general hospital, which includes being located in an institution or general hospital complex, campus or auxiliary or satellite location, may bill the department for services rendered to the provider's medical assistance program private practice clients who receive services at the institution or general hospital location if all of the following criteria are met:

(1) The provider maintains a practice at a location other than the location which is within the institution or general hospital complex, campus or auxiliary or satellite location;

(2) the provider is enrolled as a medical assistance program provider at the location that is separate from the institution or general hospital location and actively bills, as determined by the department, the Medical Assistance Program for services rendered at that separate location;

(3) the operations of the provider are entirely separate and independent from the institution or general hospital. The department considers the operations of a provider as entirely separate and independent if the following criteria are met:

(A) the provider does not utilize space that is directly or indirectly owned by the institution or general hospital unless the space is rented at fair market value;

(B) the provider and provider staff do not receive compensation in any form from the institution or general hospital for any reason for clinical services at the institution or general hospital;

(C) the provider and the institution or general hospital do not share administrative and support staff; and

(D) the provider and the institution or general hospital have no direct or indirect relationship relative to ownership or control;

(4) any direct and indirect costs associated with the services performed by the provider or provider staff are not included in the annual cost report of the institution or general hospital; and

(5) the provider has performed an evaluation and management service for the client at its separate location within the previous year.

(h) Notwithstanding the criteria identified in subdivision (3) of subsection (g) of this section, the provider may bill if the provider can demonstrate to the satisfaction of the department that the arrangements between the provider and the institution or general hospital do not result in duplication of payments. Evidence of lack of duplication of payments may include, but is not limited to, a copy of the provider-facility contract.

(i) Notwithstanding the requirements of subsections (g) and (h) of this section, a medical foundation established pursuant to sections 33-182aa to 33-182ff, inclusive, of the Connecticut General Statutes may bill the department for goods or services provided to Medical Assistance Program clients only after obtaining the department's approval. In order to obtain such approval, and as requested by the department from time to time, the medical

foundation shall demonstrate, to the department's satisfaction, that mechanisms are in place to ensure that there will be no duplicate billing to or payment by the department relating to the provision of such goods or services. Not later than three months after the medical foundation begins billing the department, and as requested by the department from time to time, the medical foundation shall demonstrate to the department that no such duplicate billing in fact occurs. Duplicate billing includes, but is not limited to, claims for costs associated with related party transactions among the medical foundation, the hospital and any other related party, as defined in subsection (o) of section 17b-262-531 of the Regulations of Connecticut State Agencies.

(Adopted effective February 8, 1999; Amended April 1, 2003; Amended June 5, 2012)

Sec. 17b-262-525. Termination or suspension of provider agreement

(a) Providers shall be subject to all of the conditions contained in section 17b-99 of the Connecticut General Statutes and sections 17-83k-1 through 17-83k-7 of the Regulations of Connecticut State Agencies.

(b) A provider agreement may be terminated by mutual consent or without cause by either the department or the provider by giving a thirty day written notification to the affected party, or as otherwise provided by federal or state law.

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

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

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

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

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

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

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

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

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

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

(8) maintain all required documentation for at least five years or longer as required by state or federal law or regulation in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning goods or services provided, documentation shall be maintained until the end of the dispute,for five years, or the length of time required by state or federal law or regulation, whichever is greatest. Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request, as permitted by state and federal law;

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

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

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

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

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

beyond nominal costs incurred by such participation.

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

Sec. 17b-262-527. Need for goods or services

The department shall review the medical appropriateness and medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such goods and services.

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

Sec. 17b-262-528. Prior authorization

(a) Prior authorization, to determine medical appropriateness and medical necessity, shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

(b) Prior authorization shall be granted by the department to a provider to furnish specified goods or services within a defined time period as set forth in the regulations of the department governing specific provider types and specialties.

(c) Payment for medical goods or services provided to a client, for which prior authorization is given, is contingent upon the client's eligibility at all times such goods and services are furnished.

(d) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(e) Coverable Medical Assistance Program goods or services requiring prior authorization may be so identified on the department's applicable fee schedule or identified in regulation.

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

Sec. 17b-262-529. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent within twelve months of the date the service was provided or the good was delivered and shall include all information required by the department to process the claim for payment, as set forth in the Regulations of Connecticut State Agencies and specified in the department's provider billing manuals. The date of service is the actual date on which the service was provided.

(b) Exceptions to the procedures set forth in subsection (a) of section 17b-262-529 of the Regulations of Connecticut State Agencies shall be as follows:

(1) when an individual is an applicant of the Medical Assistance Program or an applicant for a categorically related program which qualifies the individual for the Medical Assistance

Program, and the determination of eligibility comes after the last date of service and eligibility is retroactive, the provider shall submit claims for goods or services received within one year of the effective date of the determination of eligibility or effective date of award, whichever comes later;

(2) when there is an issue related to Medical Assistance Program eligibility or to payment for goods or services which is subject to the grievance process, the provider shall submit claims within the guidelines in subsection (a) of section 17b-262-529 of the Regulations of Connecticut State Agencies or within twelve months of the effective date of the resolution in favor of Medical Assistance Program payments for goods or services, whichever is later; and

(3) when a provider has submitted a claim to a third party insurer and has not received a response within a reasonable time, the one year shall begin twelve months from the date of receipt of the explanation of benefits form. The provider shall be responsible for any followup to the third party insurers.

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

Sec. 17b-262-530. Payment rates

(a) All schedules of payment for coverable Medical Assistance Program goods and services shall be established by the commissioner and paid by the department in accordance with all applicable federal and state statutes and regulations.

(b) A provider whose rates are established by the department based on the provider's cost may be required to submit data in a format prescribed by the department which may include but not be limited to, the following:

(1) a copy of the provider's financial statement and an independent auditor's report for the most recently completed fiscal year, or anticipated costs if the program or service is new;

(2) a copy of the provider's financial statement for the current year to date;

(3) a current copy of the provider's usual and customary charges to the general public; and

(4) the provider's most recent Medicare cost report, if one is required to be filed by the provider.

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

Sec. 17b-262-531. Payment limitations

Payment, by the department, to all providers shall be limited to medically appropriate and medically necessary goods or services furnished to Medical Assistance Program clients. The following payment limitations shall also apply:

(a) the department shall not make payment for any claim for Medical Assistance Program goods or services for persons not eligible for the Medical Assistance Program on the date the good or service is provided, except for those medical services required and requested by the department to determine a person's eligibility for the program;

(b) the department shall not make payment for any Medical Assistance Program goods or services which are not covered under, and furnished in accordance with federal and state statutes and regulations including 42 USC 1396b(f);

(c) the department shall not make an additional payment when a third party payment is equal to or greater than the department's schedule of payment for the same Medical Assistance Program good or service, except to meet the department's obligations as defined by federal and state laws and regulations;

(d) the department shall not make payment for Medical Assistance Program goods or services furnished by a provider after the date of termination of the provider, or during a period of suspension, from the Medical Assistance Program, except as may be determined by the commissioner;

(e) the department shall make payment only to a duly enrolled provider;

(f) the department shall not pay for goods or services that are furnished to providers or clients free of charge;

(g) the department shall not pay for any procedures, goods, or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment goods or services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(h) the department shall not pay for cancelled office visits and appointments not kept;

(i) the department shall make payment only to the provider to whom a client is locked-in, pursuant to section 17-134d-11 of the Regulations of Connecticut State Agencies, except in an emergency;

(j) a provider shall not charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for any portion of the cost of goods or services which are covered and payable under the Connecticut Medical Assistance Program. If a client or representative has paid for the goods or services and the client subsequently becomes eligible for the medical assistance program, payment made by or on behalf of the client shall be refunded by the provider to the payer. The provider then may bill the Medical Assistance Program for the goods or services provided. The provider shall obtain appropriate documentation that the payment was refunded prior to the submission of the claim and shall maintain said documentation;

(k) a provider shall not charge for medical goods or services for which a client would be entitled to have payment made, but for the provider's failure to comply with the requirements for payment established by these regulations;

(*l*) a provider shall only charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the Medical Assistance Program, when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them;

(m) Refunds by vendors to persons eligible for the medical assistance program shall be

in acordance with section 17b-103 of the Connecticut General Statutes. The provider shall obtain and maintain appropriate documentation that the payment was refunded prior to submission of the claim;

(n) a provider shall charge a client a copayment for Medical Assistance Program goods or services only when the department specifically authorizes the provider to collect such copayment from the client;

(o) Any cost used to establish the amount to be reimbursed by the medical assistance program which was incurred by a provider through a related party transaction shall not include any amount in excess of the cost to the related party. Only the actual cost of the product or service to the related party may be used to establish reimbursement by the Medical Assistance Program. Such related party cost shall also meet all other requirements for reimbursement, including, but not limited to, being reasonable and directly related to patient care. For purposes of this section, "related party" is defined as persons or organizations related through an ability to control, ownership, family relationship or business association, and includes persons related through marriage; and

(p) The provider shall be prohibited from reassigning claims in accordance with 42 CFR 447.10.

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

Sec. 17b-262-532. Payment for out-of-state goods or services

(a) Pursuant to 42 CFR 431.52, payment for Medical Assistance Program goods or services furnished to clients while they are out-of-state shall be made by the department to the same extent as payment is made to in-state providers, unless otherwise specified in state statutes or regulations which govern the provider's assigned type and specialty, only when any of the following conditions is met:

(1) Medical Assistance Program goods or services are needed by a client because a medical emergency occurred while the client was outside of the state;

(2) Medical Assistance Program goods or services are needed because a client's health would be endangered if required to travel to Connecticut;

(3) the department determines that the Medical Assistance Program goods or services are[more readily] available only in another state and prior authorization was granted to the provider; or

(4) it is general practice for clients in a particular locality of Connecticut to use the medical resources in a bordering state. The department shall allow providers, who are designated by the department to be border providers, to be treated in the same manner as in-state providers.

(b) In addition, payment for Medical Assistance Program goods or services furnished to clients while they are out-of-state shall be made to the same extent as payment is made to in-state providers when:

(1) enrollment is for copayment or deductible of a Medicare claim; and

(2) a child for whom the department makes adoption assistance or foster care

maintenance payment resides outside of Connecticut, or an individual approved to attend school out-of-state resides in Connecticut.

(c) In order to be paid for goods or services, out-of-state providers shall enroll in the Connecticut Medical Assistance Program.

(d) Out-of-state pharmacies rendering services in-state to clients shall:

(1) participate in on-line point of sale and prospective drug use review claims processing; and

(2) pursuant to section 20-627 of the Connecticut General Statutes, out-of-state pharmacy providers shall, when doing business in Connecticut, receive a certificate of registration from the Department of Consumer Protection, upon approval of the Commission of Pharmacy, and provide a toll-free telephone number disclosed on labels for drugs dispensed in Connecticut.

(e) For payment for emergency services, providers shall be required to submit a claim and applicable medical emergency room reports, discharge summaries, or other documentation as determined by the department which confirms the emergency.

(f) In most cases, enrollment shall be for dates of service or provision of goods only. An exception to this rule may apply to providers of goods or services to children for whom the department makes adoption assistance or foster care maintenance payments who reside outside of Connecticut, or individuals approved to attend school out-of-state who reside in Connecticut. In these situations, a provider shall not be required to submit a claim to initiate the enrollment process. The provider shall indicate the name of the child or individual for whom it shall be providing services at the time of enrollment.

(g) Timely filing requirement shall be the same for out-of-state providers as for in-state providers except that the date of first contact with the department's fiscal agent to become enrolled in the Medical Assistance Program or to submit a claim shall be within twelve months of the date of provision of the service or delivery of the good.

(h) Pursuing other third party liabilities shall be the same for out-of-state providers as for in-state providers.

(i) Out-of-state independent laboratories, border hospitals, and physician groups having admitting privileges in a border hospital shall be exempt from the out-of-state criteria delineated in subsection (a) of section 17b-262-532 of the Regulations of Connecticut State Agencies. All other border providers shall be considered for enrollment in the Medical Assistance Program on a case-by-case basis.

(j) The Medical Assistance Program shall not cover out-of-state long-term care services unless such services are not available in the state of Connecticut and receive prior authorization from the department.

(k) Out-of-state providers shall, upon request of authorized department representatives, make available fiscal and medical records as required by applicable Medical Assistance Program regulations and the provider agreement. Such records shall be made available for review by authorized department representatives at a location within the State of

Connecticut.

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

Sec. 17b-262-533. Sums paid in excess of the authorized schedules of payment or for other reasons of ineligibility for payment

Any payment, or part thereof, for Medical Assistance Program goods or services which represents an excess over the payment authorized, or a violation due to abuse or fraud, shall be payable to the department. Any such sum not returned to the department by a provider may be recovered in an action brought by the department against the provider. Such sums may also be recouped from current payment due the provider in accordance with law.

(Adopted effective February 8, 1999)

Sec. 17b-262-534. Reserved

Requirements for Payment of Chiropractic Services

Sec. 17b-262-535. Scope

Sections 17b-262-535 through 17b-262-545 inclusive set forth the Department of Social Services requirements for payment of chiropractic services, performed by licensed practitioners of chiropractic in private or group practices, for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-536. Definitions

For the purposes of sections 17b-262-535 through 17b-262-545 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Chiropractic" means the services described in Title 42 of the Code of Federal Regulations (CFR), Part 440, section 440.60, and subsection (1) of section 20-24 of the Connecticut General Statutes.

(3) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(4) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(5) "Department" means the Department of Social Services or its agent.

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

(7) "HealthTrack Services" means the services described in subsection (r) of section

1905 of the Social Security Act.

(8) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(9) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(10) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(11) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(12) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(13) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(14) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(15) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(16) "Provider" means one who is licensed to practice chiropractic.

(17) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(18) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(19) "Subluxation" means an incomplete dislocation, off centering, misalignment

fixation of a joint or abnormal spacing of a vertebra as used by the practitioner of chiropractic.

(Adopted effective March 6, 1998)

Sec. 17b-262-537. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-538. Eligibility

Payment for chiropractic services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-539. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for the following:

(1) the manual manipulation of the spine, but not for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(2) services provided in the provider's office, client's home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR); and

(3) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) those services listed in the department's fee schedule and within the scope of the provider's practice;

(2) the department shall pay for no more than one visit per day per client per provider; and

(3) the department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR).

(Adopted effective March 6, 1998)

Sec. 17b-262-540. Services not covered

The department shall not pay for the following chiropractic services which are not covered under the Medical Assistance Program:

(a) chiropractic practice does not include the prescription or administration of any medicine or drug or the performance of any surgery;

(b) x-rays furnished by a practitioner of chiropractic;

(c) an initial visit for exam and diagnosis;

(d) manipulation of other parts of the body such as: the shoulder, arm, knee—even when for subluxation of the spine;

(e) lab work ordered by a practitioner of chiropractic;

(f) for information or services provided to a client over the telephone; and

(g) for cancelled office visits or appointments not kept.

(Adopted effective March 6, 1998)

Sec. 17b-262-541. Need for service

The department shall pay for medically necessary and medically appropriate treatment only when:

(a) provided by a licensed practitioner of chiropractic and the services are within the scope of practice of the practitioner, and

(b) the services are made part of the client's medical record.

(Adopted effective March 6, 1998)

Sec. 17b-262-542. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) manipulation of the spine in excess of five per client per provider per month; and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service required;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months

of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-543. Billing procedures

(a) The amount billed to the department shall represent the practitioner of chiropractic's usual and customary charge for the services delivered.

(b) Claims from practitioners of chiropractic shall be submitted on a hard copy invoice or electronically transmitted to the department's fiscal agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim.

(Adopted effective March 6, 1998)

Sec. 17b-262-544. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) **Payment Rate**

(1) The commissioner establishes the fees contained in the practitioner of chiropractic's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(2) Payment rates, as established by the commissioner, are the same for in- and out-of-state providers.

(c) **Payment Limitations**

The fee paid by the department for visits to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR) shall include payment for travel and all such incidental expenses.

(Adopted effective March 6, 1998)

Sec. 17b-262-545. Documentation

(a) Practitioners of chiropractic shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the practitioner of chiropractic's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective March 6, 1998)

Sec. 17b-262-546. Reserved

Requirements for Payment of Natureopathic Services

Sec. 17b-262-547. Scope

Sections 17b-262-547 through 17b-262-557 inclusive set forth the Department of Social Services requirements for payment of natureopathic services provided by licensed natureopaths for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-548. Definitions

For the purposes of sections 17b-262-547 through 17b-262-557 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Emergency" means a medical condition, including labor and delivery, manifesting

itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily part or organ.

(6) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(7) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(8) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(9) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(10) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(11) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(12) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(13) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(14) "Natureopathy" means the practice of natureopathy as defined in subsections (a) and (b) of section 20-34 of the Connecticut General Statutes.

(15) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(16) "Provider" means one who is licensed to practice natureopathy.

(17) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(18) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Adopted effective March 6, 1998)

Sec. 17b-262-549. Provider participation

In order to participate in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements,

(b) meet and maintain all departmental enrollment requirements, and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-550. Eligibility

Payment for natureopathic services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-551. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed natureopath which conform to accepted methods of diagnosis and treatment, but shall not pay for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following:

(1) services provided in the provider's office or client's home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR), and

(2) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) services covered shall be limited to those listed in the department's fee schedule and within the scope of the provider's practice;

(2) only one visit per day per client per provider shall be paid for; and

(3) the department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR).

(Adopted effective March 6, 1998)

Sec. 17b-262-552. Services not covered

The department shall not pay for the following natureopathic services:

(a) the administration of internal medication or substances simulating medicine, or the form of medicine;

(b) the administration of dehydrated foods;

(c) for information or services provided to a client over the telephone; and

(d) for cancelled office visits or appointments not kept.

(Adopted effective March 6, 1998)

Sec. 17b-262-553. Need for service

The department shall pay for medically necessary and medically appropriate treatment only when:

(a) provided by a licensed natureopath and the services are within the scope of the natureopath's scope of practice, and

(b) the services are made part of the client's medical record.

(Adopted effective March 6, 1998)

Sec. 17b-262-554. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, shall be required for:

(1) professional office or home visits in excess of five per client per provider per month, and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months

of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) Eligibility for Medical Assistance Program coverage must be verified at every visit even though prior authorization has been received for the entire number of visits.

(h) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-555. Billing procedures

(a) Claims for natureopathic services shall be submitted on hard copy invoice or electronically transmitted to the department's fiscal agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim.

(b) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

(Adopted effective March 6, 1998)

Sec. 17b-262-556. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) **Payment Rate**

(1) The commissioner establishes the fees contained in the natureopath's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(2) Payment rates, as established by the commissioner, are the same for in- and out-of-

state providers.

(c) **Payment Limitations**

The fee issued by the department for visits to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR) shall include payment for travel and all such incidental expenses.

(Adopted effective March 6, 1998)

Sec. 17b-262-557. Documentation

(a) Natureopathic care providers shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the natureopathic care provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective March 6, 1998)

Sec. 17b-262-558. Reserved

Requirements for Payment of Vision Care Services

Sec. 17b-262-559. Scope

Sections 17b-262-559 through 17b-262-571, inclusive, set forth the Department of Social Services requirements for payment of accepted methods of treatment provided by an ophthalmologist, optometrist, or optician for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-560. Definitions

For the purposes of sections 17b-262-559 through 17b-262-571 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Doctor of Osteopathy" means a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes.

(6) "Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)" means the services described in subsection (r) of section 1905 of the Social Security Act.

(7) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(8) "Fees" means the rates for services, treatments, and drugs administered by ophthalmologists, optometrists, and opticians which shall be established by the commissioner of the department and contained in the department's fee schedules.

(9) "Incomplete Eye Exam" means an annual eye exam which is not completed since the preliminary findings reveal that visual analysis is not indicated.

(10) "Interperiodic Encounter" means any medically necessary visit to a Connect-icut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(11) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(12) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(13) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(14) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(15) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(16) "Modified Lens Prescription" means a prescription given to a client because of:

(A) a radical change in the prescription;

(B) a large initial prescription; or

(C) amblyopia, latent hyperopia, or inadequate care previously received.

(17) "Ophthalmologist" means a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes, who within his or her scope of practice as defined by state law, specializes in the branch of medicine dealing with the structure, functions, pathology,

and treatment of the eyes. The practice includes the use of surgery, x-ray, photocoagulation, ionizing radiation, and drugs for examination of the eyes.

(18) "Optician" means an individual licensed pursuant to section 20-145 of the Connecticut General Statutes having a knowledge of optics and is skilled in the technique of producing and reproducing ophthalmic lenses and kindred products and who, within his or her scope of practice as defined by state law, prepares and dispenses ophthalmic lenses and products to correct visual defects.

(19) "Optometrist" means an individual licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as delineated in subsections (a) (1) and (2) of section 20-127 of the Connecticut General Statutes.

(20) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes.

(21) "Prior Authorization" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

(22) "Progressive Myopia" means a known progressive myopia, changing .75 diopters in the past six months.

(23) "Provider" means a licensed ophthalmologist, optometrist, or optician.

(24) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(25) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(26) "Usable Lens" means a lens which is not scratched or otherwise defective so as to impair use or endanger the wearer.

(27) "Usual and Customary Charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. When calculating the median charge, token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-561. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration

of the agreement or for the stated period in the agreement. The provider agreement specifies the conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-562. Eligibility

Payment for vision care services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-563. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed ophthalmologist, optometrist, or optician which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(b) The department shall pay providers for:

(1) only those procedures listed in the provider's fee schedule and within the scope of the provider's practice;

(2) services provided in the provider's office, client's home, hospital, nursing facility, rest home, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or state-operated institution, or home for the aged;

(3) two pairs of eyeglasses, distance and near, permitted in lieu of bifocals, when need for same is substantiated in the client's medical record by clinical data from the provider; and

(4) Early periodic screening, diagnostic and treatment services.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-564. Services not covered

The department shall not pay for the following:

(a) information or services provided to a client by a provider over the telephone;

(b) cancelled office visits and appointments not kept;

(c) a spare pair of eyeglasses; and

(d) visual analysis within forty-two consecutive days from the date of an eye examination.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-565. Need for service

The department shall pay for medically necessary and medically appropriate vision care services for Medical Assistance Program eligible clients, in relation to the diagnosis for which care is required, provided that:

(a) the services are within the scope of the provider's practice;

(b) the services are made part of the client's medical record; and

(c) for contact lenses, glasses, or vision training, only when prescribed by a physician, doctor of osteopathy, or optometrist.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-566. Early periodic screening, diagnostic and treatment services

(a) Prior authorization for EPSDT services not on the Vision Care fee schedule or which are on such fee schedule but for which there are limitations in the amount, frequency or circumstances under which such services can be used, either in the fee schedule or in the Regulations of Connecticut State Agencies published by the department, may be obtained using the following procedures:

(1) Services not on the fee schedule, or for which there are limitations on their use, may be authorized on a case-by-case basis. Requests for prior authorization to provide services shall be made on forms and in a manner as specified by the department.

(2) Providers requesting prior authorization to provide services shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. This information shall include: (A) a written statement from the prescribing physician, or other practitioner of the healing arts, performing such services within such practitioner's respective scope of practice as defined under state law, justifying the need for the item or service requested; (B) a description of the outcomes of any alternative measures tried; and (C) if applicable and requested by the department, any other documentation required in order to render a decision.

(3) Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered. In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided.

(b) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department, in its sole discretion determines what information is necessary in order to approve an authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-567. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically submitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) Claims for a full or partial eye examination in a nursing facility or a state-owned or state-operated institution shall contain the name of the prescribing practitioner.

(c) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-568. Payment

(a) Payment rates shall be the same for in-state and out-of-state providers.

(b) Payment for professional services shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider.

(c) Payment for supplies and equipment shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider.

(d) The department shall pay for lenses for clients who own their own frames and are eligible for lenses.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-569. Payment rate

The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-570. Payment limitations

(a) Contact lenses shall be covered, when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia, Keratoconus, Corneal Transplant, and High Anisometropia.

(b) Prescription sunglasses shall be covered when light sensitivity which will hinder driving or seriously handicap the outdoor activity of a client is evident.

(c) Trifocals shall be covered only when the client has a special need due to a job training program or extenuating circumstances.

(d) Oversize lens shall be covered only when needed for physiological reasons, and not for cosmetic reasons.

(e) Services and materials covered shall be limited to those listed in the department's fee schedule.

(f) Extended wear contact lenses shall be covered for aphakia and for clients whose

coordination or physical condition makes daily usage of contact lenses impossible.

(g) When the preliminary findings of an eye examination reveal that a visual analysis cannot or should not be completed, payment shall be made only for an incomplete eye exam.

(h) Providers shall be limited to a maximum of six full or partial eye examinations in a chronic disease hospital, boarding home, home for the aged, nursing facility, ICF/MR, or state-owned or state-operated institution in any one day, in any one home or institution.

(i) A written request shall be provided by the provider from the prescribing practitioner of a nursing facility and state-owned or state-operated institution, for a full or partial eye examination, to be performed on a client in the facility or institution.

(j) Payment for ocular prosthesis shall be made only to the provider performing the actual fitting.

(k) The payment limitations set forth in section 17b-262-448 of the department's regulations governing physicians' services are hereby incorporated by reference and made applicable to services provided by ophthalmologists.

(*l*) The department shall pay for eyeglasses for a client, as long as the client was eligible on the date the eyeglasses were ordered or requested by the client.

(m) The department shall pay for eyeglass frames when the client meets all eligibility requirements. The Medical Assistance Program published fee shall be considered maximum payment in full. A provider shall not bill the Medical Assistance Program for eyeglass frames and receive payment from the client for the difference in cost.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-571. Documentation

(a) Vision care providers shall maintain a specific record for all services and supplies received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services and supplies provided, and the dates the services or supplies were provided.

(b) All required documentation in its original form shall be maintained for at least five years in the vision care provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service or supply provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the vision care provider for which the required documentation is not maintained and not provided to the department upon request.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-572. Reserved

Requirements for Payment of Nurse-Midwifery Services

Sec. 17b-262-573. Scope

Sections 17b-262-573 through 17b-262-585 inclusive set forth the Department of Social Services requirements for payment of nurse-midwifery services performed by licensed nurse-midwifes for clients who are determined eligible to receive such services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-574. Definitions

For the purposes of sections 17b-262-573 through 17b-262-585 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Consultation and Collaborative Management" means those services rendered by the obstetrician-gynecologist who is part of the health care team whose opinion or advice is requested by the client's nurse-midwife in the evaluation or treatment of the client. The consultant obstetrician-gynecologist may prescribe a course of treatment provided by the nurse-midwife. It does not necessarily mean the client shall be seen by the obstetrician-gynecologist.

(5) "Department" means the Department of Social Services or its agent.

(6) "Directed" means a nurse-midwife shall always function within a health care system in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.

(7) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(8) "Essentially Normal" means a philosophic view of childbirth as a natural, normal process. Essentially normal means that if a client develops complications, the nurse-midwife either consults or collaborates with the physician in the management of care of the client or, depending on the severity of the complication, refers the client to the physician. This reflects again the team relationship with the physician, because normal is defined by the nurse-midwifes and physicians in a particular practice setting.

(9) "Family Planning Services" means any medically approved diagnostic procedure,

treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

(10) "Health Care Team" means the nurse-midwife shall function in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(13) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(14) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(15) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities,

(B) chronic disease hospitals—inpatient, and

(C) intermediate care facilities for the mentally retarded (ICFs/MR).

(16) "Management of Care" means the responsibilities and accountability the nurse-midwife shall assume and the mandatory relationship this shall require with a physician. This management is independent in the fact that a client who experiences an essentially normal maternity cycle or requires well-woman gynecological care may have her care provided entirely by the nurse-midwife.

(17) "Maternity Cycle" means a period limited to:

(A) pregnancy,

(B) labor,

(C) birth, and

(D) the immediate postpartum period, not to exceed six weeks from the child's date of

birth.

(18) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(19) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(20) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(21) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(22) "Nurse-midwife" means a person who meets all of the conditions established in subsection (2) of section 20-86a of the Connecticut General Statutes.

(23) "Nurse-midwifery Services" are the services established in subsection (1) of section 20-86a and section 20-86b of the Connecticut General Statutes.

(24) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who practices as an obstetrician-gynecologist.

(25) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(26) "Provider" means a licensed nurse-midwife.

(27) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(28) "Referral" means the nurse-midwife requests a consultation and collaboration with the physician on a client which results in the physician providing the care for the client.

(29) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Adopted effective March 6, 1998)

Sec. 17b-262-575. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, a nurse-midwife shall:

(a) meet all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration

of the agreement or for the stated period in the agreement. The provider agreement specifies the conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-576. Eligibility

Payment for nurse-midwifery services shall be available on behalf of all women and newborns, only throughout the maternity cycle, eligible for the Medical Assistance program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-577. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed and certified nurse-midwife which conform to accepted methods of diagnosis and treatment, but shall not pay for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following:

(1) services provided in the provider's office, client's home, hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or -operated institution, or home for the aged;

(2) family planning services as described in the Regulations of Connecticut State Agencies; and

(3) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) services concerned with the care and management of the care of essentially normal mothers and newborns, only throughout the maternity cycle, and well-woman gynecological care, including family planning services; and

(2) services covered shall be limited to these listed in the department's applicable fee schedule.

(Adopted effective March 6, 1998)

Sec. 17b-262-578. Services not covered

The department shall not pay for the following:

(a) nurse-midwifery services to newborns occurring beyond the maternity cycle;

(b) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge;

(c) information or services provided to a client by a provider over the telephone;

(d) an office visit for the sole purpose of the client obtaining a prescription where the

need for the prescription has already been determined; and

(e) cancelled office visits and appointments not kept.

(Adopted effective March 6, 1998)

Sec. 17b-262-579. Need for service

The department shall pay for medically necessary and appropriate nurse-midwifery services for Medical Assistance Program eligible clients:

(a) requiring care during an essentially normal maternity cycle or requiring well-woman gynecological care;

(b) of child-bearing age who indicate a need for family planning services and are free from coercion or mental pressure and are free to choose the method of family planning to be used;

(c) provided by a licensed and certified nurse-midwife within the scope of the nurse-midwife's practice; and

(d) if the services are made part of the client's medical record.

(Adopted effective March 6, 1998)

Sec. 17b-262-580. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) more than one visit per day per client; and

(2) HealthTrack Special Services.

(A) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(B) the request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or services required;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, request for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a nurse-midwife shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are

rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-581. Billing procedures

(a) Claims from nurse-midwifes shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) If a provider assumes the continuing care of a client or provides services to a client as a result of a referral by a nurse-midwife because the services cannot be provided by the nurse-midwife, an obstetrical-gynecological surgical procedure as an example, this procedure would be billed as a separate procedure, by any provider giving this service.

(c) When a Medical Assistance Program client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant provider shall enter the entire name as well as the state license number of the referring provider on the billing form.

(d) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(e) The following routine laboratory tests shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination, and urine glucose. Payment for these tests is included in the fee for a routine workup.

(f) Laboratory services performed in the nurse-midwife's office are payable to the nurse-midwife. Nurse-midwife's shall bill for these services as separate line items. When a nurse-midwife refers a client to a private laboratory for services, the laboratory shall bill directly. No laboratory charge shall then be paid to the nurse-midwife.

(g) Payment for laboratory services shall be limited to services provided by Medical Assistance providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

(h) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care

and routine care for the same child.

(Adopted effective March 6, 1998)

Sec. 17b-262-582. Payment

Payment shall be made at the lowest of:

(a) the provider's usual and customary charge to the general public;

(b) the lowest Medicare rate;

(c) the amount in the applicable fee schedule as published by the department;

(d) the amount billed by the provider; or

(e) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(Adopted effective March 6, 1998)

Sec. 17b-262-583. Payment rate

(a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Payment rates shall be the same for in-state and out-of-state providers.

(c) Nurse-midwifery rates for each procedure shall be set at 90% of the department's fee for physician procedure codes.

(Adopted effective March 6, 1998)

Sec. 17b-262-584. Payment limitations

(a) The department shall pay for an initial visit by a nurse-midwife only once per client. Initial visits refer to the nurse-midwife's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the nurse-midwife-client relationship has been discontinued for three or more years and is then reinstated.

(b) The department shall pay for an initial visit once per inpatient hospitalization.

(c) Nurse-midwifes who are fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department unless the nurse-midwife maintains an office for private practice at a separate location from the hospital, institution, group, or clinic in which the nurse-midwife is employed. Nurse-midwifes who are solely hospital, institution, group, or clinic based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(d) A nurse-midwife who maintains an office for private practice separate from the hospital, institution, group, or clinic, shall be able to bill for services provided at the private practice location or for services provided to the nurse-midwife's private clients in the hospital, institution, group, or clinic only if the client is not a client of the hospital, institution, group, or clinic.

(e) Fees for medical procedures shall include the fee for an emergency room visit. The

department shall not pay a provider at a higher rate for any medical procedure which is performed in an emergency room.

(f) Payment for the total obstetric care procedure, shall include office visits for maternity care six months prior to delivery and six weeks after delivery.

(g) If antepartum care, vaginal delivery, or postpartum care are billed as separate procedures, total payment shall not exceed the fee for the total obstetric care procedure.

(h) If a client's medical problem necessitates the concurrent services and skills of two or more providers, each provider shall be entitled to the listed fee for the service.

(i) There shall be no payment for consultation and collaborative management services with an obstetrician-gynecologist when functioning as part of the health care team in the evaluation and treatment of a client.

(j) Although a nurse-midwife shall always function within a health care system in a team relationship with a physician which is directed and shall never be independent of physician back-up for consultation and collaborative management, or referral, directed does not necessarily imply the physical presence of the physician when care is being given by a certified and licensed nurse-midwife.

(Adopted effective March 6, 1998)

Sec. 17b-262-585. Documentation

(a) Nurse-midwifes shall maintain a specific medical record for all services rendered to each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the nurse-midwife, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the nurse-midwife's file subject to review by the authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the nurse-midwife for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective March 6, 1998)

Sec. 17b-262-586. Reserved

Requirements for Payment of Personal Care Assistance Services for Adults

Sec. 17b-262-587. Purpose and scope

Sections 17b-262-587 through 17b-262-596b, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of personal care assistance services for adults. The Department operates the Personal Care Assistance Waiver Program that assists eligible disabled adults by paying for

personal care assistance services. The purpose of sections 17b-262-587 through 17b-262-596b, inclusive, of the Regulations of Connecticut State Agencies is to describe the program requirements, services available and limitations under (1) the Personal Care Assistance Waiver Program, which is conducted under a federal waiver under section 1915(c) of the Social Security Act to the Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-588. Definitions

For the purposes of sections 17b-262-587 through 17b-262-596b, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) **"Activities of Daily Living"** means hands-on activities or tasks, which are essential for a consumer's healthful and safe existence and include, but are not limited to: bathing, dressing, eating, transfers, and bowel and bladder care.

(2) **"Adult"** means a person 18 through 64 years of age inclusive.

(3) **"Applicant"** means a person who directly or through a representative completes a Personal Care Assistance Request Form and submits it to the department.

(4) **"Assessment"** means a comprehensive written evaluation conducted by non-medical department personnel which uses a standard assessment form and which consists of:

(A) an identification of the consumer's limitations in activities of daily living;

(B) the identification of the personal care assistance services required by the consumer and a determination that such services are appropriate for the consumer and, in the non-medical opinion of the department can reasonably be expected to meet the health and safety needs of the consumer;

(C) identification of the training and support needs of the consumer for personal care assistance services;

(D) a face-to-face interview with the consumer;

(E) documentation of the number of hours needed by the consumer to complete the activities of daily living and instrumental activities of daily living with the help of a personal care assistant;

(F) a determination confirming that the consumer would otherwise require institutional care in a nursing facility;

(G) development of a total cost of care plan for the consumer; and

(H) development of a consumer personal care services plan.

(5) **"Average nursing facility cost"** means a weighted average calculated by multiplying the nursing facility Medical Assistance Program rates in effect on July 1 of each calendar year for each facility by their respective number of days, adding the products and then dividing that total by the total patient days, and reducing the result by the average applied income for nursing facility patients.

(6) **"Consumer"** means an applicant or eligible person.

(7) **"Commissioner"** means the chief executive officer of the department appointed

pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(8) **"Cost Effective"** means the Department's payments for the consumer's total costs of care do not exceed the average nursing facility cost.

(9) **"Cost-of-Care Plan"** means a plan, which specifies all costs to the State of Connecticut that are associated with the care of the consumer.

(10) **"Department"** means the Department of Social Services or its agent.

(11) **"Eligible Person"** means an applicant who meets the criteria to receive personal care assistance services in accordance with section 17b-262-589 of the Regulations of Connecticut State Agencies and who meets all the eligibility requirements for participation in the Medicaid program as set forth in the Department's regulations that are contained in its Uniform Policy Manual.

(12) **"Fiscal Intermediary"** means an organization selected by the department to perform the payroll function for the administration of this program including but not limited to the fulfillment of all household employer tax obligations.

(13) **"Instrumental Activities of Daily Living"** means household maintenance activities and tasks, which are essential for a consumer's healthful and safe existence and include, but are not limited to: cooking, cleaning, and shopping.

(14) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time.

(15) **"Nursing Facility"** means an institution as defined in section 1919 of the Social Security Act, as amended from time to time, that participates in Connecticut's Title XIX medical assistance program pursuant to the terms of a provider agreement with the Department.

(16) **"Personal Care Assistance Request Form"** means a department form used to screen a consumer for financial and functional eligibility for personal care assistance services.

(17) **"Personal Care Assistant"** means any person, excluding the consumer's spouse, and excluding the consumer's conservator and any person related to the consumer's conservator who is employed by the consumer or the consumer's conservator and is qualified to assist the consumer in carrying out the tasks required in the personal care services plan.

(18) **"Personal Care Assistance Services" or "Services"** means physical assistance to enable the consumer to carry out activities of daily living and instrumental activities of daily living.

(19) **"Personal Care Services Plan" or "Service Plan"** means an individualized written plan documenting all necessary personal care assistance services, hours, costs, and training requirements for the consumer as determined by an assessment.

(20) "**Personal Emergency Response System" (PERS)-** means an electronic device that enables consumers to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once the help button is activated.

PERS service providers shall be enrolled as performing providers under Medicaid.

(21) **"Representative"** means a person designated by the consumer to act for the consumer and under the consumer's direction for purposes such as completing paperwork, making phone calls, advertising for personal care assistants, assisting with interviewing or scheduling, and sending paperwork to the fiscal intermediary. When the consumer has a court appointed conservator that person shall act as the consumer's representative in all matters. The conservator cannot also be employed as the consumer's personal care assistant or be related to any person employed as the consumer's personal care assistant.

(22) **"Uniform Policy Manual"** means department regulations promulgated pursuant to section 17b-10 of the Connecticut General Statutes governing eligibility for public assistance and special programs, and maintained in policy manual form including the Department's Title XIX medical assistance program.

(23) **"Waiting List"** means a record maintained by the department, which includes the names of the consumers seeking personal care assistance services, and specifies the date the Personal Care Assistance Request Form was received.

(24) **"Waiver Program"** means the program described in the federal waiver approved pursuant to section 1915(c) of the Social Security Act, as amended from time to time, by the Secretary of the United States Department of Health and Human Services for the provision of personal care assistance services to adults, as a partially federally reimbursed service that may be provided under Connecticut's Medicaid program.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-589. Eligibility and determination of need

(a) In order to be eligible to receive coverage for the cost of personal care assistance services under the Department's Personal Care Assistance Waiver Program, an individual shall either have already been determined eligible to participate in the Department's Title XIX medical assistance program and also be determined to meet the additional programmatic requirements for coverage of personal care assistance services that are specified in this section or qualify for personal care assistance services by meeting all of the technical, special financial, and programmatic requirements stated in this section.

(b) An individual who has not previously been determined eligible for medical assistance and who receives personal care assistance services after meeting the requirements of this section is thereby automatically determined eligible for the medical assistance program and for all other medically necessary services that are covered by the program.

(c) The technical requirements for eligibility are:

(1) A recipient of medical assistance benefits who applies for coverage of personal care assistance services and applicants for personal care assistance services shall meet all requirements for eligibility in the Department's medical assistance program that are applicable to disabled adults as stated in the regulations promulgated by the Department and contained in its Uniform Policy Manual pursuant to Section 17b-10 of the Connecticut General Statutes, including, without limitation, all regulations establishing medical

assistance eligibility requirements related to the filing of applications for assistance, verifications, redeterminations, existence of a disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

(2) Applicants for personal care assistance services are treated as if they were institutionalized and all medical assistance eligibility rules that apply to institutionalized applicants or recipients of medical assistance benefits are also applied in the same way to applicants or recipients of personal care assistance services. Specifically, without limiting the scope of this subsection, applicants and recipients for personal care assistance services are subject to the same rules that govern eligibility related to the transfer of assets and to the treatment of the resources and income of spouses of institutionalized applicants for assistance.

(d) The special financial eligibility rules are:

(1) A recipient of medical assistance benefits who applies for personal care assistance services or an applicant for personal care assistance services who meets all other technical requirements for eligibility may only be found eligible for personal care assistance services if his or her countable income is less than the special institutional income limit of 300 percent of the benefit amount that would be payable under the federal Supplemental Security Income ("SSI") program to an individual in his or her own home who has no income or resources. Income eligibility for personal care assistance services under this section is determined solely by reference to the individual's countable income, and does not involve consideration of the incurred medical expenses or any other liabilities that may have been incurred by the applicant for assistance. Except as noted below, the applicant's countable income for purposes of this subsection is determined by reference to the same methodologies that are employed by the Department in determining the countable income of an institutionalized applicant for assistance. Individuals who qualify for medical assistance related to the treatment of income under other optional coverage groups, including the medically needy, but who do not qualify for personal care assistance services under the 300 percent of the SSI income limit, may receive coverage of medically necessary services to the extent such services are available generally to recipients of medical assistance, but may not receive coverage for those services that are only provided to individuals who are covered under this or any other waiver of federal Medicaid requirements.

(2) An applicant or recipient of assistance may not reduce his or her income, or fail to pursue potential sources of income in order to obtain or retain eligibility for assistance under the special institutional income limit of 300 percent of the SSI benefit amount.

(e) The programmatic requirements for eligibility are:

In addition to meeting all technical and special financial eligibility requirements stated above in subsections (c) and (d) of this section, an applicant for coverage of personal care assistance services shall meet all of the following programmatic requirements for eligibility:

(1) the consumer shall be 18 through 64 years of age inclusive;

(2) the consumer shall have a primary medical diagnosis that is a chronic, severe, and permanent physical disability which results in a significant need for physical assistance

with two or more of the following activities of daily living: bathing, dressing, eating, transfers, bowel and bladder care; and the consumer shall be in a condition that would otherwise require institutionalization in a nursing facility without such services. An individual whose primary disability is mental retardation, mental illness or whose need for personal care assistance is the result of a degenerative neurologically based dementia, including but not limited to Alzheimer's disease, is not eligible for personal care assistance services. In the case of dual diagnosis, the Department may request an assessment, made by a qualified medical provider, to determine which disabling condition is primary;

(3) the consumer shall have the cognitive ability to be the essential participant in the development of his or her personal care services plan and to hire, direct, and fire his or her personal care assistants unless the consumer has a conservator who acts on his or her behalf and fulfills the foregoing requirements;

(4) the consumer shall lack family and community supports to meet his or her needs for personal care assistance services;

(5) the consumer shall wish to live in the community by utilizing personal care assistance services;

(6) the consumer shall be capable of understanding and shall acknowledge that there is risk inherent in his or her living in the community, that his or her safety cannot be guaranteed, and shall accept full liability if he or she chooses to live in the community and absolve the Department of responsibility for anything that might result from this choice;

(7) the consumer shall acknowledge that he or she is the employer of his or her personal care assistants and shall sign a written document accepting full responsibility as the employer of his or her personal care assistants;

(8) the consumer, in order to insure his or her health and safety, shall have a back-up plan which shall be documented in the department's record identifying how he or she will provide for personal care assistance service needs in the event that a personal care assistant is not available to provide the services as scheduled;

(9) the consumer shall file such forms as may be necessary with the Internal Revenue Service and the State Department of Labor designating the fiscal intermediary as the consumer's agent for the purpose of managing employment benefit accounts for the personal care assistants and shall provide all other documentation needed by the fiscal intermediary in order to process payroll;

(10) the consumer shall have a personal care assistance plan that is cost effective; (refer to section 17b-262-594)

(11) the consumer shall replace state funded homemaker, companion, and personal care assistance services provided by the Department under the Community Based Services Program or Personal Care Assistance Working Person's Program with personal care assistance services under this waiver program;

(12) the consumer shall replace home health aide services provided under the Medicaid program with personal care services funded under the waiver program unless the provision of both services is otherwise determined necessary by the Department. If any home health

aide services are approved, there shall be no duplication of services provided by the personal care assistance plan;

(13) if an applicant is eligible for, or receiving, comparable services under Section 101 (a)(8) of the Rehabilitation Act as amended in 1992, such applicant is ineligible for personal care assistance services under this Personal Care Assistance Waiver program. The applicant may be eligible for additional services through the waiver as long as those services are not related to attendance at school or employment. A plan, which is developed for a consumer in these circumstances, shall be developed jointly by appropriate staff from the Department's Social Work Services Division and the consumer;

(14) the consumer shall hire qualified personal care assistants within three months of approval of the service plan and a determination of Medicaid eligibility or the application shall be denied and the consumer will not maintain his or her slot on the waiting list. The application and eligibility determination process can be resumed at any time in the future;

(15) the consumer shall pursue and accept comparable services from other resources when requested by the Department.

(f) If a cost of care plan that is both cost effective and reasonably ensures the health and safety of the consumer in the non-medical opinion of the Department cannot be developed, the consumer is not eligible for personal care assistance waiver services. If the consumer requires full time acute care hospitalization he or she is not eligible for waiver services if unable to receive them for a period of thirty days or more due to such hospitalization. A new application and assessment shall be completed for such consumer.

(g) A disabled individual who is determined eligible for and who receives personal care assistance services under this Title XIX Medical Assistance Personal Care Assistance Waiver program as an alternative to institutionalization is subject to the same rights and responsibilities as an institutionalized recipient of medical assistance, including, without limitation, those requirements relating to third party liability, securing support, recovery, and liens that are applicable to institutionalized recipients of public assistance.

(h) Any consumer who is found by the Department to have knowingly signed a time sheet authorizing payment for services that were not provided may be discharged from the Personal Care Assistance Waiver program. Any consumer discharged under this subsection shall be ineligible for personal care assistance services under the Personal Care Assistance Waiver program for a period of not more than two years.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-590. Application process

(a) The application process consists of:

(1) a financial eligibility determination by the Department in accordance with the eligibility standards for participation in the Department's Title XIX medical assistance program that are contained in the Uniform Policy Manual;

(2) a preliminary determination by central office administrative staff as to the consumer's needs and financial eligibility based on a review of the information provided on the

"Personal Care Assistance Request" form; and

(3) a referral to the appropriate regional office when an assessment for services is indicated to determine if a cost effective plan of services can be developed to provide services to the person in the community.

(b) A determination as to whether the consumer needs services without which the consumer would otherwise require institutionalization shall be made by non-medical Department staff based upon an assessment conducted in collaboration with the consumer.

(c) A determination of the personal care assistance services required by the consumer shall consist of:

(1) completion of an assessment by the department; and

(2) development of a personal care services plan by the department in consultation with the consumer. The plan shall be reviewed annually or more often when a change in the consumer's condition has occurred or when other circumstances may warrant; and

(3) a determination documented on a cost of care plan of whether the personal care assistance services combined with all other state administered services are cost effective; and

(4) authorization for personal care assistance services in the community if appropriate and cost effective.

(d) Eligibility shall be redetermined annually for each recipient.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-591. Waiting list

(a) As a result of the limitation of the number of slots and/or funding, the Department shall establish and maintain a statewide waiting list for the Personal Care Assistance Waiver program when the Department has filled its maximum allocation of slots or reached the funding level in the approved waiver. Names shall be placed on the waiting list in the same order as the "Personal Care Assistance Request" form is received in Central Office.

(b) When an opening occurs, applications shall be solicited by contacting consumers in the order their names appear on the waiting list.

(c) A consumer is removed from the waiting list if he or she:

(1) asks to be removed;

(2) moves out of state;

(3) reaches age 65; or

(4) is deceased.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-592. Limitations

(a) The Department does not offer Personal Care Assistance Waiver services to more than the number of consumers specified in the federally approved Personal Care Assistance Waiver or to more than the number of consumers who can be served within the funding limitations established in the approved waiver.

(b) In order to be eligible for a personal care services plan that, combined with all other state administered home care and community based services, exceeds 60% of the average nursing facility cost, the consumer shall require physical assistance with three or more of the following activities of daily living: bathing, dressing, eating, transferring and bowel and bladder care.

(c) In order to be eligible for a personal care services plan that, combined with all other state administered home care and community based services, exceeds 80% of the average nursing facility cost, the consumer shall require assistance with all of the following activities of daily living: bathing, dressing, eating, transferring and bowel and bladder care.

(d) In addition, any plan exceeding 60% of the average nursing facility cost shall meet the following requirements:

(1) there shall be documentation of any changes in the consumer's needs or other circumstances which affect the plan if the cost of care plan exceeds the costs of services provided prior to application to this program; and

(2) the projected overall program costs for the total personal care assistance services population shall not be exceeded as a result of the approval of this consumer's personal care services plan; and

(3) all informal and family supports shall have been explored and documented in the record. It is not the intent of the program to displace services that have been provided free of charge by family members and relatives, and may reasonably be expected to continue in the future, and a personal care services plan shall not be developed which substitutes the paid services of a personal care assistant for voluntary services provided by family members.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-593. Services covered

(a) Services covered are:

(1) personal care assistance services provided in accordance with a personal care services plan which enable the consumer to carry out activities of daily living and instrumental activities of daily living in a community living arrangement; and

(2) as a result of being determined eligible for Medicaid, any other covered service to the extent that it is necessary, in accordance with Title XIX contained in the Social Security Amendments of 1965 and state and federal regulations adopted pursuant thereto.

(3) personal care assistance services up to 25.75 hours per week provided by a single personal care assistant and up to 40 hours per week provided by a single personal care assistant if the consumer documents, to the department's satisfaction, that the consumer has obtained and maintained worker's compensation insurance for the single personal care assistant and that such insurance shall remain in full force and effect for at least one year from the date the personal care assistant begins providing personal care assistance services to the consumer. Personal care assistance services beyond 25.75 hours per week shall not be covered without the submission of such documentation. The social worker shall verify the continuation of the worker's compensation insurance coverage at the time of the annual

review.

(4) up to 10 additional hours of personal care assistance services beyond those already included in the approved service plan for the purpose of communicating with medical providers during a crisis or an emergency for those consumers who have difficulty communicating verbally their needs to medical providers, as determined by the social worker during the assessment process.

(5) for those consumers who either live alone or who remain at home alone with no available caregiver, a personal emergency response system (PERS) may be provided. The department social worker shall determine the need for the PERS as part of the assessment process.

(b) Services not covered are:

(1) services that are not in the consumer's approved cost of care plan;

(2) personal care assistance services provided either in a health care institution that is licensed by the Department of Public Health or in a living arrangement funded by the department which includes funding for the purpose of assisting clients to meet their daily needs as a component in the rate of reimbursement;

(3) personal care assistance services provided by the consumer's spouse, the consumer's conservator or any person related to the conservator;

(4) personal care assistance services which are duplicative of home health services which the consumer will receive concurrently while participating in the program;

(5) scheduled hours which a personal care assistant does not keep;

(6) transportation of the personal care assistant to and from the consumer's home;

(7) services in excess of those deemed necessary by the department to serve the consumer;

(8) services not related to the condition of the consumer or the consumer's physical limitations in performing activities of daily living and instrumental activities of daily living;

(9) any service that is required by state law to be provided by licensed staff;

(10) services in excess of 25.75 hours per week provided by a single personal care assistant, except as otherwise provided in subdivision (3) of subsection (a) of this section;

(11) services provided by an individual who formerly performed such services at no cost;

(12) personal care services provided at school or in the workplace;

(13) personal care services when the consumer is eligible to receive comparable services that are available from another resource;

(14) services performed by someone other than the provider designated in the service plan; and

(15) services performed by a provider who does not meet the qualifications outlined in the federally approved waiver.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-594. Determining the cost effectiveness of the service plan

In order to determine the cost effectiveness of the consumer's service plan, the

Department shall do all of the following:

(1) Obtain the monthly average nursing facility cost; and

(2) Determine the monthly cost of the service plan; and

(3) Determine the monthly cost of other medical services that the consumer will require in order to live in the community. These other medical services include: home health care, nursing services, physical therapy, occupational therapy and/or speech therapy. These costs are based on the consumer's expected utilization of these services, multiplied by the Medicaid rates established by the Department for such services; and

(4) Determine the monthly cost of other state administered home and community based services. These other home and community based services costs include but are not limited to those services provided by the department's Community Based Services Program and all funds provided by programs administered by any other state agency which help to maintain the consumer in the community; and

(5) Add the cost of other medical services and other state administered home and community based services to the costs of the service plan to obtain the consumer's total cost of care; and

(6) Compare the consumer's total cost of care to the average nursing facility cost.

The Department may not approve a personal care assistance plan when the cost of all of the foregoing services exceeds the cost of care in a nursing facility.

If due to a temporary acute condition the consumer requires personal care assistance services that exceed the monthly average nursing facility cost for a period that is not expected to exceed four months, the Department, at its discretion, may approve a plan that provides such additional personal care assistance services provided that the annualized cost of personal care assistance services and other services does not exceed the annualized cost of nursing facility services.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-595. Payment

(a) Payment for personal care assistance services for adults is made at the lowest of:

(1) the maximum rate determined by the department for personal care assistance services;

(2) a rate below the maximum based on an amount the consumer has negotiated with the personal care assistant; or

(3) the amount billed.

(b) Payment is made directly to the fiscal intermediary who, on behalf of the consumer, shall pay all required employment taxes and issue paychecks to the consumer made out in the names of the personal care assistants or directly to the personal care assistants.

(c) The fiscal intermediary shall inform consumers about the requirement that they obtain worker's compensation insurance for those single personal care assistants who provide the consumer with more than 25.75 hours per week of personal care assistance services, as set forth in subdivision (3) of subsection (a) of section 17b-262-593 of the Regulations of Connecticut State Agencies, and shall not issue payment for personal care assistance services

in excess of 25.75 hours per week by a single personal care assistant unless the consumer has complied with this requirement.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-596. Personal care assistant qualifications

(a) The consumer is responsible for ensuring that his or her personal care assistants meet all of the following qualifications:

(1) be at least 16 years of age except that, if the consumer chooses to hire an individual who is 16 or 17 years old, the consumer shall comply with specific standards and restrictions imposed by state and federal law;

(2) be able to understand and carry out directions given by the consumer or conservator;

(3) be physically able to perform all duties delineated in the service plan;

(4) be willing to receive training from the consumer or conservator in performance of all personal care assistance services delineated in the service plan;

(5) be able to handle emergencies; and

(6) demonstrate competencies in effective employer/employee relationships, disability awareness, use of equipment, and activities of daily living.

(b) The Commissioner shall require any person providing personal care assistance services to a consumer to submit to a criminal background check.

(c) The Commissioner shall have the discretion to refuse payments for personal care assistance services if the personal care assistant performing the services has been convicted in this state or any other state of a felony, as defined in section 53a-25 of the Connecticut General Statutes, involving forgery under section 53a-137 of the Connecticut General Statutes, robbery under section 53a-133 of the Connecticut General Statutes, larceny under sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes, or of a violation of section 53a-290 to 53a-296, inclusive involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons, sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, or 53a-73a of the Connecticut General Statutes involving sexual assault, section 53a-59 of the Connecticut General Statutes involving assault, section 53a-59a of the Connecticut General Statutes involving assault of an elderly, blind, disabled, pregnant or mentally retarded person, and sections 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of elderly, blind, disabled or mentally retarded persons.

(d) A personal care assistant may be suspended from participation in the program if he or she has accepted payment for services that were never provided to the consumer or otherwise violates the rules, regulations, standards or laws governing the program, in accordance with sections 17-83k-1 to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies.

(e) The department may deny coverage of services performed by a personal care assistant who does not meet the department's qualifications as set forth in this section.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-596a. Fair hearings

Applicants for and recipients of services under the Personal Care Assistance program may request and receive a fair hearing, in accordance with the rules of the Department's Medicaid program when the Department:

(1) did not offer the choice of home and community-based services as an alternative to institutional care in a nursing facility; or

(2) does not reach a determination of financial eligibility within the Department's standard of promptness; or

(3) denies the application for any reason other than the limitations on the number of individuals who can be served and/or funding limitations as established in the approved waiver; or

(4) disapproves the consumer's service plan; or

(5) denies or terminates payment to a qualified personal care assistant of the consumer's choice; or

(6) discharges the consumer from the waiver program.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-596b. Repealed

Repealed March 9, 2006.

Requirements for Payment for Early Intervention Services to Children Age Birth to Three Years with Developmental Delays

Sec. 17b-262-597. Scope

Sections 17b-262-597 through 17b-262-605 inclusive set forth the Department of Social Services (DSS) requirements for payment of early intervention services provided by the Department of Mental Retardation (DMR), or another state agency, and their funded contractors, to children age Birth to Three years with developmental delays who are determined eligible for Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

(Effective August 28, 1998)

Sec. 17b-262-598. Definitions

For the purposes of section 17b-262-597 through 17b-262-605 the following definitions shall apply:

(1) "Allied Health Professional or AHP" means an individual who is licensed or certified or who is qualified by special training, education, skills, and experience to provide early intervention services. Such individuals include, but are not limited to: nurses, physician assistants, masters level social workers, special education teachers, speech therapy assistants, nutritionists, and family therapists.

(2) "Assessment" means the definition contained in Part H of the Individuals with

Disabilities Education Act (IDEA), Title 20 United States Code (USC), section 1477(a), and at Title 34 Code of Federal Regulations (CFR), Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322, and at subdivision (2) of subsection (b) of section 303.322.

(3) "Assessment Team" means a multidisciplinary team of qualified, as defined in Title 34 CFR, Part 303, section 303.21, service providers selected by the performing provider, based on results of the child's evaluation, to perform an assessment to determine the service needs of the child based on the diagnosis of the evaluation team.

(4) "Assistive Technology Devices" means the assistive technology devices as defined in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (1) of subsection (d) of section 303.12.

(5) "Assistive Technology Services" means the assistive technology services defined in Part H of IDEA, 20 USC et seq., and at Title 34 CFR, Part 303, subdivision (1) of subsection (d) of section 303.12.

(6) "Audiology" means the definition contained in Part H of IDEA, Title 20 USC et seq., and at Title 34 CFR, Part 303, subdivision (2) of subsection (d) of section 303.12.

(7) "Audiologist" means one who is licensed to practice audiology pursuant to Chapter 399 of the Connecticut General Statutes.

(8) "Billing Provider" means DMR or another state agency responsible for coordinating and delivering early intervention services to Birth to Three eligible children. Billing providers may also be responsible for service coordination and may be a performing provider.

(9) "Birth to Three Eligible Child" means a child from birth to age three who is:

(A) experiencing a significant developmental delay as measured by standardized diagnostic test or clinical opinion in one or more of the following areas:

(i) cognitive development;

(ii) physical development, including vision or hearing;

(iii) communication development; or

(iv) adaptive skills; or

(B) diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay; and

(C) qualified to receive services under the Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

(10) "Birth to Three System" means a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities.

(11) "Child" means a person who is under twenty-one years of age.

(12) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(13) "Department" means the Department of Social Services or its agent.

(14) "Developmental Delay" means a significant delay in one or more of the following areas: cognitive development; communication development; physical development,

including vision or hearing; social or emotional development; or adaptive skills or development.

(15) "Developmental Therapy" means special instruction.

(16) "DMR" means the Department of Mental Retardation.

(17) "Early Intervention Record" means the written record maintained for both the eligible child and the noneligible child for the Birth to Three System.

(18) "Early Intervention Services" means services which are defined in Part H of IDEA, Title 20 USC 1471 et seq., and those listed explicitly in Title 34 CFR, Part 303, subsection (d) of section 303.12.

(19) "Evaluation" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322, and subdivision (1) of subsection (b) of section 303.322, and as defined in section 17a-248 of the Connecticut General Statutes.

(20) "Evaluation Team" means two or more qualified allied health professionals, as defined in Title 34 CFR, Part 303, section 303.21, selected by the performing provider, from different disciplines matched to the needs of the child based on available information, to perform an evaluation.

(21) "Family Training, Counseling, and Home Visits" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (3) of subsection (d) of section 303.12.

(22) "Health Care Financing Administration or HCFA" means the federal agency within the Department of Health and Human Services which administers both the Medicaid and Medicare programs.

(23) "Health Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (4) of subsection (d) of section 303.13.

(24) "Individualized Family Service Plan (IFSP)" means the definition contained under Part H of IDEA, Title 20 USC 1471 et seq., and Title 20 USC, section 1477(d), and at Title 34 CFR, Part 303, subsection (b) of section 303.340.

(25) "Lead Agency" means the Department of Mental Retardation (DMR) pursuant to Title 34 of the CFR, Part 303, section 303.500.

(26) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(27) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(28) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319V of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(29) "Medical Necessity or Medically Necessary" means health care provided to correct

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

(30) "Medical Services" means the definition contained in Part H of IDEA and at Title 34 CFR, Part 303, subdivision (5) of subsection (d) of section 303.12.

(31) "Multidisciplinary Team" means the definition contained in Part H of IDEA, Title 20 USC, and at Title 34 CFR, Part 303, section 303.17, and a team of two or more persons from different disciplines, one of whom shall be an allied health professional.

(32) "Natural Environments" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subsection (b) of section 303.12.

(33) "Nursing Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (6) of subsection (d) of section 303.12.

(34) "Nutrition Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (7) of subsection (d) of section 303.12.

(35) "Occupational Therapy" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (8) of subsection (d) of section 303.12.

(36) "Part H of IDEA" means Part H of the Individuals with Disabilities Education Act (IDEA), Title 20 United States Code (USC), section 1471 et seq.

(37) "Performing Provider" means:

(A) any billing provider;

(B) any independent provider under contract with a billing provider; or

(C) any state agency under contract with a billing provider providing diagnostic services or treatment services recommended by a licensed practitioner of the healing arts and in accordance with the IFSP.

(38) "Physician" means an individual licensed under Chapter 370 or 371 of the Connecticut General Statutes as a doctor of medicine or osteopathy.

(39) "Physical Therapy" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (9) of subsection (d) of section 303.12, and section 20-74 of the Connecticut General Statutes.

(40) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(41) "Psychological Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (10) of subsection (d) of section 303.12.

(42) "Service Coordination" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34, CFR Part 303, subdivision (11) of subsection (d) of section 303.12.

(43) "Service Coordinator" means the person from the profession most immediately

relevant to the child's or family's needs who is employed or contracted by the performing provider to provide service coordination as defined in Title 34 CFR, Part 303, subsection (g) of section 303.344.

(44) "Service Page" means the section of the Individualized Family Service Plan (IFSP) which specifies service information as delineated in Part H of IDEA, Title 20 of the USC, section 1477 (d) (4), (5), and (6).

(45) "Social Work Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (d) of subsection (12) of section 303.12.

(46) "Special Instruction" means the services described in Part H of IDEA, Title 20 of the USC, and at Title 34 CFR, Part 303, subdivision (13) of subsection (d) of section 303.12, when delivered by a multidisciplinary team.

(47) "Speech-Language Pathology" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (14) of subsection (d) of section 303.12.

(48) "Transportation and Related Costs" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (15) of subsection (d) of section 303.12.

(49) "Vision Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (16) of subsection (d) of section 303.12.

(Effective August 28, 1998)

Sec. 17b-262-599. Provider participation

(a) **Billing Provider**

In order to enroll in the Medical Assistance Program and receive payment from the department for early intervention services rendered, the billing provider shall:

(1) meet and maintain all departmental enrollment requirements;

(2) have a valid billing provider agreement on file which is signed by the billing provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the billing provider is mandated to adhere in order to participate in the program;

(3) ensure that an individual employed or contracted by the performing provider shall be selected as service coordinator for each child to serve as the person responsible for compliance with the duties as defined in Title 34 CFR, Part 303, section 303.22;

(4) provide early intervention services directly or by means of a contract with qualified allied health professionals pursuant to all applicable federal and state statutes and regulations and ensure that all performing providers are enrolled with the Medical Assistance Program prior to provision of service;

(5) select one or more performing providers through a competitive or non-competitive bidding process;

(6) process all claims submitted by all other performing providers under contract for provision of early intervention services in the Birth to Three System; and

(7) comply with all Medical Assistance Program documentation and other requirements.

(b) **Performing Provider**

In order to enroll in the Medical Assistance Program as a performing provider the provider shall:

(1) have a contract with the billing provider;

(2) meet and maintain all departmental enrollment requirements;

(3) have a valid performing provider agreement on file which is signed by the performing provider and the department;

(4) provide all early intervention services directly with allied health professionals pursuant to all applicable provisions of federal and state statutes and regulations; and

(5) comply with all Medical Assistance Program documentation and other requirements.

(Effective August 28, 1998)

Sec. 17b-262-600. Eligibility

(a) Payment for early intervention services shall be available for all children eligible for the Medical Assistance Program subject to the conditions and limitations which apply to early intervention services as provided by these regulations.

(b) Payment for early intervention services shall be available only for evaluations, assessments, and services that are contained in an IFSP and by consent of a parent or other person authorized to consent to such activities on behalf of an eligible child.

(c) Significant delay shall be demonstrated with scores on an appropriate norm-referenced standardized diagnostic instrument or other procedures, such as formal observations and informed clinical opinion, to substantiate:

(1) a score two standard deviations below the mean in one area of development; or

(2) scores one and one-half standard deviations below the mean in two areas of development.

(d) Other procedures shall be used to demonstrate significant delay when the use of the standardized diagnostic instrument is not appropriate due to a child's age or when a child requires significant adaptation to perform on a standardized instrument.

(Effective August 28, 1998)

Sec. 17b-262-601. Services covered and limitations

(a) The department shall pay for the following:

(1) evaluations and assessments;

(2) early intervention services, which are medically appropriate and medically necessary as follows:

(A) assistive technology devices and assistive technology services;

(B) audiology;
(C) family training, counseling, and home visits;
(D) health services;
(E) medical services;
(F) nursing services;
(G) nutrition services;
(H) occupational therapy;
(I) physical therapy;
(J) psychological services;
(H) service coordination;
(I) social work services;
(J) special instruction;
(K) speech-language pathology;
(L) transportation and related costs; and
(M) vision services; and

(3) services provided in the child's natural environment to the maximum extent appropriate to the needs of the child.

(b) Limitations on covered services shall be as follows:

(1) DMR, or another state agency, shall be the agencies eligible for enrollment with the department to bill for early intervention services to Birth to Three eligible children and their families and to enter into a billing provider agreement with the department for the provision of such services;

(2) services shall be limited to those early intervention services authorized, by a parent or other person empowered to consent on behalf of an eligible child, in the IFSP;

(3) effective July 1, 1996, service coordination shall become part of the early intervention services fee;

(4) special instruction, developmental therapy, requires a signature by a licensed practitioner of the healing arts documenting the existence of a multidisciplinary team, and stating that he or she has periodically reviewed the child's progress and has recommended appropriate techniques, activities, and strategies during discussions with the child's early intervention teacher. Documentation of this requirement in a format and manner to be described by the department shall be signed and dated quarterly;

(5) treatment services are limited to a maximum of one per day of the same type of treatment service per child;

(6) evaluation services are limited to a maximum of one per month, per child;

(7) services are limited to those listed in the department's fee schedule;

(8) services of an unproven, educational, social, experimental, research, or cosmetic nature are not covered;

(9) immunizations, biological products, and other products or examinations and laboratory tests for preventable diseases available free of charge are not covered;

(10) speech services involving nondiagnostic, nontherapeutic, routine, repetitive, and

reinforced procedures or services for the child's general welfare that are not planned and performed or supervised by a licensed speech pathologist are not covered;

(11) payment for services by an AHP whose scope of practice is defined under state law when the service that was provided is not within said scope of practice; and

(12) payment for services by an AHP whose scope of practice is not defined under state law when the service that was provided is not within the accepted standard in his or her respective profession or the AHP is otherwise prohibited under state law from providing said service.

(Effective August 28, 1998)

Sec. 17b-262-602. Billing procedures

All claims submitted to the department for payment of evaluation and early intervention services including assessments and assistive technology devices, shall be substantiated by documentation in the Birth to Three eligible child's early intervention record.

(Effective August 28, 1998)

Sec. 17b-262-603. Payment

(a) The department shall establish payment rates effective July 1, 1996.

(b) The rate period shall be the state fiscal year.

(c) Interim rates shall be issued for each rate period and such rates shall be replaced by rates computed on the basis of actual cost and service volume submitted to the department by the billing provider by December 31 each year for the immediately preceding state fiscal year.

(d) Payment shall not be made directly to AHPs or organizations under contract to a performing provider or a billing provider.

(e) Payment limitations shall be as follows:

(1) payment for evaluations; early intervention services, which includes assessments; and assistive technology devices shall not duplicate payments made under the Medical Assistance Program for other services which are covered under the Program;

(2) any Medical Assistance Program Birth to Three eligible child is qualified to be evaluated for eligibility for Part H of IDEA;

(3) payment shall be made for early intervention services only for the period covered by the written authorized IFSP;

(4) once a child is determined ineligible for Part H of IDEA, payment shall not be made for assessment and early intervention services;

(5) claims for payment shall be submitted to the department only by the billing provider or its designated agent;

(6) payment for early intervention services, excluding evaluations, shall not be made unless one or more of the individual services pursuant to section 17b-262-601 are rendered in a calendar month;

(7) payment shall be made for evaluations regardless of whether the child becomes

eligible for the Birth to Three System;

(8) evaluations shall be based on a cost per evaluation basis;

(9) other early intervention services, including assessments, shall be no more than two units per child per calendar month;

(10) rates for early intervention services shall include assistive technology devices having a cost equal to or less than two hundred and fifty dollars; and

(11) rates for assistive technology devices having a cost of more than two hundred and fifty dollars, shall be based on the applicable Medical Assistance Program durable medical equipment fee schedule.

(Effective August 28, 1998)

Sec. 17b-262-604. Documentation requirements

Early intervention services shall be paid by the department only when the lead agency ensures compliance of the following documentation requirements on file with the performing provider, as appropriate:

(a) **Evaluation**

(1) A copy of the evaluation report which shall meet the requirements of Part H of IDEA, Title 20 USC 1471 et seq., Title 20 USC section 1477(a), and at Title 34 CFR, Part 303, subdivision (1) of subsection (b) of section 303.322, shall be on file, recommending the specific medical diagnosis or diagnoses according to the International Classification of Diseases (ICD) in a form and manner specified by the department, and signed by all members of the evaluation team.

(2) The evaluation shall include:

(A) for eligible Birth to Three children, a signature on a form and manner to be specified by the department, by the physician who recommended the evaluation and stated diagnosis or diagnoses; which authorizes the development of the IFSP, and

(B) for ineligible children, a signature by a physician within forty-five days of the date the evaluation was completed and signed.

(b) **Assessment**

(1) A copy of the assessment which shall meet the requirements of Part H of IDEA, Title 20 USC 1471 et seq., Title 20 USC, section 1477(a), and at Title 34 CFR, Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322 and subdivision (2) of subsection (b) of section 303.322, shall be on file.

(2) The assessment shall be a multidisciplinary team assessment of the child's and child's family's unique needs and the identification of services appropriate to meet such needs.

(3) The written assessment report shall be signed by all members of the multidisciplinary team recommending the type of services appropriate for the child as listed in the IFSP.

(4) If any member of the multidisciplinary team does not attend the IFSP meeting, that member shall provide a written report regarding recommended services appropriate to their scope of practice.

(c) **Individualized Family Service Plan (IFSP)**

(1) The IFSP shall meet the requirements of Part H of IDEA, Title 20 USC 1471 et seq., Title 20 USC, section 1477(b), (c), and (d), and at Title 34 CFR, Part 303, sections 303.340 through 303.346, and be provided in accordance with the Birth to Three eligible child's service page as delineated in the IFSP. The IFSP shall be evaluated not less than once a year and the family shall be provided a review of the plan at six month intervals, or more often where appropriate, based on infant and toddler and family needs.

(2) At a minimum, the IFSP shall:

(A) be developed by the multidisciplinary team, of which the service coordinator shall be a member, within forty-five days of referral for early intervention services and indicate that the Birth to Three eligible child, his or her family or their representative has participated in, or been given the opportunity to participate in, the development of the child's plan of services service page of the IFSP;

(B) include a signature by a physician functioning within his or her scope of practice as defined in state law recommending the diagnostic and treatment services contained in the IFSP and the ICD diagnosis code. The physician shall sign the document within forty-five days of the date the IFSP was completed and signed by the parent;

(C) be based on an assessment of a Birth to Three eligible child's and child's family's needs which include, but are not limited to, assessments of medical, clinical, social, educational, or other needs;

(D) include a statement of the major outcomes expected to be achieved for the Birth to Three eligible child and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary;

(E) include a statement of specific early intervention services necessary to meet the unique needs of the Birth to Three eligible child and the family, including the frequency, intensity, and the method of delivering services;

(F) include the name of the service coordinator from the profession most immediately relevant to the Birth to Three eligible child's or family's needs who shall be responsible for the implementation of the plan and coordination with other agencies and persons;

(G) include the steps to be taken supporting the transition of the Birth to Three eligible child to other appropriate services; and

(H) develop and implement an interim IFSP for a Birth to Three eligible child whose developmental status requires early intervention services while the evaluation and assessment are being completed such as a Birth to Three eligible child discharged from a hospital and who needs immediate continuation of care. Interim IFSPs may be developed and implemented if written parental consent is obtained, the name of the service coordinator and the early intervention services that are needed immediately for the child and the child's family are included in the interim IFSP, and the initial evaluation is completed within forty-five days after the performing provider receives the referral.

(d) **Progress Notes**

(1) Progress notes shall be kept in a form and manner as specified by the department.

They shall provide a comprehensive treatment narrative of the contacts with the child and family throughout the month, highlighting activities, nature and extent of the contacts, and relationship of activities to the medical necessity and medical appropriateness of the early intervention services in relation to the outcomes specified in the evaluation, assessment reports, and the service page as delineated in the IFSP.

(2) Any changes or differences in treatment shall be noted and related to the dates of services. Any increases in services shall meet signature requirements contained in these regulations. If a child is seen more than once during the same week, a summary and progress note for the month is acceptable if any changes in progress or treatment are documented each time they occur with the specific date that they occurred. The progress notes at a minimum shall:

(A) include a summary of progress made according to the IFSP;

(B) include a summary statement of service delivered noting any significant changes in the child's condition;

(C) be kept by the performing provider or the state agency in a form and manner to be determined, as specified by the department; and

(D) include the signature of the AHP providing the service.

(e) **Medical Expertise**

(1) Records of services provided by individuals who are AHPs but do not have a scope of practice defined by state law, such as a special education teacher, shall include written documentation of the involvement of a licensed practitioner of the healing arts in the delivery of service.

(2) Except for service coordination, the documentation required by this subsection shall be updated and signed, and in the child's early intervention record at least quarterly. This documentation shall include:

(A) identifying information about the child;

(B) the name of the AHP; and

(C) a signed statement by a licensed practitioner of the healing arts who shall be a member of the multidisciplinary team.

(f) **Early Intervention Record**

(1) An early intervention record for a child eligible for the Birth to Three System shall be maintained as provided by these regulations. At a minimum, the record shall contain the following:

(A) the initial written referral, all evaluations, all assessments, and reassessments, as necessary, to determine needed services;

(B) the Birth to Three eligible child's name, date of birth, address, social security or medical assistance number, and other relevant historical and financial information;

(C) all IFSPs;

(D) a statement by a physician recommending diagnostic or treatment services;

(E) all records of actual service delivery indicating the dates of service, type of service, location of service, units of service, and dated signature of the individual AHP providing

the service;

(F) all records of service entries of service coordination indicating the date, place of service, the name of the service coordinator, and type of ongoing service coordination provided, and a signature, by an AHP, confirming monthly data; and

(G) a transition plan, as appropriate, and an exit form.

(2) For a child who is determined ineligible for the Birth to Three System, the early intervention record shall include at a minimum:

(A) a written review of the diagnostic services by a physician;

(B) the ineligible child's name, date of birth, address, social security or medical assistance number, and other relevant historical and financial information; and

(C) all evaluations and ICD code.

(g) **Other Documentation Requirements**

(1) A contract establishing the independent provider as a Birth to Three performing provider for a particular type of service at a particular rate shall be available and include the following:

(A) any relevant terms and conditions associated with being a Birth to Three performing provider including the agreement not to bill the Medical Assistance Program for these services provided to Birth to Three children; and

(B) the performing provider shall be responsible for the development, maintenance, and monitoring of current and updated lists of the names and credentials of all employed and contracted Birth to Three performing providers and their employees, and the effective dates they were eligible to provide Birth to Three services. The list shall:

(i) include the performing provider's certification number, license number, and the Medical Assistance Program number, if applicable; and

(ii) be kept by the performing providers, in a central location, and be available upon request to authorized persons such as the Health Care Financing Administration (HCFA) or the department.

(2) The billing provider may choose to require performing providers which employ more than twenty people qualified to provide services under the contract, when contracted for service provision, to maintain and update the necessary list of persons providing services, their credentials, and their Medical Assistance Program billing number if they are enrolled with the Medical Assistance Program as a billing provider. A statement to this effect shall be part of the contract between the billing provider and the performing provider and shall be signed and dated:

(A) the contract shall also provide for the transfer of employee lists, should the organization subsequently go out of business; and

(B) each state agency shall be responsible for maintaining the licensure and certification document on each state employee providing direct service in the Birth to Three System.

(3) The performing provider shall be responsible for maintaining fiscal and medical records which fully disclose services and goods rendered or delivered to all persons receiving services in the Birth to Three System:

(A) these records and information shall be made available to authorized representatives of the department and billing provider upon request;

(B) all documentation shall be entered in ink and incorporated into the early intervention record in a complete, prompt, and accurate manner; and

(C) all documentation shall be made available to authorized department personnel upon request in accordance with Title 42 CFR, Part 431, section 431.17.

(4) The procedural safeguards required by Part H of IDEA, Title 20, USC 1471 et seq., Title 20. USC, section 1480, and specifically Title 34 CFR, Part 303, section 303.400 et seq., shall be developed and implemented by the lead agency. In addition to these safeguards, any child who is a Birth to Three eligible child and is also a Medical Assistance Program client may avail themselves of the department's fair hearing process pursuant to section 17b-60 of the Connecticut General Statutes.

(Effective August 28, 1998)

Sec. 17b-262-605. Audit and record retention

(a) All supporting accounting and business records, statistical data, early intervention records, and other records relating to the provision of evaluation, assessment, service coordination, and early intervention services paid for by the department shall be subject to audit.

(b) Documentation as required for the Birth to Three System, including census and accounting records, shall be maintained for the longer of:

(1) six years from the end of the billing period; or

(2) six years from the date of services by the performing provider; or

(3) until such time as the department audit of documented services is completed and said audit is approved or disallowed as the case may be by the commissioner.

(Effective August 28, 1998)

Sec. 17b-262-606. Reserved

Requirements for Payment of Nurse Practitioner Services

Sec. 17b-262-607. Scope

Sections 17b-262-607 through 17b-262-618 inclusive set forth the Department of Social Services requirements for payment of nurse practitioner services provided by licensed advanced practice registered nurses for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Effective August 10, 1998)

Sec. 17b-262-608. Definitions

For the purposes of sections 17b-262-607 through 17b-262-618 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Allied Health Professional (AHP)" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in providing health care and treatment and shall include, but shall not be limited to: licensed practical nurses, certified nurse assistants, and other qualified therapists.

(3) "By or Under the Supervision" means the nurse practitioner shall assume professional responsibility for the service performed by the allied health professional, overseeing or participating in the work of the allied health professional including, but not limited to:

(A) availability of the nurse practitioner to the allied health professional in person and within five minutes;

(B) availability of the nurse practitioner on a regularly scheduled basis to review the practice, charts, and records of the allied health professional and to support the allied health professional in the performance of services; and

(C) a predetermined plan for emergency situations, including the designation of an alternate nurse practitioner in the absence of the regular nurse practitioner.

(4) "Child" means a person who is under twenty-one years of age.

(5) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(6) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(7) "Concurrent Review" means the review of the medical necessity and appropriateness of admission upon or within a short period following an admission and the periodic review of services provided during the course of treatment.

(8) "Consultation" means those services rendered by a nurse practitioner whose opinion or advice is requested by the client's nurse practitioner or agency in the evaluation or treatment of the client's illness.

(9) "CPT or Physician's Current Procedural Terminology" means a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by licensed practitioners as published by the American Medical Association, as amended from time to time.

(10) "Criteria" means the predetermined measurement variables on which judgment or comparison of necessity, appropriateness, or quality of health services shall be made.

(11) "Department" means the Department of Social Services or its agent.

(12) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(13) "Family Planning Services" means any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely

determine the number and spacing of their children.

(14) "Fees" means the rates for services, treatments, and drugs administered by nurse practitioners which shall be established by the commissioner and contained in the department's fee schedules.

(15) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(16) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(17) "Home" means the client'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; long-term care facility includes a nursing facility, chronic disease hospital, and intermediate care facility for the mentally retarded (ICF/MR).

(18) "Hospital" means a facility licensed by the Department of Public Health as a general short-term hospital or a hospital for mental illness as defined in section 17a-495 of the Connecticut General Statutes, or a chronic disease hospital as defined in subdivision (2) of subsection (b) of section 19-13-D1 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

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

(20) "Institution" means the definition contained in Title 42 of the CFR, Part 435, section 435.1009.

(21) "Interperiodic Encounter" means any medically necessary visit to a Connect-icut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(22) "Legend Device" means the definition contained in section 20-571 of the Connecticut General Statutes.

(23) "Legend Drug" means the definition contained in section 20-571 of the Connecticut General Statutes.

(24) "Licensed Practitioner" means any Connecticut medical professional granted prescriptive powers within the scope of his or her professional practice as defined and

limited by federal or state law.

(25) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(26) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities,

(B) chronic disease hospitals—inpatient, and

(C) intermediate care facilities for the mentally retarded (ICFs/MR).

(27) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(28) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(29) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(30) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(31) "Nurse Practitioner" means an advanced practice registered nurse (APRN) who holds a current license as such issued by the Department of Public Health (DPH) under Chapter 378 of the Connecticut General Statutes, and who performs within the scope of practice for APRNs established pursuant to the Connecticut General Statutes and all relevant regulations.

(32) "Panel or Profile Tests" means certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple tests performed on an individual, immediate, or "stat" reporting basis.

(33) "Physician" means an individual licensed under Chapter 370 or 371 of the Connecticut General Statutes as a doctor of medicine or osteopathy.

(34) "Plan of Care" means the definitions contained in Title 42 of the CFR, Part 441, sections 441.102, 441.103, 441.155, and 441.156.

(35) "Prescription" means an order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order. The prescription needs to be renewed six months from the date of issuance. In long-term care facilities the signed order of a licensed practitioner shall be accepted in lieu of a written or oral prescription. The written prescription shall include:

(A) the date of the prescription;

(B) the name and address of the client;

(C) the client's date of birth;
(D) the diagnosis;
(E) the item prescribed;
(F) the quantity prescribed and strength, when applicable;
(G) the timeframe for the product's use;
(H) the number of refills, if any:
(I) the name and address of the prescribing practitioner and his or her Drug Enforcement Act number when appropriate;
(J) the dated signature of the licensed practitioner prescribing; and
(K) directions for the use of the medication and any cautionary statements required.

(36) "Prior Authorization" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

(37) "Provider" means a nurse practitioner who is enrolled in the Medical Assistance Program.

(38) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(39) "Quality of Care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment.

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

(41) "Routine Medical Visits" means visits intended to check a client's general medical condition rather than visits which are medically necessary to treat a specific medical problem. For clients under twenty-one years of age, this can mean a Health-Track interperiodic encounter or a periodic comprehensive health screening.

(42) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(43) "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 concurrent, prospective, or retrospective basis.

(Effective August 10, 1998)

Sec. 17b-262-609. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall meet the following requirements:

(a) **General:**

(1) meet and maintain all applicable licensing, accreditation, and certification requirements;

(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 Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) **Specific:**

In order to qualify for payment under the Medical Assistance Program for laboratory procedures, a nurse practitioner shall be in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), as amended from time to time.

(Effective August 10, 1998)

Sec. 17b-262-610. Eligibility

Payment for nurse practitioner services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Effective August 10, 1998)

Sec. 17b-262-611. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for:

(1) medically necessary and medically appropriate professional services of a nurse practitioner which conform to accepted methods of diagnosis and treatment;

(2) services provided in the practitioner's office, client's home, hospital, long-term care facility, or other medical care facility;

(3) family planning services as described in the Regulations of Connecticut State Agencies;

(4) unless defined elsewhere, CPT descriptive terms used by the department as standards;

(5) medical and surgical supplies used by the provider in the course of treatment of a client;

(6) injectable drugs which are payable by the department and administered by a provider; and

(7) HealthTrack Services and HealthTrack Special Services.

(b) **Limitations on covered services shall be as follows:**

(1) The department reserves the right to review the medical necessity and medical appropriateness of visits and to disallow payment for those visits it determines are not medically necessary or medically appropriate.

(2) A nurse practitioner who is fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department

unless the nurse practitioner maintains an office for private practice at a separate location from the hospital, institution, group, or clinic in which the nurse practitioner is employed. Nurse practitioners who are solely hospital, institution, group, or clinic based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(3) Nurse practitioners who maintain an office for private practice separate from the hospital, institution, group, or clinic, shall be able to bill for services provided at the private practice location or for services provided to the nurse practitioner's private practice clients in the hospital, institution, group, or clinic.

(4) The department shall pay nurse practitioners for drugs or devices which are administered or dispensed directly to a client under the following conditions:

(A) excluding oral medications, payment shall be made to a nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drugs or devices which are administered directly to the client; and

(B) for legend drugs or legend devices which shall be administered by a nurse practitioner, the department shall pay the nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drug or device which is administered.

(5) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(6) Admission or annual exams for long-term care facility residents shall meet the following criteria:

(A) the exam shall be performed in the facility;

(B) the admission examination shall be performed within forty-eight hours of admission to the facility and shall be limited to one per client, per provider, regardless of the number of admissions. However, if the nurse practitioner who attended the client in an acute or chronic care hospital is the same nurse practitioner who shall attend the client in the facility, a copy of a hospital discharge summary completed within five working days of admission and accompanying the client may serve in lieu of this requirement. An additional admission exam shall be performed only when a new medical record is opened for the client; and

(C) the annual comprehensive medical examination shall be limited to one per client per calendar year.

(7) When billing allergy procedures the nurse practitioner shall bill for followup visits which include intracutaneous tests only if subsequent visits require testing. If follow-up visits do not include testing, regular office visit codes for established clients shall be used.

(8) Payment for panel or profile tests shall be made according to the fees listed in the department's fee schedule for panel tests and not at the rate for each separate test included in the panel or profile.

(9) Payment for any laboratory service shall be limited to services provided by Medical Assistance Program providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

(10) The fees listed in the department's fee schedule shall be payable only when these services are provided by or under the supervision of a nurse practitioner.

(11) The department shall not pay a higher rate for any procedure which is performed in an emergency department.

(12) The department shall pay for an initial visit by a nurse practitioner in the office, home, or long-term care facility only once per client. Initial visits refer to the provider's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The exception to this is when the nurse practitioner-client relationship has been discontinued for three or more years and is then reinstated.

(13) The department shall pay for an initial visit once per inpatient hospitalization.

(14) The fee for a consultation shall apply only when the opinions and advice of a consultant nurse practitioner are requested by the client's nurse practitioner or agency in the evaluation or treatment of the client's illness. In a consultation the client's nurse practitioner carries out the plan of care. In a referral a second provider provides direct service to the client.

(15) When the consultant nurse practitioner assumes the continuing care of the client, any service subsequent to the initial consultation rendered by the consultant provider shall no longer be a consultation and shall be paid according to the fee listed for the procedure.

(16) A consultation initiated by a client or family, and not requested by a nurse practitioner, shall not be billed as an initial consultation, but shall be billed as a confirmatory consultation or as an office visit, whichever is appropriate.

(17) If a consultant nurse practitioner, subsequent to the consultation, assumes responsibility for management of a portion, or all of the client's medical condition, consultation codes shall not be billed. A specifically identifiable procedure, identified with a specific CPT code, performed on, or subsequent to the date of the initial consultation, shall be billed separately.

(18) When a newborn requires other than routine care following delivery, the nurse practitioner shall bill for the appropriate critical care. The department shall not pay both critical care and routine care for the same child.

(Effective August 10, 1998)

Sec. 17b-262-612. Services not covered

The department shall not pay for the following:

(a) any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment procedures in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(b) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge;

(c) information or services provided to a client by a provider over the telephone;

(d) an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;

(e) cancelled office visits and appointments not kept;

(f) cosmetic surgery;

(g) services provided in an acute care hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies;

(h) services provided by the admitting provider in an acute care hospital shall not be made or may be recouped if it is determined by the department's utilization review, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting, or quality of care;

(i) a laboratory charge for laboratory services performed by a laboratory outside of the nurse practitioner's office—the laboratory shall bill the department for services rendered when a nurse practitioner refers a client to a private laboratory;

(j) the following routine laboratory tests which shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination, and urine glucose; and

(k) transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone treatment and electrolysis.

(Effective August 10, 1998)

Sec. 17b-262-613. Need for service

The department shall pay for an initial office visit and continuing services which the department deems are medically necessary and medically appropriate, in relation to the diagnosis for which care is required, provided that:

(a) the services are within the scope of the provider's practice, and

(b) the services are made part of the client's medical record.

(Effective August 10, 1998)

Sec. 17b-262-614. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for the following services:

(1) more than one visit on the same day for the same client by the same provider. Authorization for additional visits need not be submitted in advance of the service, but providers shall submit the authorization request prior to billing for the second or subsequent visits;

(2) admissions to acute care hospitals pursuant to section 17-134d-80 of the Regulations

of Connecticut State Agencies;

(3) electrolysis epilation;

(4) physical therapy services in excess of two treatments per calendar week per client per provider;

(5) physical therapy services in excess of nine treatments per calendar year per client per provider, involving the following primary diagnoses:

(A) all mental disorders including diagnoses related to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;

(B) cases involving musculoskeletal system disorders covered by ICD, as amended from time to time; and

(C) cases involving symptoms related to nutrition, metabolism, and development covered by ICD, as amended from time to time;

(6) reconstructive surgery, including breast reconstruction following mastectomy;

(7) plastic surgery;

(8) transplant procedures; and

(9) HealthTrack Special Services.

(A) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(B) the request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service required;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a nurse practitioner shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Effective August 10, 1998)

Sec. 17b-262-615. Billing procedures

(a) Claims from nurse practitioners shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the nurse practitioner's usual and customary charge for the services delivered.

(c) When a Medical Assistance Program client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant provider shall enter the entire name as well as the state license number of the referring provider on the billing form.

(d) Injectables shall be billed according to the number of units administered to the client by the nurse practitioner.

(e) When billing for anesthesia services, providers shall include the name of the primary surgeon on the bill and enter the total number of minutes in units.

(f) Providers shall bill for drugs or devices which are dispensed directly to the client as separate line items.

(g) All charges billed for supplies and materials provided by a provider, except glasses, shall be reviewed by the department.

(Effective August 10, 1998)

Sec. 17b-262-616. Payment

(a) Payment rates shall be the same for in-state and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(Effective August 10, 1998)

Sec. 17b-262-617. Payment rate and limitations

(a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Nurse practitioner rates for each procedure shall be set at 90% of the department's fees for physician procedure codes.

(c) The fees listed apply only when services are directly performed by the nurse practitioner or provided under the supervision of the nurse practitioner.

(d) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not at the rate for each separate test included in the panel or profile.

(e) Fees for surgical and medical procedures shall include the fee for an emergency room visit. The department shall not pay a provider at a higher rate for any surgical or medical procedure which is performed in an emergency room.

(f) The department shall pay nonhospital based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.

(g) If a client is referred to a provider for advice and treatment of a condition which the referring provider does not usually treat, the fee for a consultation shall not be paid.

(h) If a client's medical condition necessitates the concurrent services and skills of two or more providers, each nurse practitioner provider shall be entitled to the listed fee for the service.

(i) When a Medical Assistance Program applicant visits a provider for the purpose of determining eligibility, the department shall pay only for the test required to establish eligibility as requested by the department. No other procedures shall be paid.

(j) Newborn resuscitation may be billed in addition to billing for routine care of a newborn or billing for critical care.

(k) The admission and annual comprehensive medical examination, in a long-term care facility, shall be performed by or under the direct supervision of a provider.

(*l*) The admission examination, in a long-term care facility, shall be performed within forty-eight hours of admission to the long-term care facility and shall be limited to one per client, per provider, regardless of the number of admissions.

(Effective August 10, 1998)

Sec. 17b-262-618. Documentation

(a) Nurse Practitioners shall maintain a specific record for all services rendered for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the nurse practitioner, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the nurse practitioner's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the nurse practitioner for which the required documentation is not maintained or provided to the department upon request.

(Effective August 10, 1998)

Requirements for Payment of Podiatric Services

Sec. 17b-262-619. Scope

Sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of podiatric services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective February 11, 2009)

Sec. 17b-262-620. Definitions

As used in section 17b-262-619 to section 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acute" means symptoms that are severe and have a rapid onset and short course;

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

(3) "Border provider" means an out-of-state provider who routinely serves clients and is deemed a border provider by the department on a provider by provider basis;

(4) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(5) "Client" means a person eligible for goods or services under the department's Medicaid program;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Consultation" means those services rendered by a podiatrist or other practitioner whose opinion or advice is requested by the client's podiatrist or other appropriate source in the evaluation or treatment of the client's illness;

(8) "Customized item" means an item or material adapted through modification to meet the specific needs of a particular client;

(9) "Department" means the Department of Social Services or its agent;

(10) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(11) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

(12) "Freestanding clinic" means "freestanding clinic" as defined in section 171B of the department's Medical Services Policy for clinic services;

(13) "General hospital" means "general hospital" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(14) "Home" means the client's place of residence, including, but not limited to, a boarding home, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(15) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(16) "Legend device" means "legend device" as defined in section 20-571 of the Connecticut General Statutes;

(17) "Legend drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(18) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(19) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(20) "Medical necessity" or "medically necessary" means health care provided; to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(21) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(22) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(23) "Out-of-state provider" means a provider that is located outside Connecticut and is not a border provider;

(24) "Physician" means a person licensed pursuant to chapter 370 of the Connecticut General Statutes;

(25) "Podiatric Services" means services provided by a podiatrist within the scope of practice as defined by state law, including chapter 375 of the Connecticut General Statutes;

(26) "Podiatrist" means a doctor of podiatric medicine licensed pursuant to section 20-54 of the Connecticut General Statutes;

(27) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(28) "Provider" means a podiatrist or a podiatrist group enrolled in Medicaid;

(29) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;

(30) "Routine foot care" means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryposis or onychauxis; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;

(31) "Simple foot hygiene" means self-care including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;

(32) "Systemic condition" means the presence of a metabolic, neurologic, or peripheral vascular disease, including, but not limited to: diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neu-ropathies involving the feet, which would justify coverage of routine foot care;

(33) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

(34) "Utilization review" means the evaluation of the necessity and appropriateness of medical services and procedures as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(Adopted effective February 11, 2009)

Sec. 17b-262-621. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective February 11, 2009)

Sec. 17b-262-622. Eligibility

Payment for podiatric services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(Adopted effective February 11, 2009)

Sec. 17b-262-623. Services covered and limitations

Subject to the limitations and exclusions identified in sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay providers for podiatric services provided by podiatrists:

(1) for only for those procedures listed in the provider's fee schedule that are medically necessary and medically appropriate to treat the client's condition;

(2) for podiatric services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;

(3) for laboratory services provided by a podiatrist in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

(4) for medical and surgical supplies used by the podiatrist in the course of treatment of a client;

(5) for drugs and supplies administered by a podiatrist;

(6) for a second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation; and

(7) for EPSDT services including, but not limited to, treatment services which are indicated following screening but not otherwise covered, provided that prior authorization is obtained.

(Adopted effective February 11, 2009)

Sec. 17b-262-624. Services not covered

The department shall not pay a podiatrist:

(1) for information or services provided to a client by a podiatrist over the telephone;

(2) for any product available to podiatrists free of charge;

(3) for more than one visit per day per client to the same podiatrist;

(4) for cosmetic surgery;

(5) for simplified tests requiring minimal time or equipment and employing materials nominal in cost, including, but not limited to, urine testing for glucose, albumin and blood;

(6) for simple foot hygiene;

(7) for repairs to devices judged by the department to be necessitated by willful or malicious abuse on the part of the client;

(8) for repairs to devices under guarantee or warranty. The podiatrist shall first seek payment from the manufacturer;

(9) for an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;

(10) for cancelled services and appointments not kept;

(11) for services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies; or

(12) for any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis,

symptoms or medical history.

(Adopted effective February 11, 2009)

Sec. 17b-262-625. Need for service

Payment for an initial office visit and continuing services which the department deems medically necessary and medically appropriate, in relation to the diagnosis for which care is required, is available provided that:

(1) the services are within the scope of the podiatrist's practice; and

(2) the services are made part of the client's medical record.

(Adopted effective February 11, 2009)

Sec. 17b-262-626. Prior authorization

(a) To receive payment from the department, a podiatrist shall comply with the prior authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(b) Prior authorization, on forms and in the manner specified by the department, shall be required for:

(1) physical therapy services in excess of two visits per calendar week per client per podiatrist;

(2) physical therapy services in excess of nine visits per calendar year per client per podiatrist, when the therapy is for the treatment of the following diagnoses:

(A) cases involving musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; and

(B) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time;

(3) reconstructive surgery;

(4) plastic surgery;

(5) EPSDT services that are identified during a periodic screening as medically necessary and which are not listed on the existing fee schedule; and

(6) other services and supplies identified as requiring prior authorization on the fee schedule.

(c) Prior authorization is required for payment of all hospital admissions as required and described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(d) The authorization period shall be for a period not to exceed six months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered for up to an additional six month period per request.

(f) Except in emergency situations, prior authorization shall be received before services are rendered.

(g) In an emergency situation that occurs after working hours or on a weekend or holiday, the podiatrist shall secure verbal prior authorization on the next working day for the services provided. This applies only to those services that normally require prior authorization.

(Adopted effective February 11, 2009)

Sec. 17b-262-627. Billing procedures

(a) Claims from podiatrists shall be submitted on the department's designated form or electronically transmitted to the department, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the podiatrist's usual and customary charge for the services delivered.

(c) When a client is referred to a podiatrist for consultation, the consultant podiatrist shall include the referring practitioner's name.

(d) Laboratory services performed in the podiatrist's office shall be payable to the podiatrist and shall be billed as separate line items. When a podiatrist refers a client to a private laboratory for services, the laboratory shall bill directly and no laboratory charge shall be paid to the podiatrist.

(e) All charges billed for supplies and materials provided by a podiatrist may be reviewed by the department.

(f) When services are provided by more than one member of a group, the authorization request shall be submitted prior to billing as described in the billing instructions in the provider manual.

(Adopted effective February 11, 2009)

Sec. 17b-262-628. Payment

(a) The commissioner shall establish, and may periodically update, the fees for covered services in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Fees shall be the same for in-state, border and out-of-state podiatrists.

(c) Payment shall be made at the lowest of:

(1) the podiatrist's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the podiatrist.

(d) Notwithstanding the provisions of the regulations of connecticut state agencies or any of the Medical Services Policies to the contrary, the department shall not pay any podiatrist under sections 17b-262-619 through 17b-262-629, inclusive, of the regulations of connecticut state agencies for a client seen at a freestanding clinic enrolled in Medicaid. Only the clinic may bill for such services. As an exception to the foregoing, a podiatrist

may bill for covered services for a client seen at an outpatient surgical facility. a podiatrist who is enrolled with medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.

(e) The department shall not pay interns or residents for their services nor shall the department pay for assistant surgeons in general or chronic disease hospitals staffed by interns and residents, unless the procedure is significantly complicated to justify a full surgeon acting as an assistant. If the surgery is performed by a resident or intern and the supervising surgeon assists, only the assistant's fee shall be paid to the surgeon. The regular surgical fee shall not be paid.

(f) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, no fee shall be paid to the surgeon even when the surgeon is on call.

(g) **Payment limitations**

(1) Fees for initial fittings and adjustments shall be included in the cost of the item or device.

(2) The department shall pay a podiatrist for physical therapy only if the podiatrist personally provides the physical therapy.

(3) Payment shall be made for a customized item for a client who dies, or is not otherwise eligible on the date of delivery, provided the client was eligible:

(A) on the date prior authorization was given by the department; or

(B) on the date the client ordered the item, if the item does not require prior authorization. For purposes of this section, the date the client orders the item means the date on which the podiatrist presents the order to the manufacturer or supplier. The podiatrist shall verify to the department the date the client ordered the item.

(4) The department shall pay for routine foot care only if the client has a systemic condition. Services are limited to one treatment every sixty days.

(5) The fees listed in the department's fee schedule shall be payable only when the services are performed by the podiatrist.

(6) The department shall pay for an initial visit by a podiatrist in an office, home, ICF/MR or nursing facility visit only once per client. Initial visits refer to the podiatrist's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the podiatrist-client relationship has been discontinued for three or more years and is then reinstated.

(7) Fees for consultations shall apply only when the opinions and advice of a consultant podiatrist are requested by the referring provider or other appropriate source in the evaluation and treatment of the client's illness. After the consultation is provided, the consultant shall prepare a written report of his or her findings and provide a copy of the report to the referring podiatrist or physician. In a consultation, the client's referring provider carries out the plan of care. In a referral, a second provider provides direct service to the client.

(h) **Surgery**

(1) When a claim is submitted by a podiatrist for multiple surgical procedures performed on the same date of service, the department will pay for the primary surgical procedure at the Medicaid allowed amount for podiatrists or the billed amount, whichever is lower. The department shall pay for additional surgical procedures performed on that day at fifty percent of the Medicaid allowed amount for podiatrists.

(2) When an assistant surgeon, in addition to staff provided by the hospital, is required, the amount payable by the department to the assistant surgeon shall be as indicated on the fee schedule.

(3) Subsequent to the decision for surgery, fees for surgical procedures include one related evaluation and management encounter on the date immediately prior to, or on, the date of the procedure, including history and physical.

(4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care while in the general or chronic disease hospital. Followup visits related to the surgery shall not be payable as office visits.

(5) The listed fees for surgery on the musculoskeletal system shall include payment for the application of the first cast or traction device.

(i) **Radiology**

(1) The listed fees for all diagnostic radiology procedures shall include consultation and a written report to the referring provider.

(2) The listed fees for all diagnostic radiology procedures shall apply only when the podiatrist's own equipment is being used. If the equipment used to perform the procedure is owned directly or indirectly by the general or chronic disease hospital or a related entity, or if a hospital includes the operating expenses of the equipment in its cost reports, the podiatrist shall not be paid for the technical component of the listed fee.

(j) **Laboratory**

(1) The following routine laboratory tests shall be included in the fee for an office visit and shall not be payable on the same date of service: urinalysis without microscopy, hemoglobin determination and urine glucose determination.

(2) No payment shall be made for tests which are provided free of charge.

(3) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not according to the fee for each separate test included in the panel or profile.

(k) **Drugs**

(1) The department shall pay the actual acquisition costs for oral medications incident to an office visit as billed by the podiatrist.

(2) The department shall pay for legend drugs and legend devices administered by the podiatrist based on a fee schedule determined by the department.

(3) No payment shall be made for drugs provided free of charge.

(*l*) **Admission to a general hospital**

Payment for services provided by the admitting podiatrist in a general hospital shall not be made available if it is determined by the department's utilization review program, either

prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting or quality of care. Specific requirements are described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(Adopted effective February 11, 2009)

Sec. 17b-262-629. Documentation and audit requirements

(a) Podiatrists shall maintain a specific record for all services received by each client eligible for Medicaid payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the podiatrist, documentation of services provided and the dates the services were provided and a signed receipt for all devices dispensed. The receipt for any dispensed device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the podiatrist's name;
(2) the client's name;
(3) the delivery address;
(4) the date of delivery; and
(5) itemization of the device delivered, including:
(A) a product description;
(B) a brand name;
(C) a model name and number, if applicable;
(D) a serial number, if applicable;
(E) the quantity delivered; and
(F) the amount billed per device.

(b) All required documentation shall be maintained in its original form for at least five years or longer by the podiatrist in accordance with statute or regulation, subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the podiatrist for which the required documentation is not maintained and not provided to the department upon request.

(d) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(e) Podiatrists shall maintain documentation supporting all prior authorization requests.

(Adopted effective February 11, 2009)

Requirements for Payment of Services Provided by Independent Licensed Audiologists, Physical Therapists, Occupational Therapists and Speech Pathologists

Sec. 17b-262-630. Scope

Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of services provided by independent licensed audiologists, physical therapists, occupational therapists and speech pathologists for clients who are determined eligible to receive services under Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes. Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies shall not apply to therapy services provided by home health agencies, clinics, rehabilitation centers, hospitals or other health care providers.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-631. Definitions

For the purposes of sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Advanced practice registered nurse" or "APRN" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;

(2) "Audiologist" means a person licensed to practice audiology pursuant to chapter 397a of the Connecticut General Statutes and who meets the definition of "qualified audiologist" in 42 CFR 440.110(c)(3);

(3) "Audiology" means evaluation and treatment provided by an audiologist;

(4) "Border provider" has the same meaning as provided in section 17b-262-523 of the Regulations of Connecticut State Agencies;

(5) "Chronic disease hospital" has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;

(6) "Client" means a person eligible for goods or services under Medicaid;

(7) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(8) "Department" means the Department of Social Services or its agent;

(9) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services that are not otherwise covered under Medicaid but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider and the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;

(10) "Home" means the client's place of residence, which includes a boarding home or residential care home. Home does not include a hospital or long-term care facility;

(11) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies. It shall also include an out-of-state hospital or

a hospital that is a border provider;

(12) "Independent therapist" means an audiologist, physical therapist, occupational therapist or speech pathologist practicing in the community independently and not associated with a hospital, long-term care facility, clinic, home health agency or any other health care provider;

(13) "Independent therapy" means those services provided by an independent therapist, a physical therapy assistant or an occupational therapy assistant;

(14) "Intermediate Care Facility for the Mentally Retarded" or "ICF/MR" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(15) "International Classification of Diseases" or "ICD" means the most recent system of disease classification established by the World Health Organization or such other disease classification system that the department requires providers to use when submitting Medicaid claims;

(16) "Licensed practitioner" means a physician, a physician assistant, an advanced practice registered nurse or a podiatrist providing services within the licensed practitioner's scope of practice under state law;

(17) "Long-term care facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities;

(B) inpatient chronic disease hospitals; and

(C) intermediate care facilities for the mentally retarded;

(18) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(19) "Medical necessity" or "medically necessary" have the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(20) "Nursing facility" has the same meaning as provided in 42 USC 1396r(a) and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or a rest home with nursing supervision;

(21) "Occupational therapist" has the same meaning as provided in section 20-74a(2) of the Connecticut General Statutes;

(22) "Occupational therapy" means services provided by an occupational therapist or an occupational therapy assistant and that meet the definition of occupational therapy in 42 CFR 440.110(b);

(23) "Occupational therapy assistant" has the same meaning as provided in section 20-74a(3) of the Connecticut General Statutes;

(24) "Physical therapist" has the same meaning as provided in section 20-66 of the

Connecticut General Statutes;

(25) "Physical therapy assistant" has the same meaning as provided in section 20-66 of the Connecticut General Statutes;

(26) "Physical therapy" means the evaluation and treatment provided by a physical therapist or physical therapy assistant in accordance with 42 CFR 440.110(a);

(27) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;

(28) "Physician assistant" has the same meaning as provided in section 20-12a(5) of the Connecticut General Statutes;

(29) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to chapter 375 of the Connecticut General Statutes;

(30) "Prior authorization" means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(31) "Provider" means an independent therapist enrolled with Medicaid;

(32) "Provider agreement" means the signed, written agreement between the department and the provider for enrollment in Medicaid;

(33) "Speech pathologist" means a "licensed speech and language pathologist" as defined in section 20-408 of the Connecticut General Statutes;

(34) "Speech pathology services" means the evaluation and treatment provided by a speech pathologist in accordance with 42 CFR 440.110(c); and

(35) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" means the median charge. Token charges for charity patients and other exceptional charges shall be excluded when calculating the usual and customary charge.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-632. Provider participation

In order to participate in Medicaid and receive payment from the department, providers shall:

(a) Comply with all applicable licensing, accreditation and certification requirements;

(b) comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(c) comply with sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies; and

(d) have a valid provider agreement on file with the department.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-633. Eligibility

Payment for independent therapy services prescribed by a licensed practitioner is

available on behalf of all clients who have a need for such services and which are medically necessary subject to the conditions and limitations which apply to such services.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-634. Services covered and limitations

Subject to the limitations and exclusions in this section, the department shall pay for independent therapy which conforms to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental or cosmetic nature; for services in excess of those deemed medically necessary by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

(a) The department shall pay for the following:

(1) Services provided in the provider's office or the client's home; and

(2) EPSDT Special Services.

(b) Limitations on covered services shall be as follows:

(1) Evaluation services for physical therapy, speech therapy, occupational therapy and audiology shall be limited to one of each type per day, per client regardless of the length of time it takes to complete the evaluation;

(2) for physical therapy and occupational therapy services, the department shall pay per modality as listed on the fee schedule;

(3) for speech therapy and audiology services, the department shall not pay for more than one and one half hours of treatment per day;

(4) the fee for evaluation shall include all treatment when evaluation and treatment are provided on the same day; and

(5) group speech therapy services shall include a maximum of three persons per group, per session regardless of each participant's payment source.

(c) The department shall not pay for the following independent therapy:

(1) Independent therapy when the client is concurrently receiving the same therapy services from a hospital, chronic disease hospital, clinic, rehabilitation clinic, home health agency or any other health care provider;

(2) services provided to clients who are residents of a hospital, long-term care facility or any other facility that is required to include independent therapy in its rates;

(3) cancelled office visits or appointments not kept; and

(4) information or services provided to a client by a provider electronically or over the telephone.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-635. Need for service

(a) The department shall pay for independent therapy that is medically necessary when a licensed practitioner prescribes the client's need for the service.

(b) A licensed practitioner shall reestablish the need for service by performing an

evaluation not more than twelve months after the previous evaluation.

(c) The provider shall document the initial and subsequent need for service in the client's record.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-636. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) All audiology, physical therapy, occupational therapy and speech pathology evaluation services in excess of one evaluation per calendar year, per client, per provider;

(2) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of nine treatments per calendar year per provider per client, involving the following primary diagnoses:

(A) All mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the ICD;

(B) cases involving musculoskeletal system disorders of the spine covered by the ICD; and

(C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD;

(3) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of two services per calendar week, per client, per provider;

(4) EPSDT Special Services, as follows:

(A) EPSDT Special Services are determined medically necessary on a case-by-case basis; and

(B) the request for EPSDT Special Services shall include:

(i) A written statement from a licensed practitioner justifying the need for the item or services requested; and

(ii) any other documentation required by the department in order to render a decision; and

(5) any service that is not on the department's fee schedule.

(b) The length of the initial authorization period is at the department's discretion, but shall be for no longer than three months;

(c) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request or longer if determined appropriate by the department on a case- by-case basis.

(d) For services requiring prior authorization, a provider shall provide pertinent medical or social information adequate to evaluate the client's medical need for the services.

(e) In order to receive payment from the department, a provider shall 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. Prior authorization

does not guarantee payment unless all other requirements for payment are met.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-637. Billing procedures

Providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-638. Payment

(a) Payment rates shall be the same for in-state, border and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the independent therapy fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(c) Notwithstanding the provisions of subsection (b)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-639. Payment rates

The commissioner shall establish the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-640. Documentation

(a) Providers shall maintain a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the provider, documentation of services provided and the dates the services were provided.

(b) The provider shall maintain all required documentation in its original form, paper or electronic, for at least five years or longer, as required by applicable statutes and regulations in the provider's file, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation until the end of the dispute or five years, whichever is greater.

(c) The department may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon

request.

(d) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Requirements for Payment of Laboratory Services

Sec. 17b-262-641. Scope

Sections 17b-262-641 through 17b-262-650, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of laboratory services provided by licensed clinical laboratories, in settings other than hospital inpatient or outpatient departments or a physician's, nurse-midwife's, or nurse practitioner's office, for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective May 10, 2000)

Sec. 17b-262-642. Definitions

For the purposes of sections 17b-262-641 through 17b-262-650, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) **"Client"** means a person eligible for goods or services under the department's Medicaid Program.

(2) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to section 17b-1(a) of the Connecticut General Statutes.

(3) **"Department"** means the Department of Social Services or its agent.

(4) **"HealthTrack Services"** means the services described in section 1905(r) of the Social Security Act.

(5) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(6) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits,

clinic visits, and other primary care visits.

(7) **"Laboratory"** means a licensed clinical laboratory as defined in section 19a-30 of the Connecticut General Statutes and which is independent of a physician's, nurse-midwife's, or nurse practitioner's office, or an inpatient or outpatient hospital department or clinic.

(8) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(9) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(10) **"Medicaid"** means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.

(11) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(12) **"Panel or Profile Tests"** means certain multiple tests performed on a single specimen or material derived from the human body which are related to a condition, disorder, or family of disorders, which when combined mathematically or otherwise, comprise a finished identifiable laboratory study or studies.

(13) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(14) **"Provider"** means a laboratory which provides testing and analysis services and which is independent of a physician's, nurse-midwife's, or nurse practitioner's office, or an inpatient or outpatient hospital department.

(15) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(16) **"State Plan"** means the document which contains the services covered by the Connecticut Medicaid Program in compliance with 42 CFR 430(B).

(Adopted effective May 10, 2000)

Sec. 17b-262-643. Provider participation

In order to enroll in the Medicaid Program and receive payment from the department, providers shall:

(1) be in compliance with the provisions of the Clinical Laboratories Improvement Amendments (CLIA) of 1988 for the procedures performed at the laboratory for which claims are submitted, including but not limited to, 42 CFR 493.1809;

(2) meet and maintain all applicable licensing, accreditation, and certification

requirements;

(3) meet and maintain all 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. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective May 10, 2000)

Sec. 17b-262-644. Eligibility

Payment for independent clinical laboratory services shall be available on behalf of all persons eligible for the Medicaid Program subject to the conditions and limitations which apply to these services.

(Adopted effective May 10, 2000)

Sec. 17b-262-645. Services covered and limitations

(a) The department shall pay for the following:

(1) medically appropriate and medically necessary clinical laboratory services, for which the laboratory holds certification according to the provisions of CLIA, which are listed in the department's fee schedule; and

(2) for HealthTrack and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) payment shall not be made for laboratory fees to the physician, nurse-midwife, nurse practitioner, or referring laboratories for services performed in a separate private laboratory;

(2) when laboratory services are performed in a private laboratory, billing for the service shall be made by the laboratory. Payment shall not be made to the referring physician, nurse-midwife, nurse practitioner, or to another laboratory which has referred the specimen to the performing laboratory for testing;

(3) payment shall not be made for testing and analysis which is available free of charge; and

(4) payment shall not be made for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(Adopted effective May 10, 2000)

Sec. 17b-262-646. Need for service

The department shall pay for medically necessary and medically appropriate testing and analysis services only when ordered by a licensed physician or other licensed practitioner

of the healing arts.

(Adopted effective May 10, 2000)

Sec. 17b-262-647. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(1) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(2) a description of the outcomes of any alternative measures tried; and

(3) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective May 10, 2000)

Sec. 17b-262-648. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) Laboratory services performed in a physician's, nurse-midwife's, or nurse practitioner's office shall be payable pursuant to respective Regulations of Connecticut State Agencies which describe these services.

(c) Payment for services performed in a laboratory shall not be made to the referring physician, nurse-midwife, or nurse practitioner.

(d) Payment for the components of a panel or profile of tests consists of the following:

(1) the sum of any number of the components of a panel or profile of tests shall not exceed the total charged for the group offering, the panel or profile, whether done by automation or bench testing and whether or not the equipment is available in the facility where some Medicaid Program clients reside; and

(2) where multiple tests constitute a panel or profile, they shall be billed in that manner.

(Adopted effective May 10, 2000; Amended November 4, 2005)

Sec. 17b-262-649. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) Notwithstanding the provisions of subsection (a) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual enrollee without affecting the amount paid by the department for the same or substantially similar goods or services.

(c) **Payment Rate**

The commissioner establishes the fees contained in the department's published fee schedule for independent clinical laboratories pursuant to section 4-67c of the Connecticut General Statutes.

(d) **Payment Limitations**

(1) A specimen collection fee by an independent clinical laboratory is limited to specimen collection by venipuncture or catherization.

(2) One specimen collection fee is permitted per encounter. A physician or duly authorized practitioner of the healing arts shall order the collection, and the order shall include the covered procedure or procedures from the independent clinical laboratory fee schedule. Payment shall be made to the provider performing the collection.

(Adopted effective May 10, 2000)

Sec. 17b-262-650. Documentation

(a) Independent clinical laboratory providers shall maintain a specific record for all services received for each client eligible for Medicaid Program payment including, but not limited to: name, address, birth date, Medicaid Program identification number, pertinent diagnostic information, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which required documentation is not maintained or provided to the department upon request.

(Adopted effective May 10, 2000)

Requirements for Payment of Dialysis Services

Sec. 17b-262-651. Scope

Sections 17b-262-651 through 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of

dialysis services provided by physicians, general hospitals, and freestanding dialysis clinics for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective May 10, 2000)

Sec. 17b-262-652. Definitions

For the purposes of sections 17b-262-651 through 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) **"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.

(2) **"Client"** means a person eligible for goods or services under the department's Medicaid Program.

(3) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to section 17b-1(a) of the Connecticut General Statutes.

(4) **"Department"** means the Department of Social Services or its agent.

(5) **"Dialysis"** means dialysis as defined in 42 CFR 405.2102.

(6) **"Freestanding Dialysis Clinic"** means those centers licensed by the Department of Public Health (DPH) and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

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

(8) **"HealthTrack Services"** means the services described in section 1905(r) of the Social Security Act.

(9) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(10) **"Home"** means the client's place of residence which includes a boarding home or residential care home. Home does not include a hospital, chronic disease hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

(11) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut

Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(12) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(13) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(14) **"Medicaid"** means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.

(15) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(16) **"Medical Record"** means medical record as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(17) **"Physician"** means a physician licensed pursuant to section 20-1 of the Connecticut General Statutes or a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes.

(18) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(19) **"Provider"** means:

(A) a physician;

(B) a general hospital—inpatient or outpatient; or

(C) a freestanding dialysis clinic licensed by the Department of Public Health (DPH) and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

(20) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(21) **"State Plan"** means the document which contains the services covered by the Connecticut Medicaid Program in compliance with 42 CFR(430)(B).

(Adopted effective May 10, 2000)

Sec. 17b-262-653. Provider participation

In order to enroll in the Medicaid Program and receive payment from the department, providers shall:

(1) meet and maintain all applicable licensing, accreditation, and certification

requirements;

(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. This agreement, which will be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective May 10, 2000)

Sec. 17b-262-654. Eligibility

Payment for dialysis services shall be available on behalf of all persons eligible for the Medicaid Program subject to the conditions and limitations which apply to these services.

(Adopted effective May 10, 2000)

Sec. 17b-262-655. Services covered and limitations

Subject to the limitations and exclusions listed below and those set forth in the Regulations of Connecticut State Agencies dealing with physicians, general hospitals, and freestanding dialysis clinics, the department shall pay for dialysis services which conform to accepted methods of diagnosis and treatment.

(a) The department shall pay for the following:

(1) for services provided by an enrolled provider in a home, clinic, hospital, or institution having an organized and approved dialysis program; and

(2) for HealthTrack Services and HealthTrack Special Services.

(b) The department shall not pay for the following:

(1) cancelled office visits and appointments not kept;

(2) information or services provided to a client by a provider over the telephone;

(3) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge; and

(4) for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(Adopted effective May 10, 2000)

Sec. 17b-262-656. Need for service and authorization process

(a) The department shall pay for medically necessary and medically appropriate dialysis services for Medicaid Program clients, in relation to the diagnosis for which care is required, provided that:

(1) the services are within the scope of the provider's practice;

(2) a physician documents the need in writing and orders the service; and

(3) the services are made part of the client's medical record.

(b) Prior authorization, on forms and in a manner as specified by the department, is required for HealthTrack Special Services:

(1) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(2) the request for HealthTrack Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her scope of practice as defined under state law, justifying the need for the item or services requested;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(c) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(d) The initial authorization period shall be up to three months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(f) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visits in the same day, approval shall be received before services are rendered.

(g) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies to only those services which normally require prior authorization.

(h) In order to receive payment from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective May 10, 2000)

Sec. 17b-262-657. Billing procedures

Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(Adopted effective May 10, 2000)

Sec. 17b-262-658. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) Notwithstanding the provisions of subsection (a) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual enrollee without affecting the amount paid by the department for the same or substantially similar goods or services.

(Adopted effective May 10, 2000)

Sec. 17b-262-659. Payment rate

(a) The commissioner establishes the fees contained in the provider's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Payment rates for physicians and physician groups are found in the department's fee schedule for physicians' services.

(c) Payment rates for dialysis services performed by freestanding dialysis clinics shall be based on the fee published by the department and contained in the department's fee schedule for clinics.

(d) Payment rates for dialysis services performed in a hospital on an inpatient basis are paid through the inpatient hospital interim per diem rate and published in the department's fee schedule for general hospital inpatient services.

(e) Payment rates for dialysis services performed in a hospital on an outpatient basis are paid as published in the department's fee schedule for general hospital outpatient services.

(Adopted effective May 10, 2000)

Sec. 17b-262-660. Documentation

(a) Providers shall maintain a specific medical record for all services received for each client eligible for Medicaid Program payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective May 10, 2000)

Sec. 17b-262-661—17b-262-671. Reserved

Requirements for Payment of Durable Medical Equipment

Sec. 17b-262-672. Scope

Sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of durable medical equipment (DME) to providers, for clients who are determined eligible to receive services under Connecticut Medicaid pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective August 22, 2000)

Sec. 17b-262-673. Definitions

For the purposes of sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) "Chronic disease hospital" means an institution as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Certificate of Medical Necessity" or "CMN" means an approved Medicare form or a similar form which has been submitted to and approved by the department for use. This form shall contain all the documentation required for DME;

(4) "Commissioner" means the commissioner of social services;

(5) "Customized equipment" means devices or equipment prescribed by a licensed practitioner which is specifically manufactured to meet the special medical, physical, and psychosocial needs of the client. The equipment shall be individualized to preclude its use by any other person except the client for whom it was originally developed;

(6) "Department" means the department of social services or its agent;

(7) "Documented in writing" means that the prescription has been handwritten, typed, or computer printed;

(8) "Durable medical equipment" or "DME" means equipment that meets all of the following requirements:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to a person in the absence of an illness or injury; and

(D) is nondisposable;

(9) "Equipment replacement" means any item that takes the place of original equipment lost, destroyed, or no longer medically useable or adequate;

(10) "Home" means the client's place of residence which includes a boarding home, community living arrangement, or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), or other facilities that are paid an all inclusive rate directly by Medicaid for the care of the client;

(11) "Hospital" means an institution as defined in Section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means an institution licensed by, or operated by, the department of mental retardation (DMR) according to state law, and certified as a Medicaid intermediate care facility for the mentally retarded by the department of public health (DPH) to provide health or rehabilitative services for individuals with mental retardation or related conditions who, because of their mental or physical condition, require care and services, above the level of room and board, which can be made available to them only through a residential facility. Individuals residing in an ICF/MR shall be receiving active treatment pursuant to 42 CFR 483.440(a);

(13) "Licensed practitioner" means any person licensed by the state of Connecticut, any other state, District of Columbia, or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(14) "Manufactured" means constructed or assembled;

(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(16) "Medicaid" means the program operated by the department of social services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(17) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(18) "Nursing facility" or "NF" means an institution as defined in 42 USC 1396r(a);

(19) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order;

(20) "Prior authorization" or "PA" means approval for the service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(21) "Provider" means the vendor or supplier of durable medical equipment who is enrolled with the department as a medical equipment, devices, and supplies supplier; and

(22) "Provider agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(Adopted effective August 22, 2000)

Sec. 17b-262-674. Provider participation

In order to enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the

Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-675. Eligibility

Payment for DME and related equipment is available for Medicaid clients who have a medical need for such equipment which meets the department's definition of DME when the item is prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-676. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay for the purchase or rental and the repair of DME, except as limited by sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, that conforms to accepted methods of diagnosis and treatment and is medically necessary and medically appropriate.

(2) DME services are available to all clients who live at home. Additionally, the department shall pay for ventilators, customized wheelchairs, and Group 2 Pressure Reducing Support Surfaces for residents of nursing facilities and ICFs/MR.

(3) The department shall maintain a non-exclusive fee schedule of items which it has already determined meet the department's definition of DME and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule includes, but is not limited to:

(A) wheelchairs and accessories;

(B) walking aides, such as walkers, canes, and crutches;

(C) bathroom equipment such as commodes and safety equipment;

(D) inhalation therapy equipment such as IPPB machines, suction machines, nebulizers, and related equipment;

(E) hospital beds and accessories; and

(F) enteral/parenteral therapy equipment.

(4) When the item for which Medicaid coverage is requested is not on the department's fee schedule, prior authorization is required by the department. The recipient requesting Medicaid coverage for a prescribed item not on the list shall submit such prior authorization request to the department through an enrolled provider of DME. Such request shall include a signed prescription and shall include documentation showing the recipient's medical need for the prescribed item. If the item for which Medicaid coverage is requested is not on the department's fee schedule, the provider shall also include documentation showing that the item meets the department's definition of DME and is medically appropriate for the client requesting coverage of such item.

(5) In the last quarter of each calendar year, the department shall make modifications to its non-exclusive DME fee schedule. In deciding which items to add to this schedule, the department shall give consideration to:

(A) items requested for individual consideration through the process described in subdivision (4) of this subsection;

(B) input from the provider community; and

(C) input from the consumer community.

Providers and consumers who wish to provide input may make suggestions to the department's Medical Operations unit. Any suggestions shall be considered during the department's annual modification of its fee schedule.

(b) **Limitations**

(1) The department shall not pay for 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) Notwithstanding any other provisions of the Regulations of Connecticut State Agencies, the department shall pay for customized wheelchairs for clients of nursing facilities and ICFs/MR only when such customized wheelchairs are medically necessary in accordance with section 17-134d-46 or section 17-134d-47 of the Regulations of Connecticut State Agencies. The department shall pay for the purchase, modification or repair of these customized wheelchairs. The customized wheelchair may or may not be motorized. The need for the customized wheelchair shall be documented in accordance with section 17-134d-46 or section 17-134d-47 of the Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-677. Services not covered

The Department shall not pay DME providers for:

(1) standard or stock DME items prescribed and ordered for a client who:

(A) dies prior to delivery of the item, or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the item is delivered;

(2) the purchase or repair of DME necessitated by inappropriate, willful, or malicious misuse on the part of the client as determined by the department;

(3) the repairs and maintenance of DME furnished on a rental basis. The rental fee shall cover the services necessary to maintain the equipment in working order;

(4) DME supplied to clients in hospitals or chronic disease hospitals; and

(5) any service or item not identified as covered in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, unless it is approved in accordance with section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-678. Prior authorization

(a) In order to receive reimbursement from the department a provider shall 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. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(b) The department requires prior authorization for: 1) any item identified on the department's published fee schedule as requiring prior authorization; and 2) any item requested under section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies.

(c) A PA request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and subject to review by the department.

(d) A provider may FAX in prior authorization requests that are medically necessary to: 1) facilitate institutional discharge, or 2) avoid imminent hospitalization. Specifics that substantiate the nature of the request need to be clearly documented. Other PA requests for DME shall be submitted by mail.

(e) The initial authorization period for the rental of DME is determined by the department. If the medical need continues beyond the initial authorization period, a request for the extension of the authorization shall be submitted to the department with documentation by a licensed practitioner that service continues to be medically necessary. Such request and documentation shall arrive at the department prior to the start date of the extension or prior authorization shall be denied.

(f) Providers shall include an estimated delivery date when submitting a request for prior authorization, allowing for the department to take up to four weeks to process the request. The department shall share such estimated date with the client so that expectations for service delivery can be clear. Prior authorizations that do not include an estimated delivery date shall be denied.

(Adopted effective August 22, 2000)

Sec. 17b-262-679. Billing procedure

(a) Claims from DME providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) Claims submitted for DME not requiring prior authorization shall include the name of the licensed practitioner or clinic making the referral. A licensed practitioner's original prescription for these items shall be on file with the provider and shall be subject to review by the department.

(c) DME providers shall bill and the department shall pay at the lowest of:

(1) the usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount prior authorized in writing by the department; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(d) Notwithstanding the provisions of subsection (c)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

(Adopted effective August 22, 2000)

Sec. 17b-262-680. Payment limitations

(a) Payment shall be made for customized DME for a client who dies or is not otherwise eligible on the date of delivery providing the client was eligible:

(1) on the date prior authorization was given by the department; or

(2) on the date the client ordered the item, if the item does not require prior authorization. For purposes of this section, the date the client orders the item means the date on which the written medical order for the item is presented to the provider. The provider shall verify to the department the date the client ordered the item.

(b) If the cost of repairs to any item exceeds its replacement cost, the item shall be replaced.

(c) The price for any item listed in the fee schedule published by the department shall include:

(1) fees for initial fittings and adjustments and related transportation costs;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping;

(4) travel to the client's home, postage and handling, and set up or installation charges;

(5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the equipment; and

(6) information furnished by the provider to the client over the telephone.

(d) Payment for servicing, repairs, or replacement of DME that are purchased by the department shall be contingent upon the exhaustion of any manufacturer's or dealer's warranty. The supplier shall first utilize existing warranties covering required servicing, repairs, and replacement.

(e) The department may pay for the rental of a wheelchair, for a period not to exceed three (3) months, in situations involving the pending delivery of a customized model to a client who resides in his or her own home.

(f) The department has the authority to determine the maximum rental period for DME,

at which time the item shall be considered purchased. Such maximum rental periods shall be published on the fee schedule.

(Adopted effective August 22, 2000)

Sec. 17b-262-681. Documentation

(a) All required documentation shall be maintained for at least five (5) years in the DME provider's file subject to review by the department. In the event of a dispute concerning a service or an item provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is greater.

(b) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the DME provider for the item or service for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for DME shall be on file with the DME provider and shall be subject to review by the department. Such prescription shall specify the items ordered.

(d) The department requires that DME providers maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid clients. A new prescription is required prior to replacement of DME.

(e) A signed receipt is required for all deliveries of DME, documenting that the client or, if the client is unable to sign, a designated representative other than the DME provider or the DME provider's employees, took delivery of the item. The receipt for DME, regardless of format used, shall, at a minimum, contain the following elements:

(1) provider's name;
(2) client's name;
(3) itemization of DME delivered, including:
(A) product description;
(B) brand name;
(C) model name and number;
(D) serial number (if applicable);
(E) quantity delivered;
(F) amount billed per item; and
(4) date of delivery.

(f) All prescriptions for DME regardless of format used (e.g., CMN, prescription pad, or letter) shall, at a minimum, contain the following elements:

(1) the client's name, address, and date of birth;
(2) diagnosis for which the DME is required;
(3) detailed description of the DME, including quantities and any special options or add-ons;
(4) length of need for the DME use;
(5) name and address of prescribing practitioner; and

(6) prescribing practitioner's signature and date signed.

(g) All requests for purchase of DME to replace an item shall be fully explained, documenting the continuing medical necessity and including reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

(Adopted effective August 22, 2000)

Sec. 17b-262-682. Other

(a) All equipment or devices purchased by the department shall be new and shall become the property of the client as of the date of delivery to the client.

(b) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(c) Used equipment when rented shall be completely refurbished and in proper condition to meet the client's specific medical need.

(d) The provider shall instruct the client, or his or her family, on the proper use and care of the equipment. This instruction shall be provided as a part of the cost of the item. Additionally, the services and items shall be appropriate to both the environment and the client's current medical necessity.

(e) When the DME item is delivered, the provider shall ensure that proper assembly occurs and that the item meets the client's needs.

(f) DME providers shall notify the department of returns of DME items delivered to a client. Providers shall initiate necessary reimbursement adjustments resulting from such returns.

(g) It shall be the department's decision to rent or purchase DME, except in cases where the rental or payment option is determined by the primary payor source.

(Adopted effective August 22, 2000)

Sec. 17b-262-683. Reserved

Requirements for Payment Under the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE)

Sec. 17b-262-684. Scope

Sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment for pharmacy services provided to enrollees determined eligible under provisions of sections 17b-490 to 17b-498, inclusive, of the Connecticut General Statutes, the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE) Program.

(Adopted effective January 1, 2002)

Sec. 17b-262-685. Definitions

As used in sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Administrative lock-in" means the restriction by the department of an enrollee to a provider of the enrollee's choice pursuant to section 17b-275 of the Connecticut General Statutes;

(2) "Average wholesale price" or "AWP" means the published wholesale price as listed by one or more national drug databases which obtain their pricing information either directly from the manufacturer or by surveying drug wholesalers;

(3) "Brand name" means "brand name" as defined in section 20-619 of the Connecticut General Statutes;

(4) "Commissioner" means the Commissioner of the Department of Social Services or his or her agent;

(5) "ConnPACE" means the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program as described in section 17b-491 of the Connecticut General Statutes;

(6) "Copayment" means the dollar amount which is required under section 17b-491 of the Connecticut General Statutes to be paid to providers by enrollees for each prescription;

(7) "Department" means the Department of Social Services or its agent;

(8) "Dispensing fee" means an amount of money paid to a pharmacy for rendering a professional service involving the preparation and dispensing of a prescribed drug ordered by a prescribing practitioner;

(9) "Drug efficacy study implementation" or "DESI" means the review through which the United States Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved indication(s);

(10) "Drug utilization review program" or "DUR" means the prospective and retrospective utilization review as mandated by the Omnibus Budget Reconciliation Act (OBRA) of l990 (P.L. 101-508);

(11) "Enrollee" means a person who meets the relevant requirements specified in the department's Uniform Policy Manual, section 8075 and whose application for enrollment in the ConnPACE program has been approved by the department;

(12) "Estimated acquisition cost" or "EAC" means the department's best estimate of the price as related to the average wholesale price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler, as identified by the national drug code (NDC);

(13) "Experimental drug" means a drug currently being administered under an investigational new drug application as required by the United States Food and Drug Administration under 21 CFR 312;

(14) "Federal upper limit" or "FUL" means the listing of multiple source drugs and pricing according to criteria set forth in 42 CFR 447.332;

(15) "Generic name" means "generic name" as defined in section 20-619 of the Connecticut General Statutes;

(16) "Generically equivalent drug" means a therapeutically equivalent generic drug product which may be substituted for a brand name drug under section 20-619(b) of the

Connecticut General Statutes;

(17) "Legend drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(18) "Manufacturer rebate program" means the program as described in section 17b-491(d) of the Connecticut General Statutes;

(19) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(20) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(21) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring;

(22) "National drug code" or "NDC" means the numeric characters identifying a drug product by labeler code, product name and package size;

(23) "Pharmaceutical manufacturer" means any entity holding legal title to or possession of a national drug code issued by the United States Food and Drug Administration;

(24) "Pharmacy" means "pharmacy" as defined in section 20-571 of the Connecticut General Statutes;

(25) "Prescribing practitioner" means "prescribing practitioner" as defined in section 20-571 of the Connecticut General Statutes;

(26) "Prescription" means "prescription" as defined in section 20-571 of the Connecticut General Statutes;

(27) "Prescription drugs" means "prescription drugs" as defined in section 17b-490 of the Connecticut General Statutes;

(28) "Provider" means a pharmacy that is enrolled with the department as a ConnPACE provider;

(29) "Unit" means the lowest identifiable amount of a drug, for example: tablet or capsule for solid dosage forms, milliliter for liquid forms, gram for ointments or creams; and

(30) "Usual and customary charge" means an enrolled provider's charge to the general public for a prescription drug, in a specific strength and quantity on the day the prescription is dispensed. In determining such charges all charges made to third party payers shall be excluded.

(Adopted effective January 1, 2002)

Sec. 17b-262-686. Provider participation

In order to receive payment from the department under the ConnPACE program, a

pharmacy shall meet the following requirements:

(a) meet and maintain all departmental enrollment requirements for a pharmacy participating in Medicaid as described in sections 17b-262-522 to 17b-262-533, inclusive, with the exception of section 17b-262-526(12) of the Regulations of Connecticut State Agencies. A ConnPACE provider does not need to be enrolled as a provider under Medicaid; and

(b) be located in the State of Connecticut.

(Adopted effective January 1, 2002)

Sec. 17b-262-687. Eligibility

In order to be eligible for ConnPACE a person must meet all relevant requirements specified in the department's Uniform Policy Manual, section 8075.

(Adopted effective January 1, 2002)

Sec. 17b-262-688. Services covered and limitations

(a) The department shall pay for prescription drugs dispensed under the Conn-PACE program:

(1) that are medically necessary and appropriate and listed in section 17b-490(b) of the Connecticut General Statutes; and

(2) that do not exceed the recommended dosage level and duration as approved by the United States Food and Drug Administration and presented in the manufacturer's literature, and as monitored and operationalized in the department's drug utilization review program.

(b) The department shall pay for any number of authorized refills by the prescribing practitioner for a maximum period of six (6) months. The exception is controlled substances that are regulated by 21 USC 829(b) and section 21a-249(h) of the Connecticut General Statutes.

(c) A provider shall substitute a therapeutically equivalent generic drug product for a prescribed drug product unless the prescribing practitioner has written on the prescription "brand medically necessary" in accordance with sections 17b-274 and 17b-493 of the Connecticut General Statutes.

(d) The department shall pay at the estimated acquisition cost for the generic drug only when available but not yet on the federal upper limit list.

(Adopted effective January 1, 2002)

Sec. 17b-262-689. Services not covered

The department shall not pay providers for:

(1) the replacement of lost or destroyed prescription drugs;

(2) any prescription drug of a manufacturer that does not participate in the manufacturer rebate program, unless the department determines the prescription drug is medically necessary and medically appropriate for the program enrollees;

(3) any drugs excluded pursuant to section 17b-490(b). The department shall pay for

amphetamines and amphetamine-like drugs for specific diagnoses as specified in the billing instructions;

(4) over the counter preparations;

(5) DESI drugs;

(6) prescriptions dispensed but not received by the enrollee;

(7) drugs for an administrative lock-in enrollee who is not locked in to the billing pharmacy;

(8) anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary and medically appropriate by the department to meet the enrollee's condition or for services not directly related to the enrollee's diagnosis, symptoms or medical history;

(9) claims of quantities which exceed 120 oral dosage units or a 30 day supply, whichever is greater; and

(10) claims for services which are covered by other insurance.

(Adopted effective January 1, 2002)

Sec. 17b-262-690. Payment rate

(a) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the estimated acquisition cost (EAC) plus the dispensing fee minus the copayment;

(2) the federal upper limit (FUL) plus the dispensing fee minus the copayment;

(3) the billed amount to the department, i.e. ingredient cost plus the dispensing fee, minus the copayment;

(4) the usual and customary charge of the provider minus the copayment.

(b) The commissioner shall determine the dispensing fee for each prescription.

(c) The provider shall collect the full copayment as described in section 17b-491 of the Connecticut General Statutes.

(d) The department shall pay at the federal upper limit price for brand name drugs that appear on the federal upper limit list when the prescribing practitioner has indicated "brand medically necessary" in accordance with section 17b-493 of the Connecticut General Statutes.

(e) If an enrollee requests the brand name product and the prescribing practitioner has not specified "brand medically necessary" in accordance with section 17b-493 of the Connecticut General Statutes, then the enrollee is responsible for paying for the full amount of the prescription and the claim may not be billed to ConnPACE.

(f) Providers are prohibited from seeking reimbursement for covered drugs from enrollees with the exception of the co-payment.

(Adopted effective January 1, 2002)

Sec. 17b-262-691. Documentation

(a) The pharmacy shall maintain the original prescription which shall conform to the

documentation requirements described in section 20-614(c) of the Connecticut General Statutes.

(b) The pharmacy shall maintain patient profiles as required in section 17b-494(5) of the Connecticut General Statutes.

(c) In addition, prescriptions transmitted by facsimile machine shall meet all requirements of sections 20-164-1 to 20-164-5, inclusive, of the Regulations of Connecticut State Agencies.

(d) For any prescription for a brand name drug for which a generically equivalent drug exists, there shall be a prescription on file on which, in the prescribing practitioner's handwriting, the phrase "brand medically necessary" is written and signed by the prescribing practitioner in accordance with section 17b-493 of the Connecticut General Statutes.

(e) Prescriptions for controlled substances shall also meet the requirements of sections 21a-244-1 to 21a-244-6, inclusive, of the Regulations of Connecticut State Agencies.

(f) The provider shall maintain all required documentation for at least five years, or longer in accordance with statute or regulation, in the provider's file subject to review by the department. In the event of a dispute concerning a service or item provided, documentation shall be maintained until the end of the dispute, five years, or the length of time required by statute or regulation, whichever is longest.

(g) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider.

(Adopted effective January 1, 2002)

Sec. 17b-262-692. Manufacturer rebate program

Pharmaceutical manufacturers must apply to participate in a rebate program with the department in order to have their prescription drugs covered by the ConnPACE program. All prescription drugs allowed by the program of a pharmaceutical manufacturer that participates in the manufacturer rebate program shall be immediately available. The cost of such drugs shall be reimbursed in accordance with sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective January 1, 2002)

Requirements for Payment of Public Health Dental Hygienist Services

Sec. 17b-262-693. Scope

Sections 17b-262-693 to 17b-262-700, inclusive, set forth the requirements for payment of public health dental hygienist services for persons determined eligible for Connecticut's Medicaid Program pursuant to Section 17b-262 of the Connecticut General Statutes.

(Adopted effective July 10, 2001)

Sec. 17b-262-694. Definitions

As used in sections 17b-262-693 to 17b-262-700, inclusive, the following definitions shall apply:

(1) "Client" means a person eligible for services under the department's Medicaid program;

(2) "Clinic" means an "outpatient clinic" as defined in section 19-13-D45 of the Regulations of Connecticut State Agencies;

(3) "Commissioner" means the Commissioner of Social Services or his or her agent;

(4) "Community health center" means a "community health center" as defined in section 19a-490a of the Connecticut General Statutes;

(5) "Dental examination" means inspecting and charting of the oral structures;

(6) "Dental hygienist" means a dental hygienist licensed to practice dental hygiene pursuant to sections 20-126h to 20-126x, inclusive, of the Connecticut General Statutes;

(7) "Dental hygienist services" means "the practice of dental hygiene" as defined in section 20-126l(a)(3) of the Connecticut General Statutes;

(8) "Dentist" means a dentist licensed to practice dentistry pursuant to section 20-108 of the Connecticut General Statutes or who is licensed to practice dentistry in another state;

(9) "Department" means the Department of Social Services or its agent;

(10) "Group home" means a "community residential facility" as defined in section 17a-220 of the Connecticut General Statutes or a "community residence" as defined in section 19a-507a of the Connecticut General Statutes;

(11) "Hospital" means a "general hospital" or "special hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101 as amended from time to time;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and, is the least costly of multiple, equally effective alternative treatments or diagnostic modalities;

(15) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(16) "Medical record" means a medical record as set forth in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(17) "Nursing facility" means an institution as defined in 42 USC 1396(r)(a), as amended from time to time;

(18) "Provider" means a "public health dental hygienist" as defined in subsection (19) of this section;

(19) "Public health dental hygienist" means a dental hygienist who is providing services in accordance with section 20-1261(b)(1)(B) of the Connecticut General Statutes;

(20) "School" means any preschool, elementary or secondary school or any college, vocational, professional or graduate school; and

(21) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" means the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective July 10, 2001)

Sec. 17b-262-695. Provider participation

(a) In order to participate in Medicaid and receive payment from the department, all providers shall meet and maintain all departmental enrollment requirements as set forth in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) All dental hygienists who participate in Medicaid shall be public health dental hygienists.

(Adopted effective July 10, 2001)

Sec. 17b-262-696. Eligibility

Payment for public health dental hygienist services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(Adopted effective July 10, 2001)

Sec. 17b-262-697. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay for medically necessary and medically appropriate public health dental hygienist services provided to clients subject to the limitations listed in subsection (b) of this section.

(2) The department shall pay providers only for those procedures listed in the provider's fee schedule.

(b) **Limitations**

(1) Dental examination is limited to one (1) every six (6) calendar months per client.

(2) The department shall not pay for fluoride treatment except for the following clients, and shall limit treatment to one (1) time every six (6) calendar months per client:

(A) clients under age twenty one (21); and

(B) clients over age twenty one (21):

(i) using radiology services as oncology treatment on a regularbasis; or

(ii) residing in nursing facilities or intermediate care facilities for the mentally retarded who have six (6) or more natural teeth.

(3) Pit and fissure sealant is limited to:

(A) clients between the ages of five (5) through sixteen (16), inclusive;

(B) first and second permanent molars that are decay and restoration free; and

(C) one every five (5) calendar years per tooth.

(4) A public health dental hygienist who is salaried at a practice location shall not bill the department for dental hygienist services for clients seen at this location.

(5) Payment for dental hygienist services is available to all clients who have a need for these services, subject to the limitations in this subsection, when provided at the following locations only:

(A) a nursing facility;

(B) an ICF/MR;

(C) a group home;

(D) a school that does not have a dental clinic on site;

(E) a clinic or community health center that does not have a dental clinic on site; or

(F) a hospital outpatient department that does not have a dental clinic on site.

(Adopted effective July 10, 2001)

Sec. 17b-262-698. Services not covered

The department shall not pay for:

(1) anything not explicitly allowed pursuant to section 17b-262-697 of the Regulations of Connecticut State Agencies;

(2) information provided to the client over the telephone;

(3) cancelled visits or services not provided;

(4) any services provided by a public health dental hygienist free of charge to non-Medicaid clients;

(5) anything of an unproven, experimental or research nature, or for services in excess of those deemed medically necessary or medically appropriate by the department to treat a client's condition, or for services not directly related to the client's diagnosis, symptoms, or medical history; or

(6) any services provided by a public health dental hygienist in a dental office, a dental clinic or a location other than those set forth in section 17b-262-697(b)(5) of the Regulations of Connecticut State Agencies.

(Adopted effective July 10, 2001)

Sec. 17b-262-699. Payment rate and billing procedure

(a) The provider may sign claims and bill directly and shall submit claims to the

department in accordance with the procedures set forth in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to a public health dental hygienist.

(b) The commissioner shall establish the fees for dental hygienist services performed by the public health dental hygienist pursuant to section 4-67c of the Connecticut General Statutes;

(c) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the usual and customary charge;

(2) the amount billed by the provider to the department; or

(3) the amount in the applicable fee schedule as published by the department.

(Adopted effective July 10, 2001)

Sec. 17b-262-700. Documentation

(a) The provider shall maintain a client file that shall include, but not be limited to, the following information:

(1) identifying data:

(A) name of client;

(B) address;

(C) date of birth;

(D) gender; and

(E) Medicaid identification number;

(2) name, address, telephone number and license number of the public health dental hygienist responsible for the dental care;

(3) pertinent past and current health history of the client; and

(4) the medical record for the client.

(b) All notes and reports in the client's medical record shall be type written or legibly written in ink or maintained electronically, dated and signed by the recording person with his or her full first name or first initial, surname and title. Electronic signatures shall be permissible in accordance with state and federal law.

(c) Each public health dental hygienist shall document action taken to:

(1) refer for treatment any client with needs outside the public health dental hygienist's scope of practice;

(2) coordinate such referral for treatment to dentists; and

(3) provide meaningful medical and dental information to dentists to whom clients are referred.

(d) For fluoride treatments provided to a client pursuant to section 17b-262-697(b)(2)(B)(i) of the Regulations of Connecticut State Agencies, the provider shall maintain documentation substantiating that the client is using radiology services as oncology treatment on a regular basis.

(e) All required documentation shall be maintained for at least five (5) years or longer

as required by state or federal law in the provider's file and shall be subject to review by the authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, for five (5) years, or the length of time required by state or federal law, whichever is greatest.

(f) Failure to maintain and provide all required documentation to the department upon request may result in the disallowance and recovery by the department of any future or past payments made to the provider.

(Adopted effective July 10, 2001)

Requirements for Payment of Nursing Facilities

Sec. 17b-262-701. Scope

Sections 17b-262-701 to 17b-262-711, inclusive, set forth the Department of Social Services requirements for payment to nursing facilities for services to clients eligible to receive such services under Connecticut's Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective March 1, 2002)

Sec. 17b-262-702. Definitions

For the purposes of sections 17b-262-701 to 17b-262-711, inclusive, the following definitions shall apply:

(1) "Applied income" means the amount of income that each client receiving nursing facility services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) "Client" means a person eligible for goods or services under the department's Medicaid program;

(3) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(4) "Commissioner" means the Commissioner of Social Services, or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "DMHAS" means the Department of Mental Health and Addiction Services or its agent;

(7) "DMR" means the Department of Mental Retardation or its agent;

(8) "Home leave" means an absence from the nursing facility for any reason other than admission to a hospital. It is taken at the discretion of the resident;

(9) "Hospital" means "hospital" as defined in section 19a-537 of the Connecticut General Statutes;

(10) "Institution for Mental Diseases" or "IMD" means "institution for mental diseases" as defined in 42 CFR 435.1009, as amended from time to time;

(11) "Licensed practitioner" means any person licensed by the state of Connecticut, any

other state, District of Columbia, or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) "Nursing facility" or "NF" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(16) "Preadmission screening and resident review" or "PASRR" means the program defined in 42 USC 1396r(e)(7) and 42 CFR Part 483, Subpart C, as amended from time to time;

(17) "Preadmission MI/MR screen" means the level I screen required under the PASRR program and described in 42 CFR 483.106 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

(18) "Preadmission screening level II evaluation" means the level II screen as described in 42 CFR 483.112 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

(19) "Provider" means a nursing facility that is enrolled in the Medicaid program;

(20) "Provider agreement" means the signed, written, contractual agreement between the department and the provider;

(21) "Reserve bed day" means a day when a nursing facility client is temporarily absent from the nursing facility and for which payment is made by the department in accordance with section 19a-537 of the Connecticut General Statutes;

(22) "Resident" means a person living in a nursing facility; and

(23) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective March 1, 2002)

Sec. 17b-262-703. Provider participation

In order to enroll in the Medicaid program and receive payment from the department, a

nursing facility shall comply with sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies. Licensing and certification requirements for nursing facilities referenced in sections 17b-262-701 to 17b-262-711, inclusive, of the Regulations of Connecticut State Agencies include, but are not limited to, the criteria described in section 19-13-D8t of the Regulations of Connecticut State Agencies and the criteria described in 42 CFR Part 483, subpart B, as amended from time to time.

(Adopted effective March 1, 2002)

Sec. 17b-262-704. Eligibility

Payment for nursing facility services is available to all persons eligible for the Medicaid program subject to the conditions and limitations that apply to these services.

(Adopted effective March 1, 2002)

Sec. 17b-262-705. Services covered and limitations

The department shall pay an all-inclusive per diem rate, computed in accordance with section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, and sections 17-311-200 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies, to the provider for each Medicaid resident. This rate represents payment for the following goods and services:

(a) all services as required by section 19-13-D8t of the Regulations of Connecticut State Agencies and 42 CFR Part 483, subpart B, as amended from time to time, including, but not limited to:

(1) medical direction in accordance with sections 19-13-D8t(h) and (i) of the Regulations of Connecticut State Agencies;

(2) nursing service in accordance with 42 CFR 483.30, as amended from time to time, and sections 19-13-D8t(j),(k),(m) and (n) of the Regulations of Connecticut State Agencies;

(3) social services in accordance with 42 CFR 483.15(g), as amended from time to time, and section 19-13-D8t(s) of the Regulations of Connecticut State Agencies;

(4) therapeutic recreation in accordance with 42 CFR 483.15(f), as amended from time to time, and section 19-13-D8t(r) of the Regulations of Connecticut State Agencies;

(5) specialized rehabilitative services in accordance with 42 CFR 483.45, as amended from time to time;

(6) room and board in accordance with 42 CFR 483.10(c)(8)(i)(D), 42 CFR 483.35, and 42 CFR 483.70, as amended from time to time, and sections 19-13-D8t(q) and 19-13-D8t(v) of the Regulations of Connecticut State Agencies;

(7) consultation and assistance to residents in obtaining other needed services including:

(A) vision and hearing services in accordance with 42 CFR 483.25(b), as amended from time to time;

(B) services to address mental and psychosocial functioning in accordance with 42 CFR 483.25(f), as amended from time to time;

(C) dental services in accordance with 42 CFR 483.55, as amended from time to time;

and

(D) pharmacy services in accordance with 42 CFR 483.60(b) and (c), as amended from time to time;

(b) routine personal hygiene items as defined in 42 CFR 483.10(c)(8)(i)(E), as amended from time to time;

(c) over the counter medications except insulin;

(d) durable medical equipment except those items listed in section 17b-262-676(a)(2) of the Regulations of Connecticut State Agencies that are payable separately for nursing facility clients;

(e) supplies used in the routine care of the Medicaid resident that are included on the department's medical and surgical fee schedule including:

(1) antiseptics and solutions;
(2) bandages and dressing supplies;
(3) catheters and urinary incontinent supplies;
(4) diabetic supplies;
(5) diapers and underpads;
(6) compression, burns and specialized medical garments;
(7) ostomy supplies;
(8) respiratory and tracheotomy supplies;
(9) enteral and parenteral supplies; and
(10) miscellaneous supplies;

Some of these supplies are covered by and should be billed to Part B of the Medicare program. Such supplies are not included in the per diem rate as per section 17b-340(f)(1) of the Connecticut General Statutes.

(f) services related to the provision or arrangement for provision of customized wheelchairs that are the responsibility of the nursing facility as described in sections 17-134d-46(m) and (n) of the Regulations of Connecticut State Agencies;

(g) oxygen concentrators as described in section 17b-281 of the Connecticut General Statutes and the regulations promulgated thereunder;

(h) prescription drugs for those providers that have approval from the department to include prescription drug costs in the per diem rate; and

(i) transportation services necessary to transport a client to and from any service included in the per diem rate as described in this section. Transportation to services listed in subdivision (a)(7) of this section, which the nursing facility shall help obtain but not provide directly, is not included in the per diem rate. Nursing facilities shall follow the customary authorization procedure in arranging for such transpor tation.

(Adopted effective March 1, 2002)

Sec. 17b-262-706. Service limitations

(a) the department shall pay to reserve a bed in a nursing facility for a Medicaid resident during a temporary absence in a hospital or a temporary absence for home leave in

accordance with the provisions of section 19a-537 of the Connecticut General Statutes.

(b) Payment shall be made for the date of admission and not for the date of discharge. Exceptions to this are:

(1) Payment may be made for the date of death when the resident dies in the nursing facility. If the resident dies while in the hospital or on home leave, the date of death may be paid as a reserve bed day, provided all other bed reservation requirements as described in section 19a-537 of the Connecticut General Statutes are met; and

(2) In the case of a resident admitted and discharged on the same day, payment shall be made for one day of care.

(c) The department shall not pay nursing facilities that are characterized as institutions for mental diseases (IMD) except for services to clients aged 65 and older or under age 22 in accordance with section 17-134d-68 of the Regulations of Connecticut State Agencies and 42 CFR 435.1008.

(Adopted effective March 1, 2002)

Sec. 17b-262-707. Need for service and authorization process

(a) The department shall pay for an admission that is medically necessary and medically appropriate as evidenced by the following:

(1) certification by a licensed practitioner that a client admitted to a nursing facility meets the criteria outlined in section 19-13-D8t(d)(1) of the Regulations of Connecticut State Agencies. This certification of the need for care shall be made prior to the department's authorization of payment. The licensed practitioner shall use and sign all forms specified by the department;

(2) the department's evaluation and written authorization of the client's need for nursing facility services as ordered by the licensed practitioner;

(3) a health screen for clients eligible for the Connecticut Home Care Program for Elders as described in section 17b-342-4(a) of the Regulations of Connecticut State Agencies;

(4) a preadmission MI/MR screen signed by the department; or an exemption form, in accordance with 42 CFR 483.106(b), as amended from time to time, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen was not completed; and

(5) a preadmission screening level II evaluation for any individual suspected of having mental illness or mental retardation as identified by the preadmission MI/MR screen.

(b) The department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

(c) A nursing facility may admit a client on an emergency basis only if:

(1) the Office of Protection and Advocacy, established in accordance with section 46a-10 of the Connecticut General Statutes, in conjunction with DMHAS or DMR authorizes the emergency admission of a client with mental illness or mental retardation to a nursing facility for up to seven (7) days in accordance with 42 CFR 483.130(d)(5), as amended from time to time; or

(2) the commissioner of public health authorizes an emergency transfer as prescribed in section 19a-534 of the Connecticut General Statutes.

(d) if a client is admitted on an emergency basis, the nursing facility is not required to meet:

(1) the waiting list requirements of section 19a-533 of the Connecticut General Statutes and sections 17-311-200 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies, as long as emergency admissions are uniformly and consistently made without regard to source of payment; and

(2) the requirements of subsections (a)(3) to (a)(5) of this section.

(e) A client who requires admission after hours is not considered an emergency admission.

(Adopted effective March 1, 2002)

Sec. 17b-262-708. Applied income

(a) The department is responsible for calculating the applied income. The department shall notify the nursing facility of the amount of any applied income that the nursing facility is responsible for collecting. Applied income shall be deducted from what otherwise would have been the department's monthly payment to the nursing facility.

(b) The nursing facility shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(c) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the nursing facility multiplied by the per diem rate.

(d) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(Adopted effective March 1, 2002)

Sec. 17b-262-709. Billing and payment procedures

(a) The nursing facility shall submit claims to the department as described in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to nursing facilities established by the department.

(b) The nursing facility is responsible for:

(1) completing the daily admission and discharge forms in accordance with the department's instructions;

(2) notifying the department caseworker if the nursing facility is aware that the Medicaid resident's asset level exceeds the established resource limit. The report shall be made on the form specified by the department;

(3) notifying the convalescent payment unit of the department of any and all credits due the department on the form specified by the department; and

(4) exhausting other payment sources of which the nursing facility is aware before billing the department.

(Adopted effective March 1, 2002)

Sec. 17b-262-710. Rates

(a) The per diem rates for nursing facilities services are determined annually pursuant to section 17b-340 of the Connecticut general statutes and sections 17-311-1 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies.

(b) the department shall reimburse the nursing facility at the lower of:

(1) the per diem rate minus the applied income; or

(2) the usual and customary charge minus the applied income.

(Adopted effective March 1, 2002)

Sec. 17b-262-711. Documentation

(a) The nursing facility shall maintain all documentation required for rate setting purposes in accordance with section 17-311-56 of the Regulations of Connecticut State Agencies, including all documentation required to support the billing for bed reserve days described in subsection (e)(5) of this section. This documentation is subject to review and audit by the department.

(b) The nursing facility 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 nursing facility 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 nursing facility 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 for Nursing Facilities and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) The department requires that nursing facilities maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid residents. Records shall be maintained in accordance with the department's Provider Agreement for nursing facilities.

(e) Required documentation includes:

(1) certification for nursing facility admission as required by the department. The form shall be signed by the licensed practitioner;

(2) the department's written authorization of the client's need for nursing facility care;

(3) a health screen signed by the department for clients eligible for the Connecticut Home Care Program for Elders;

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

(5) all documentation required to support the nursing facility's billing for and the department's payment of bed reserve days as described in section 19a-537 of the Connecticut General Statutes;

(6) all documentation required by the PASRR process including:

(A) a preadmission MI/MR screen signed by the department or an exemption letter, in the form and manner prescribed by the department, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen is not on file; and

(B) a preadmission screening level II evaluation, signed by DMHAS or DMR, for any resident suspected of having mental illness or mental retardation, respectively, as identified on the preadmission MI/MR screen.

(7) medical records in accordance with section 19-13-D8t(o) of the Regulations of Connecticut State Agencies.

(Adopted effective March 1, 2002)

Requirements for Payment for Medical and Surgical Supplies

Sec. 17b-262-712. Scope

Sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment to providers of medical and surgical supplies provided to eligible Medicaid clients residing at home.

(Adopted effective May 11, 2009)

Sec. 17b-262-713. Definitions

As used in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Commissioner" means the Commissioner of Social Services or his or her designee;

(4) "Department" means the Department of Social Services or its agent;

(5) "Documented in writing" means handwritten, typed or computer printed;

(6) "EPSDT (Early & Periodic Screening & Diagnostic Treatment) special services" means services provided in accordance with subdivision 1905 (r) of the Social Security Act;

(7) "Home" means the client's place of residence, including a boarding home, community living arrangement or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(8) "Hospital" means "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(9) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a

residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(10) "Licensed practitioner" means an individual who is licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing a medical or surgical supply;

(11) "Medical and surgical supplies" or "supply" means treatment products that:

(A) are fabricated primarily and customarily to fulfill a medical or surgical purpose;

(B) are used in the treatment or diagnosis of specific medical conditions;

(C) are generally not useful in the absence of illness or injury; and

(D) are generally not reusable and are disposable.

(12) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(13) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(14) "Medical necessity" or "medically necessary" means health care needed to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(16) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

(17) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(18) "Provider" means a vendor or supplier of medical and surgical supplies who is enrolled with the department as a supplier of medical and surgical supplies;

(19) "Provider agreement" means the signed, written contractual agreement between the department and the provider; and

(20) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective May 11, 2009)

Sec. 17b-262-714. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 2009)

Sec. 17b-262-715. Eligibility

Payment for medical and surgical supplies is available for clients who have a medical necessity for such supplies, when the supplies are prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 2009)

Sec. 17b-262-716. Supplies covered and limitations

(a) **Supplies covered**

(1) The department shall pay for the purchase of medical and surgical supplies, except as limited by sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies, that conform to accepted methods of diagnosis and treatment and are medically necessary and medically appropriate.

(2) Payment for medical and surgical supplies is available only to clients who live at home.

(3) The department shall maintain a non-exclusive fee schedule of supplies which it has determined meet the department's definition of medical and surgical supplies and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

(4) When the supply for which coverage is requested is not on the department's fee schedule, prior authorization is required for that supply. The provider requesting coverage for a prescribed supply not on the list shall submit a prior authorization request to the department through an enrolled provider of medical and surgical supplies. Such request shall include a prescription and documentation showing the client's medical necessity for the prescribed supply. The provider also shall include documentation showing that the supply meets the department's definition of a medical and surgical supply and is medically appropriate for the client requesting coverage of such supply.

(5) The department shall pay for medical and surgical supplies for EPSDT special services.

(b) **Limitations**

(1) The department shall not pay for anything of an unproven, experimental or research nature or for supplies in excess of those deemed medically necessary by the department to treat the client's condition or for supplies not directly related to the client's diagnosis, symptoms or medical history.

(2) A prescription shall be valid for no longer than one year.

(3) The department may set maximum allowable quantity limitations at levels that it determines to be reasonable.

(4) Automatic shipment of goods and products shall not be allowed. Any refills shall be made only at the request of the client or the client's authorized representative with a valid prescription.

(Adopted effective May 11, 2009)

Sec. 17b-262-717. Supplies not covered

The department shall not pay providers for:

(1) standard or stock medical and surgical supplies prescribed and ordered for a client who:

(A) dies prior to delivery of the supply; or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the supply is delivered;

(2) medical and surgical supplies provided to clients in hospitals, chronic disease hospitals, nursing facilities or ICF/MRs;

(3) drugs and supplements, including, but not limited to, over-the-counter supplies such as cough medicines, herbal remedies and laxatives; and

(4) any supply routinely used for personal hygiene.

(Adopted effective May 11, 2009)

Sec. 17b-262-718. Prior authorization

(a) To receive payment from the department, providers shall 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. Prior authorization does not guarantee payment unless all other requirements are met.

(b) The department requires prior authorization for any supply identified on the department's published fee schedule as requiring prior authorization or any supply not on the department's fee schedule.

(c) A prior authorization request, on forms and in a manner as specified by the department, shall include documentation of medical necessity and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(Adopted effective May 11, 2009)

Sec. 17b-262-719. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically

transmitted to the department or its agent, in a form and manner that the department shall specify and shall include all information that the department shall require to process the claim for payment.

(b) Claims submitted for medical and surgical supplies not requiring prior authorization shall include the name of the licensed practitioner prescribing the supplies. A licensed practitioner's original prescription for the supplies shall be on file in the client's record with the provider and shall be subject to review by the department.

(c) Providers shall use the Healthcare Common Procedure Coding System (HCPCS), as maintained and distributed by the United States Department of Health and Human Services, for billing for medical and surgical supplies. Providers shall consult the Medicare SADMERC (Statistical Analysis Durable Medical Equipment Regional Carrier) if necessary to determine the proper billing code. A miscellaneous HCPCS code shall not be used unless a specific HCPCS code is not available for a supply. If a provider submits a prior authorization request to the department using a miscellaneous code for a supply that has a specific HCPCS code, the authorization request shall be denied.

(d) Providers shall bill the usual and customary charge.

(e) The department shall pay the lowest of:

(1) the lowest Medicare rate;

(2) the amount in the applicable fee schedule as published by the department;

(3) the provider's usual and customary charge; or

(4) the amount previously authorized in writing by the department.

(Adopted effective May 11, 2009)

Sec. 17b-262-720. Payment limitations

The price for any supply listed in the fee schedule published by the department shall include and the department shall pay the lowest:

(1) fees for initial measurements, fittings and adjustments and related transportation costs;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping;

(4) travel to the client's home;

(5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the supplies;

(6) information furnished by the provider to the client over the telephone; and

(7) the provider shall accept the department's payment as payment in full.

(Adopted effective May 11, 2009)

Sec. 17b-262-721. Documentation

(a) All required documentation shall be maintained for at least five years or the length of time required by statute in the provider's file subject to review by the department. In the event of a dispute concerning a service or a supply provided, documentation shall be

maintained until the end of the dispute, five years or the length of time required by statute, whichever is longest.

(b) Failure to maintain all required documentation shall result in the disallowance of payment and recovery by the department of any amounts paid to the provider for supplies for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for medical and surgical supplies shall be on file with the provider and shall be subject to review by the department.

(d) The department requires that providers maintain fiscal and medical records to fully disclose services and goods rendered or delivered to clients.

(e) A signed receipt is required for all deliveries of medical and surgical supplies documenting that the client or, if the client is unable to sign, a designated representative or adult other than the provider or the provider's employee, took delivery of the supply. The receipt for medical and surgical supplies, regardless of format used, shall, at a minimum, contain the following elements:

(1) provider's name;

(2) client's name;

(3) delivery address;

(4) date of delivery; and

(5) itemization of the medical and surgical supplies delivered, including:

(A) product description;

(B) brand name;

(C) quantity delivered; and

(D) amount billed per supply.

(f) All orders for medical and surgical supplies, regardless of format used, which includes verbal, telephone and faxed orders, shall, at a minimum, contain the following:

(1) client's name, address and date of birth;

(2) diagnosis for which the medical and surgical supplies are required;

(3) detailed description of the medical and surgical supplies, including quantities and directions for usage, when appropriate;

(4) length of need for the medical and surgical supplies prescribed;

(5) name and address of prescribing practitioner; and

(6) prescribing practitioner's signature and date signed.

(g) Original prescriptions for medical and surgical supplies shall be obtained from the prescribing practioner prior to submitting claims for payment.

(h) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deem necessary to assure compliance with these and other regulatory and statutory requirements.

(Adopted effective May 11, 2009)

Sec. 17b-262-722. Other

(a) Where brand names or stock numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client or his or her family, designated representative or adult, on the proper use and care of the supply. This instruction shall be provided as a part of the cost of the supply.

(c) Providers shall notify the department of returns of medical and surgical supplies delivered to a client. Providers shall initiate necessary reimbursement adjustments resulting from such returns.

(d) The provider shall maintain a current usual and customary price list.

(Adopted effective May 11, 2009)

Sec. 17b-262-723. Reserved

Requirements for Payment of Home Health Care Services

Sec. 17b-262-724. Scope

Sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of home health care services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective March 7, 2007)

Sec. 17b-262-725. Definitions

As used in section 17b-262-724 to section 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Activity of daily living" or "ADL" means any activity necessary for self care including bathing, dressing, toileting, transferring and feeding;

(2) "Acute" means symptoms that are severe and have a rapid onset and a short course;

(3) "Care plan" means the patient care plan as set forth in section 19-13-D73 of the Regulations of Connecticut State Agencies;

(4) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1(b)(2) of the Regulations of Connecticut State Agencies;

(5) "Client" means a person eligible for goods or services under Medicaid;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Concurrent" means in the same time period covered by the care plan;

(8) "Department" means the Department of Social Services or its agent;

(9) "Early and periodic screening, diagnostic, and treatment services" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(10) "Emergency" means a medical condition, including labor and delivery, manifesting

itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

(11) "Extended nursing services" means nursing care services that are required for more than two continuous, consecutive hours on any given day;

(12) "Hands on care" means the assistance with activities of daily living provided most often, but not exclusively, by home health aides. The assistance includes the prompting and cueing necessary for a client to perform an activity of daily living;

(13) "Home" means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. "Home" does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(14) "Home health aide" means "homemaker-home health aide" as defined in section 19-13-D66 of the Regulations of Connecticut State Agencies;

(15) "Home health care agency" means "home health care agency" as defined in section 19a-490 of the Connecticut General Statutes and which:

(A) is licensed by the Department of Public Health pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(B) meets the requirements of 42 CFR Parts 440, 441 and 484, as amended from time to time; and

(C) is enrolled in Medicaid;

(16) "Home health care services" means the services provided by a licensed home health care agency on a part-time or intermittent basis in the client's home;

(17) "Hospice" means "hospice" as defined in section 19-13-D1(b)(1)(C) of the Regulations of Connecticut State Agencies;

(18) "Hospital" means "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(19) "Household" means a situation where two or more people are living: (A) in a group home, a residential care home or other group living situation; (B) at the same street address if it is a single family house that is not divided into apartments or units; or (C) at the same apartment number or unit number if clients live in a building that is divided into apartments or units;

(20) "Instrumental activity of daily living" or "IADL" means any activity related to a person's ability to function in the home, including, but not limited to, meal preparation, housework, laundry and use of the telephone;

(21) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes, if applicable, and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as

amended from time to time;

(22) "Intermittent" means less than twenty-four hour care within a twenty-four hour period;

(23) "Licensed practical nurse" or "LPN" means "licensed practical nurse" as defined in chapter 378 of the Connecticut General Statutes;

(24) "Licensed practitioner" means a physician who orders home health care services in accordance with sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(25) "Licensed practitioner order" means an order that directs the home health care agency to provide services according to the licensed practitioner's care plan;

(26) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(27) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(28) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(29) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(30) "Medication administration" means the administration of oral, intramuscular or subcutaneous medication and also those procedures used to assess the client's medical or behavioral health status as ordered by the prescribing practitioner. Such procedures include, but are not limited to, glucometer readings, pulse rate checks, blood pressure checks or brief mental health assessments;

(31) "Normal life activities" means any activity that the client attends or in which he participates in the community including, but not limited to, school, work and day care;

(32) "Nursing care services" means the services provided by a registered nurse or a licensed practical nurse;

(33) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(34) "Occupational therapy" means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

(35) "Physical therapy" means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

(36) "Physician" means a physician or surgeon licensed pursuant to sections 20-8 to 20-14k, inclusive, of the Connecticut General Statutes;

(37) "Postpartum" means the sixty-day time period immediately following childbirth;

(38) "Prenatal" means the time period between the beginning of a pregnancy and the end of a pregnancy;

(39) "Prior authorization" or "PA" means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

(40) "Provider" means a home health care agency;

(41) "Registered nurse" means "registered nurse" as defined in chapter 378 of the Connecticut General Statutes;

(42) "Speech therapy" or "speech pathology" means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes;

(43) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

(44) "Week" means a calendar week beginning on Sunday and ending on Saturday.

(Adopted effective March 7, 2007)

Sec. 17b-262-726. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, and sections 17b-262-1 to 17b-262-9, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 7, 2007)

Sec. 17b-262-727. Eligibility

Payment for home health care services provided to persons eligible for Medicaid shall be available subject to the conditions and limitations that apply to these services as identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 7, 2007)

Sec. 17b-262-728. Services covered and limitations

(a) Subject to the limitations and exclusions identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay for medically necessary and medically appropriate home health care services provided by home health care agencies that are directly related to the client's diagnosis, symptoms or medical history. These services include:

(1) nursing care services limited to the following:

(A) physical nursing care or the teaching of nursing care, including, but not limited to, direct services such as enemas, irrigations, dressing changes, treatments and administration

and supervision of medication;

(B) admission of clients to agency services; development of the initial care plan; and subsequent reviews of the care plan, no more than one every 60 days;

(C) diabetic teaching for thirty consecutive days per diabetic client;

(D) pregnancy-related preventive prenatal and postpartum nursing care services to women at high risk of negative pregnancy outcome that are performed during the prenatal or postpartum period of pregnancy for the purpose of, but not limited to:

(i) evaluation of medical health status, obstetrical history, present and past pregnancy related problems and psychosocial factors such as emotional status, inadequate resources, supportive helping networks and parenting skills; and

(ii) the provision of general health education and counseling, referral, instruction, suggestions, support or observation to monitor for any untoward changes in the condition of a prenatal or postpartum woman at high risk so that other medical or social services, if necessary, can be instituted during the prenatal or postpartum stage of childbearing;

(2) hands on care provided by a home health aide;

(3) home health aide assistance with an IADL provided in conjunction with hands on care;

(4) physical therapy services;

(5) speech therapy or speech pathology services;

(6) occupational therapy services; and

(7) EPSDT

(b) Limitations on covered services shall be as follows:

(1) The department shall pay for home health care services only when these services are provided in the client's home. However, the department shall pay for medically necessary and medically appropriate nursing care services for clients who leave their place of residence to engage in normal life activities. The total number of hours of nursing care services shall be limited to those hours to which the client would be entitled if services were provided exclusively at the client's place of residence. Such services shall not be provided in hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client.

(2) The department shall pay for only those services that are listed in the department's fee schedule for home health care services.

(3) The department shall pay for pregnancy-related preventive postpartum nursing care services only for high risk women as described in section 17b-262-731 of the Regulations of Connecticut State Agencies. Such payment shall be limited to services provided during the sixty-day time period immediately following childbirth.

(4) Home health aide services in excess of fourteen hours per week must be cost effective, as described in section 17b-262-730 of the Regulations of Connecticut State Agencies, for Medicaid payment to be available.

(5) Extended nursing services shall be cost effective as described in section 17b-262-

730 of the Regulations of Connecticut State Agencies.

(6) The fee for medication administration shall include the administration of medication(s) while the nurse is present as well as the pre-pouring of additional doses, less than a one week supply, that the client will self administer at a later time and the teaching of self administration of the medication that has been pre-poured.

(7) When the purpose of the visit is to pre-pour medication for a week or more, the skilled nursing visit codes for either a registered nurse or a licensed practical nurse shall be used. The skilled nursing visit is provided for a client who has a documented need for this service because of his or her inability to correctly count out or draw up the medication for self-administration. Documentation shall include a full assessment of the client's medical and behavioral status as well as notes addressing the client's understanding of the drug therapy and his or her continued ability to self-administer the medications.

(8) If during the course of a scheduled medication administration visit, there is a change in the client's condition and the client's prescribing practitioner is notified, the medication administration visit may become a skilled nursing visit. This may occur even if a revision to the client's plan of care is not required. The client's medical record shall be fully updated to reflect the change in medical and behavioral health observed during the visit, the additional skilled services provided to the client and the revisions, if any, made to the plan of care. If this situation occurs and the services have been prior authorized, the provider shall contact the department to request modification of the prior authorization.

(Adopted effective March 7, 2007)

Sec. 17b-262-729. Services not covered

The department shall not pay a home health care agency:

(1) for services provided to a client who is receiving the same service concurrently from an individual therapist, clinic, hospital, practitioner, rehabilitation center or other health care provider;

(2) for services provided by or through another agency or facility as part of its licensing requirements. For example, the department shall not pay for home health aide services if the client lives in a facility that provides home health aide services as part of its licensing requirements;

(3) when the client is in a hospital, nursing facility, chronic disease hospital, ICF/MR or other facility that is paid an all-inclusive rate directly by Medicaid for the care of the client;

(4) when the client is receiving the same home health care services concurrently from another home health care agency. This limitation does not preclude a home health care agency from contracting with another agency as described in section 19-13-D70 of the Regulations of Connecticut State Agencies;

(5) for well child care or for prenatal or postpartum care that is not high risk;

(6) for medical and surgical supplies or durable medical equipment used by the nurse, home health aide or therapist as part of the course of treatment for a client;

(7) for cancelled visits, appointments not kept or services not provided;

(8) for information or services provided to a client over the telephone; or

(9) for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.

(Adopted effective March 7, 2007)

Sec. 17b-262-730. Cost effectiveness test

(a) The department shall apply a cost effectiveness test for all prior authorization requests for: (1) home health aide services in excess of fourteen hours per week; and (2) all extended nursing services. The purpose of said test is to ensure that the services requiring PA, when combined with other services provided and within the home health care agency's scope of practice, whether or not provided by the home health agency, are not more expensive than the cost of the care would be for the client if the client were to be placed in the appropriate institution.

(b) In determining whether the home health care services are cost effective, the department shall compare the monthly cost of the home health care services with the monthly rate at the appropriate institution. The monthly cost of service in the appropriate institution means the average monthly Medicaid rate, calculated by the department, for a particular type of institution, for example, a nursing facility or ICF/MR. The monthly cost of home health care services is defined as the projected costs of providing these services for the client.

(c) The department shall total the costs of the following services to determine the cost of the home health care services: nursing, home health aide, physical therapy, speech therapy and occupational therapy. All costs of providing these services shall be included whether provided by a single home health care agency or multiple Medicaid providers including any other entity that the department reimburses for these services.

(d) The department shall determine whether a nursing facility, ICF/MR, chronic disease hospital or hospice is the appropriate institutional placement. Such determination shall depend on the criteria for admission to the institution and the client's care needs.

(e) The department shall approve PA requests for home health aide services for more than fourteen hours per week or extended nursing services only if:

(1) the total monthly cost of the home health care services as described in subsection (c) of this section is less than the monthly cost of services provided at the appropriate institution as described in subsection (d) of this section; and

(2) all other requirements of sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies are met.

(f) Notwithstanding subsections (a) and (e) of this section, the department shall not apply the cost-effectiveness test for a PA request for home health aide services or extended nursing services provided during the first week after a hospital discharge. However, said services

shall require prior authorization.

(Adopted effective March 7, 2007)

Sec. 17b-262-731. Need for service

(a) The department shall pay for medically necessary and medically appropriate home health care services only under orders of a licensed practitioner as part of a care plan.

(b) The department shall pay for pregnancy-related preventive prenatal or postpartum nursing care services only if the woman has one, or a combination of, high risk indicators including, but not limited to, the following, which, in the opinion of her licensed practitioner, places the woman at high risk for negative pregnancy outcomes:

(1) an age under 20;

(2) an age over 39;

(3) a late registration for prenatal care that starts after the sixteenth week of gestation;

(4) no prenatal care;

(5) a serious weight loss or inadequate weight gain of seven pounds or less;

(6) a prenatal weight of more than eighty percent above the standard for height and age;

(7) more than one abortion, or an abortion within three months before the current pregnancy;

(8) a previous neonatal or fetal death;

(9) a previous preterm birth;

(10) an infant with a significant congenital anomaly or central nervous system damage;

(11) violence or deprivation that was abusive or damaging to the woman or her children;

(12) active substance abuse or an addiction, or a history of substance abuse or addiction, such as alcohol, drugs or nicotine;

(13) an active sexually transmitted disease or a history of such a disease;

(14) diseases or conditions including, but not limited to:

(A) human immunodeficiency virus (HIV), including related conditions such as acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC);

(B) cancer;

(C) acute or chronic cardiac disease;

(D) chronic renal disease;

(E) a seizure disorder;

(F) hypertension, either pre-existing or gestational;

(G) mental disorder without social or psychiatric supervision;

(H) mental retardation without supervision or support;

(I) endocrine or metabolic disorder;

(J) hepatitis;

(K) multiple sclerosis; or

(L) nutritional deficiency; and

(15) an infant up to sixty days of age with one or a combination of diseases or conditions such as:

(A) HIV, including related conditions such as AIDS or ARC;

(B) a birth before thirty-six weeks of gestation or a birth weight under two thousand five hundred grams;

(C) central nervous system damage;

(D) a failure to thrive or a significant infant feeding problem;

(E) an admission to a neonatal intensive care unit;

(F) a sibling who required treatment for recurring apnea or had sudden infant death syndrome;

(G) mental retardation;

(H) neonatal asphyxia;

(I) a seizure disorder;

(J) a significant congenital anomaly; or

(K) a supervising relative under sixteen years of age.

(Adopted effective March 7, 2007)

Sec. 17b-262-732. Prior authorization

(a) To receive payment from the department the provider shall comply with the prior authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies and this section. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(b) Prior authorization, on forms and in a manner as specified by the department, shall be required for:

(1) nursing care services in excess of an initial evaluation and two visits per week;

(2) all extended nursing services;

(3) pregnancy-related preventive prenatal nursing care services in excess of two visits during the prenatal period;

(4) pregnancy-related preventive postpartum nursing care services in excess of two visits during the postpartum period;

(5) home health aide services in excess of fourteen hours per week;

(6) physical therapy services in excess of an initial evaluation and two visits per week;

(7) speech therapy services in excess of an initial evaluation and two visits per week;

(8) occupational therapy services in excess of an initial evaluation and one visit per week;

(9) physical therapy, occupational therapy or speech therapy services in excess of nine visits per therapy type per calendar year per provider per client, when the therapy is for the treatment of the following diagnoses:

(A) all mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;

(B) cases involving musculoskeletal system disorders of the spine covered by the ICD,

as amended from time to time; or

(C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time; and

(10) Early and periodic screening, diagnostic and treatment services requested under section 1905(r)(5) of the Social Security Act, as amended from time to time.

(c) The provider shall obtain, and the department may give, the initial prior authorization either verbally or by mail. The length of the initial authorization is at the department's discretion, but shall be for no longer than a three-month period. The provider shall submit subsequent prior authorization requests in writing by mail at least thirty days in advance of providing services or delivering goods beyond the period of initial approval. If there is a need to change the prior authorization request, the provider shall notify the department not more than two working days after the modification was made. Any authorization period for home health aide services shall be for at least one month.

(d) If continued treatment is needed beyond an initial or subsequent authorization period, the department shall consider, and may approve, an additional prior authorization request that shall be for a period of up to twelve months. The provider shall submit subsequent prior authorization requests in writing by mail at least thirty days in advance.

(e) The provider shall present pertinent medical or social information adequate for evaluating the client's medical need for services when requesting prior authorization. The home health care agency shall maintain a valid practitioner's order on file. Except in emergency situations, the provider shall obtain approval from the department before services are rendered.

(f) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure verbal authorization on the next working day for the services provided. This applies only to those services that normally require prior authorization. If verbal authorization is obtained, the provider shall submit a written request not more than ten days after the date of service.

(Adopted effective March 7, 2007)

Sec. 17b-262-733. Billing procedures

(a) Claims from home health care agencies shall be submitted on the department's designated form or electronically transmitted to the department or its agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest non-managed care Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider to the department.

(Adopted effective March 7, 2007)

Sec. 17b-262-734. Payment

(a) **Payment**

(1) The commissioner shall establish the fees for home health care services in the department's fee schedule pursuant to section 17b-242 of the Connecticut General Statutes.

(2) The department shall pay for home health aide services based on each unit of service the aide spends providing the services as described in the fee schedule.

(3) The department shall pay therapists as described in the fee schedule.

(4) The department shall pay for nursing services based on each visit or unit of service the nurse spends providing the services as described in the fee schedule.

(b) **Payment Limitations**

(1) The department shall reimburse a provider when all of the requirements of sections 17b-262-726 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies have been met.

(2) When two or more clients in the same household are receiving nursing care services, except extended nursing services, the department shall pay the full unit fee for the primary client and a reduced fee for each subsequent client. The procedure code and modifier used for billing shall reflect the purpose of the visit for each subsequent client.

(3) The following limitations shall apply when extended nursing services are required to care for multiple clients in the same household:

(A) If one nurse is required, the department shall pay the full unit fee for the primary client and a reduced unit fee for the unit of time during which the nurse is providing care to one subsequent client. No payment shall be made for additional subsequent clients. The billing instructions for home health agencies shall include a detailed description of the billing process. The care plans shall support the ability of one nurse to provide services safely to multiple clients.

(B) If more than one nurse is required, the department shall pay the fee as described in section 17b-262-734(b)(3)(A) of the Regulations of Connecticut State Agencies for each nurse. The care plans shall support the need for multiple nurses.

(4) When home health aides are caring for multiple clients in the same household, the department shall pay each aide the full unit fee. The department shall pay for the home health aide to care for one client for any one 15-minute unit of time.

(5) The fee for home health care services shall include transportation.

(6) The fee for home health aide services shall include supervision of the home health aide by a registered nurse.

(7) The department shall pay the same fee for out-of-state providers as for instate providers.

(Adopted effective March 7, 2007)

Sec. 17b-262-735. Documentation

(a) All required documentation shall be maintained for at least five years, or longer by the provider in accordance with statute or regulation, subject to review by the department.

Documentation as set forth in sections 19-13-D75 and 19-13-D77 of the Regulations of Connecticut State Agencies shall be maintained for seven years. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(b) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request.

(c) The following information shall be documented in writing or electronically, consistent with the requirements described in the Provider Enrollment Agreement and maintained on file with the home health care agency for each Medicaid client:

(1) initial and subsequent care plans signed and dated by the licensed practitioner in accordance with section 19-13-D73 of the Regulations of Connecticut State Agencies;

(2) verbal and telephone orders signed and dated by a licensed practitioner in accordance with section 17b-242 of the Connecticut General Statutes;

(3) Medicaid identification number;

(4) pertinent diagnostic information;

(5) documentation of each service provided and its duration;

(6) dates of services provided;

(7) for pregnancy-related preventive prenatal or postpartum nursing care services, evidence that the client is high risk as described in section 17-262-731 of the Regulations of Connecticut State Agencies;

(8) time sheets documenting all home health aide hours worked and duties performed that are signed by the client or his or her representative. A client representative shall not be an employee of, or under contract to, the home health care agency. All signatures shall be accompanied by a printed name; and

(9) all information described in section 19-13-D75(b) of the Regulations of Connecticut State Agencies.

(d) Each home health care agency shall maintain fiscal and medical records that fully disclose services and goods rendered or delivered to Medicaid clients.

(e) The licensed practitioner order shall include the projected number of hours needed for home health care services. The actual number of hours provided may be less than, or the same as, the projected number of hours, but the actual number of hours provided may not exceed the projected number of hours.

(f) Providers shall maintain documentation supporting all prior authorization requests.

(Adopted effective March 7, 2007)

Requirements for Payment to Providers of Orthotic and Prosthetic Devices

Sec. 17b-262-736. Scope

Sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to providers of orthotic and prosthetic devices that are prescribed by a licensed practitioner on behalf of clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-262 of the Connecticut General Statues.

(Adopted effective January 1, 2003)

Sec. 17b-262-737. Definitions

As used in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Chronic disease hospital" means a "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Customized orthotic or prosthetic device" means a device prescribed by a licensed practitioner that is specifically manufactured to meet the special medical, physical or psychosocial needs of a client. A customized orthotic or prosthetic device requires special construction, the plans for which are taken from an exact model of a particular client's body part;

(4) "Department" means the Department of Social Services or its agent;

(5) "Documented in writing" means that the prescription has been handwritten, typed or computer printed;

(6) "Home" means the client's place of residence and includes a boarding home, community living arrangement or residential care home. Home does not include a facility such as a hospital, chronic disease hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(7) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(8) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(9) "Licensed practitioner" means an individual who is either licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing an orthotic or prosthetic device;

(10) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally-recognized standards of acceptable

medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(12) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness, to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or to prevent a medical condition from occurring;

(13) "Nursing facility" means an institution as defined in 42 USC 1396r(a), as amended from time to time;

(14) "Orthotic or prosthetic device" or "device" means a corrective or supportive device prescribed by a licensed practitioner, within the scope of his or her practice as defined by federal and state law, to:

(A) artificially replace a missing portion of the body;

(B) prevent or correct physical deformity or malfunction; or

(C) support a weak or deformed portion of the body;

(15) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

(16) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(17) "Provider" means the vendor or supplier of an orthotic or prosthetic device who is enrolled with the department as a medical equipment, devices, and supplies supplier; and

(18) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective January 1, 2003)

Sec. 17b-262-738. Provider participation

To enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective January 1, 2003)

Sec. 17b-262-739. Eligibility

A provider may receive reimbursement from the department for the provision of an orthotic and prosthetic device to a client. No reimbursement shall be made unless a licensed practitioner has prescribed the orthotic or prosthetic device subject to the conditions and

limitations set forth in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective January 1, 2003)

Sec. 17b-262-740. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay for the purchase or repair of a medically necessary and medically appropriate orthotic or prosthetic device, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies, provided such device is prescribed by a licensed practitioner in conformance with accepted methods of diagnosis and treatment.

(2) The department shall pay for an orthotic or prosthetic device for a client who lives at home or in a nursing facility, ICF/MR, hospital or chronic disease hospital, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies.

(3) The department shall maintain a fee schedule for orthotic and prosthetic devices, subject to the conditions and limitations set forth in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule is designed to meet the needs of most Medicaid clients. An item is not covered unless it is on the fee schedule. A provider or client may request that an item be added to the fee schedule. The department, at its discretion, may decide to add requested items during its regular revisions to the fee schedule, as published by the department.

(4) The department shall pay for early and periodic screening, diagnostic and treatment services (EPSDT) described in subsection 1905(r) of the Social Security Act, as amended from time to time.

(b) **Limitations**

(1) The department shall pay for replacement of a device only if the device is lost, destroyed or is no longer medically usable or adequate due to a measurable change in the client's condition. A new prescription shall be required for a replacement item. All requests for purchases of orthotic or prosthetic devices to replace a device shall be fully explained, and shall document the continuing medical necessity and include reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

(2) The department shall not pay for an orthotic or prosthetic device for a client in a nursing facility, ICF/MR, chronic disease hospital or hospital if the device is included in the facility's per diem Medicaid rate.

(3) The department shall not pay for an orthotic or prosthetic device that can be billed to another payor.

(Adopted effective January 1, 2003)

Sec. 17b-262-741. Goods and services not covered

The department shall not pay providers for:

(1) any orthotic or prosthetic device that is of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history;

(2) any non-customized orthotic or prosthetic device that does not require prior authorization and that is prescribed and ordered for a client who:

(A) dies prior to delivery of the device; or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the device is delivered; or

(3) the purchase or repair of an orthotic or prosthetic device necessitated by inappropriate, willful or malicious misuse on the part of the client as determined by the department.

(Adopted effective January 1, 2003)

Sec. 17b-262-742. Prior authorization

(a) The department shall require PA for any orthotic or prosthetic device identified on the department's published fee schedule as requiring PA.

(b) To receive reimbursement from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(c) A PA request, on a form and in a manner specified by the department, shall include documentation of medical necessity and shall be signed by the prescribing licensed practitioner and the provider. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(d) A provider may send a prior authorization request to the department via facsimile if the request is medically necessary to: (1) facilitate institutional discharge or (2) avoid imminent hospitalization. Specifics that substantiate the nature of the request shall be clearly identified in the facsimile. All other PA requests for an orthotic or prosthetic device shall be submitted by mail.

(Adopted effective January 1, 2003)

Sec. 17b-262-743. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent in a form and in a manner specified by the department and shall include all information required by the department to process the claim for payment.

(b) A claim submitted for an orthotic or prosthetic device that did not require prior authorization shall include the name of the licensed practitioner prescribing the device. A licensed practitioner's original prescription for the device shall be on file with the provider

and shall be subject to review by the department.

(c) Providers shall bill and the department shall pay at the lowest of:

(1) the usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider to the department; or

(5) the amount the department indicates in writing in a prior authorization.

(Adopted effective January 1, 2003)

Sec. 17b-262-744. Payment limitations

(a) The department shall reimburse a provider when all requirements of sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies have been met.

(b) The department shall pay for a customized orthotic or prosthetic device for a client who dies or is not otherwise eligible on the date of delivery provided the client was eligible:

(1) on the date prior authorization was given by the department; or

(2) on the date the client ordered the device, if the device does not require prior authorization. For purposes of this section, the date the client orders the device means the date on which the written medical order for the device is presented to or received by the provider. The provider shall verify to the department the date the client ordered the device.

(c) If the cost of repairs to any orthotic or prosthetic device exceeds its replacement cost, the device shall be replaced.

(d) The price for any device listed in the fee schedule published by the department shall include:

(1) fees for initial fittings and all related subsequent adjustments;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any manufacturer's delivery charges, postage, packing and shipping;

(4) all travel costs incurred by the provider associated with measurements, fittings, adjustments or repairs;

(5) technical assistance fees related to teaching the client, his or her family or the designated representative the proper use and care of the equipment; and

(6) fees for providing information to the client over the telephone.

(e) The department shall pay for the servicing, repair or replacement of an orthotic or prosthetic device that is purchased by the department, provided that any manufacturer's or dealer's warranty has been exhausted. The provider shall first utilize existing warranties that cover required servicing, repairs and replacement.

(Adopted effective January 1, 2003)

Sec. 17b-262-745. Documentation

(a) All required documentation shall be maintained for at least five (5) years in the

provider's primary place of business and shall be subject to review by the department. In the event of a dispute concerning a service or a device provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is longer.

(b) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for the device or service for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for an orthotic or prosthetic device and documentation of all notes related to fittings and adjustments shall be kept at the provider's primary place of business and shall be subject to review by the department.

(d) Providers shall maintain all fiscal and medical records related to services and goods rendered or delivered to Medicaid clients.

(e) Providers shall require and retain a signed receipt for all deliveries of orthotic and prosthetic devices, documenting that the client or, if the client is unable to sign, a designated representative other than the provider or the provider's employee, took delivery of the device. The receipt for an orthotic or prosthetic device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the provider's name;
(2) the client's name;
(3) the delivery address;
(4) the date of delivery; and
(5) itemization of the orthotic and prosthetic devices delivered, including:
(A) a product description;
(B) a brand name;
(C) a model name and number, if applicable;
(D) a serial number, if applicable;
(E) the quantity delivered; and
(F) the amount billed per device.

(f) A prescription for an orthotic or prosthetic device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the client's name, address and date of birth;
(2) the diagnosis for which the orthotic or prosthetic device is required;
(3) a detailed description of the orthotic or prosthetic device, including the quantity and any special options or add-ons, and, if needed, directions for usage;
(4) the length of need for the orthotic or prosthetic device prescribed;
(5) the name and address of the prescribing licensed practitioner; and
(6) the prescribing licensed practitioner's signature and date of his or her signature.

(Adopted effective January 1, 2003)

Sec. 17b-262-746. Other

(a) Where brand names or stock or model numbers are specified on the prescription or

the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client, his or her family or a designated representative on the proper use and care of the device.

(c) Providers shall initiate necessary reimbursement adjustments to the department resulting from returns of non-customized orthotic and prosthetic devices delivered to a client.

(d) The provider shall maintain a written usual and customary price list that details individual product and service charges. This list, including updates along with any required manufacturer's list pricing, shall be available for review by authorized department personnel.

(e) An orthotic or prosthetic device purchased by the department shall be new and shall become the property of the client on the date of delivery to the client.

(Adopted effective January 1, 2003)

Requirements for Payment of Services Provided by Private Non-Medical Institutions

Sec. 17b-262-747. Scope

Sections 17b-262-747 to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of rehabilitative services provided by private non-medical institutions to children who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective March 11, 2003)

Sec. 17b-262-748. Definitions

As used in sections 17b-262-747 through 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Billing provider" means the Connecticut Department of Children and Families.

(2) "Child" means a person who is under twenty-one (21) years of age.

(3) "Department" or "DSS" means the Department of Social Services or its agent.

(4) "DCF" means the Department of Children and Families.

(5) "Individual treatment plan" means a written plan developed by the performing provider in accordance with section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.

(6) "Licensed clinical staff" means:

(A) a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;

(B) a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;

(C) a marriage and family therapist who is licensed under chapter 383a of the

Connecticut General Statutes;

(D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an alcohol and drug counselor who is licensed under chapter 376b of the Connecticut General Statutes;

(F) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statues; or

(G) a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field.

(7) "Medicaid" means the program operated by the department pursuant to Section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.

(8) "Medically necessary" or "medically appropriate" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring.

(9) "Monthly rate" means the amount the department pays for each PNMI client for PNMI program services for each month of service.

(10) "Performing provider" means an entity that participates in the Medicaid program as a provider of PNMI children's rehabilitative services and that is a state licensed or approved (A) residential treatment facility; group home; maternity home; or similar institution; or (B) child placing agency that offers a therapeutic foster care or professional parent program.

(11) "PNMI client" or "client" means a client who is a child that (A) has been placed with a PNMI performing provider by a state agency and (B) determined by the department to be eligible for Medicaid.

(12) "Private Non-Medical Institution" or "PNMI" means an entity that is not a health insuring organization, hospital, nursing home, or a community health care center, but which (A) provides residential services for children and is licensed or approved by the state of Connecticut as (i) a residential treatment facility, group home, maternity home, or similar institution or (ii) a child placing agency that offers a therapeutic foster care or a professional parent program or (B) is an out-of-state facility determined by the Commissioner of the Department of Children and Families to meet comparable licensure standards or requirements.

(13) "Residential treatment facility" means a 24 hour mental health facility that is licensed or approved by the Department of Children and Families and that operates for the purpose of effecting positive change and normal growth and development for emotionally disturbed, behavior disordered and socially maladjusted children.

(14) "Group home" means a community based residential facility with a homelike environment that is licensed or approved by the Department of Children and Families; provides board and care, counseling, life-skill training and recreation; and arranges for or

helps residents access educational, vocational and therapy services that are offered in the community.

(15) "Maternity home" means a maternity home that (A) is licensed by DCF as a group home; (B) is a 24 hour facility that provides board, care, treatment and the therapeutic environment required to promote positive change and growth in pregnant adolescents and young mothers; and (C) has neonatal and postnatal programs that are designed to assess client needs and develop skills in parenting, socialization and independent living.

(16) "Therapeutic foster care" means a program offered by a DCF approved or licensed child placing agency that recruits, trains and supports foster parents who provide family foster care to children with emotional and behavioral needs.

(17) "Professional parent program" means a program provided by a DCF approved or licensed child placing agency that (A) recruits, trains and supports foster parents who provide family foster care to children with multiple needs and (B) serves children who need a greater level of care than those children who are served in a therapeutic foster care agency program.

(18) "Provider agreement and contract" means the signed, written contractual agreement between the department and the performing provider and the billing provider of PNMI children's rehabilitative services.

(19) "Rehabilitative services" means those services described in 42 C.F.R. 440.130(d), as amended from time to time, and include those services identified in section 17b-262-752 of the Regulations of Connecticut State Agencies.

(20) "Title V Agency" means the Department of Public Health, which administers Title V of the Social Security Act, known as the Maternal and Child Health Services Block Grant.

(21) "PNMI program" means the component part of the state's Title V program, which is administered through agreement among the billing provider, the department and the Title V Agency.

(Adopted effective March 11, 2003)

Sec. 17b-262-749. Provider and billing provider requirements

To participate in the Medicaid program and provide PNMI rehabilitative services that are eligible for Medicaid reimbursement from the department, the following requirements shall be met:

(1) The performing provider shall:

(A) Enroll with the department and have on file a valid provider agreement.

(B) Be licensed or approved by DCF or another state agency as (A) a residential treatment facility, group home, maternity home, or similar institution; or (B) a child placing agency that offers therapeutic foster care or a professional parent program.

(C) Comply with all Medicaid record keeping, documentation and other requirements, including, but not limited to, those delineated in the department's administrative manuals, provider agreements and memoranda of understanding.

(D) Follow all laws, rules, regulations, policies and amendments that govern the Medicaid

program as they relate to reimbursement for PNMI rehabilitative services.

(E) Develop an individual treatment plan for each PNMI client in accordance with section 17a-145-94 of the Regulations of Connecticut State Agencies not later than thirty days after the PNMI client's admission to the program. The individual treatment plan shall be developed in conjunction with DCF, the child and the child's family, whenever possible, and shall be signed and dated by a licensed clinical staff member employed by or under contract with the performing provider. Such plan shall contain specific behavioral health goals and objectives that are based on an evaluation and diagnosis for the maximum reduction of a client's behavioral health problems and shall identify the type, amount, frequency and duration of services to be provided.

(F) Ensure that a licensed clinical staff member employed by or under contract with the performing provider reviews and signs the individual treatment plan within each six month calendar period following the date of a PNMI client's admission.

(G) Keep current service and progress notes in a permanent case record for each PNMI client in accordance with sections 17a-145-94 and 17a-145-98 of the Regulations of Connecticut State Agencies. Such entries shall be made on at least a monthly basis.

(H) Furnish information and documentation to the billing provider that is sufficient to allow the billing provider to prepare PNMI claims for rehabilitative services.

(I) Cooperate with the department and the billing provider in the rate setting process; licensing; or any quality assurance reviews or periodic audits to ensure compliance with PNMI program requirements.

(J) Assign billing responsibilities related to the claiming of federal financial participation for state PNMI Medicaid costs to the billing provider.

(2) The billing provider shall:

(A) Have a valid provider agreement and contract on file that is signed by the performing provider, the billing provider and the department that assigns responsibility for the claiming of federal financial participation to the department. The agreement shall be updated periodically in accordance with Medicaid requirements.

(B) Ensure that the performing provider meets and maintains all applicable licensing, accreditation and certification requirements in accordance with federal and state laws.

(C) Comply with all Medicaid record keeping, documentation, and other requirements, including, but not limited to, those delineated in department PNMI rehabilitative service administrative manuals, provider agreements and memoranda of understanding.

(D) Follow all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to PNMI rehabilitative services.

(E) Carry out regular licensing and quality assurance reviews of performing providers.

(F) Assist the department in establishing PNMI rates that are based upon Medicaid eligible activities that are not otherwise being claimed for federal financial participation.

(Adopted effective March 11, 2003)

Sec. 17b-262-750. Eligibility

Payment for PNMI rehabilitative services shall be subject to available appropriations and shall be available for services rendered to PNMI clients under the conditions and limitations that are set forth in sections 17b-262-747 to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 11, 2003)

Sec. 17b-262-751. Need for services

Payment for PNMI rehabilitative services shall be made by the department only if all of the following conditions are met:

(1) The client shall be assessed by the billing provider or its agent to determine that the PNMI rehabilitative services are medically necessary or medically appropriate.

(2) For up to 30 days of a PNMI client's initial stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with an initial assessmentof need that is completed by DCF and signed by a licensed clinical staff member of the performing provider. This assessment shall, for up to 30 days of a PNMI client's initial stay, be deemed to meet the PNMI requirements for an individual treatment plan set forth in section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.

(3) After the first 30 days of a client's stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with a written individual treatment plan developed in accordance with section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies. Within each 90 day period thereafter, the individual treatment plan shall be reviewed by the licensed, clinical staff employed by or under contract with the performing provider.

(Adopted effective March 11, 2003)

Sec. 17b-262-752. Covered services

PNMI rehabilitative services shall include the following services:

(1) Assessment, treatment planning and support activities that assist the client in gaining access to authorized services. These services include:

(A) Intake and assessment, which means assessing and reassessing the client's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the client, the client's family and through consultation with other professionals; and

(B) Development of an individual treatment plan in accordance with sections 17b-262-749(a)(5) and 17b-262-751 of the Regulations of Connecticut State Agencies; and

(C) Care coordination, which means facilitating the child's access to behavioral health services identified in the individual treatment plan, including:

(i) Arranging for services;

(ii) Assuring that prescribed services are received;

(iii) Assessing the effectiveness of those services;

(iv) Attending case conferences to review and modify individual treatment plans as necessary; and

(v) Arranging home visits, discharge and aftercare services.

(2) Socialization skills development, which means client-centered activities that are provided to support the goals and objectives in the PNMI client's individual treatment plan and that are directed at reducing mental disabilities of children in care, restoring them to their best possible functioning level and assisting clients in becoming responsible for their own actions.

(3) Counseling and therapy, which includes (A) individual, group and family counseling and (B) therapy or consultation that is necessary to improve problems and to restore children to their optimal functioning level.

(Adopted effective March 11, 2003)

Sec. 17b-262-753. Limitations

Coverage of PNMI rehabilitative services shall be subject to the following limitations:

(1) PNMI rehabilitative services shall be pre-authorized by DCF based on a written service recommendation.

(2) The PNMI rehabilitative service shall be based on the individual treatment plan developed pursuant to section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies and shall be performed by the performing provider or under the supervision of licensed clinical staff employed by or under contract to the performing provider.

(3) The department shall not pay for programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.

(4) The department shall not pay for programs, services or components of services that do not relate to the client's diagnosis, symptoms or medical history.

(5) The department shall not pay for programs, services or components of services, which are not included in the fee schedule established by the department.

(6) The department shall not pay for programs, services that are academic in nature such as tutoring, study sessions or instruction in English, science, history, mathematics or foreign languages.

(7) The department shall not pay for programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms.

(8) The department shall not pay for programs, services or components of services designed to provide socialization or recreational activities for clients unless such services are provided to meet a client's need for motivational, diversionary or behavior management activities for which specific goals and objectives are identified in the client's individual treatment plan.

(9) The department shall not pay for costs associated with room and board for clients.

(10) The department shall not pay PNMI rehabilitative services that are provided out-of-state unless the services are pre-authorized by a placing state agency and are not available

within Connecticut.

(11) The department shall not pay any organization that is directly under contract to a performing provider for services covered under this regulation.

(12) The department shall not pay for care coordination services that are provided within a PNMI program if such services duplicate Medicaid-reimbursed case management services that are provided outside the facility. PNMI program staff providing care coordination services shall coordinate with any Medicaid-reimbursed case management services provided outside of the program so that such duplication does not occur.

(13) The department shall not pay other providers for services to PNMI clients that if the services are not part of a client's individual treatment plan developed pursuant to section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.

(Adopted effective March 11, 2003)

Sec. 17b-262-754. Documentation and record retention requirements

PNMI rehabilitative services shall be reimbursed by the department when documentation of compliance with the following requirements is on file with the billing provider or the performing providers:

(1) Individual treatment plan requirement.

(A) An individual treatment plan shall be maintained.

(B) An initial assessment of need completed by DCF in conformance with section 17b-262-751 of the Regulations of Connecticut State Agencies is maintained.

(2) Permanent case record requirement.

(A) A permanent case record, as required by section 17a-145-98 of the Regulations of Connecticut State Agencies, is maintained and includes, at a minimum, identifying information including the name of the client, date of birth, gender, Medicaid identification number, LINK person number; the client's family, social and health history; the reason for admission to the PNMI program; the individual treatment plan; identification of the care and services provided; the progress of the child in the program; and the plan for discharge and disposition of the PNMI client.

(B) All documentation shall be physically placed into the eligible PNMI client's permanent case record in a complete, prompt and accurate manner. All documents shall be made available to authorized Department personnel upon request.

(3) Other documentation and record retention requirements.

(A) The performing provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified individuals furnishing PNMI rehabilitative services.

(B) The performing provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.

(C) The performing provider shall maintain all required records for at least five (5) years or longer as required by statutes or regulation subject to review by the department. In the

event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is greater.

(Adopted effective March 11, 2003)

Sec. 17b-262-755. Billing requirements

(a) Claims for payment of PNMI rehabilitation services shall be submitted by the billing provider on the department's uniform billing form or electronically transmitted to the Department's fiscal agent and shall include all information required by the Department to process the claim for payment.

(b) All claims submitted to the department for payment of services covered under sections 17b-262-747 to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the PNMI client's permanent case record.

(Adopted effective March 11, 2003)

Sec. 17b-262-756. Payment

Payment by the department for PNMI rehabilitative services shall be made in accordance with the following provisions.

(1) The department shall make payments on the basis of monthly rates for each of three types of PNMI programs: (A) residential treatment centers, (B) group homes or maternity homes and (C) therapeutic foster care and professional parent programs. The Department shall establish interim PNMI rates each year based upon the cost to the public agency for the purchase of PNMI services during the most recently completed year. These rates shall be adjusted based upon actual cost experience of the public agency at the close of the fiscal year by adjusting the interim rate for the subsequent year accordingly. To identify costs not covered by the Medicaid program, the Department shall establish a method for cost allocation acceptable to the Centers for Medicare and Medicaid Services.

(2) The calculation of the PNMI rates shall not include any services that have been reimbursed by Medicaid under other service categories.

(3) The PNMI rates shall exclude payment for non-Medicaid covered services, such as room and board.

(4) Payments shall not be made if the recipient has been absent from the program for the entire calendar month.

(5) The billing provider shall seek payment from any other resources that are available for payment of rendered services prior to billing the Department.

(6) The billing provider shall provide the non-federal match funds required for the PNMI program.

(Adopted effective March 11, 2003)

Sec. 17b-262-757. Audit and compliance review

All supporting accounting and business records, statistical data and all other records

relating to the provision of PNMI rehabilitative services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available to authorized personnel upon request in accordance with 42 C.F.R. section 431. The Department of Children and Families shall take full financial responsibility for any Medicaid claims disallowed due to inadequate documentation by any performing provider or failure to comply with requirements set forth in statute or regulations.

(Adopted effective March 11, 2003)

Requirements for Payment of Mental Health Rehabilitation Services for Adults Provided by Private Non-Medical Institutions

Sec. 17b-262-758. Scope

Sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of rehabilitative services provided by private non-medical institutions to adults who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective December 1, 2005)

Sec. 17b-262-759. Definitions

As used in sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adult" means a person who is 18 years of age or older;

(2) "Department" or "DSS" means the Department of Social Services or its agent;

(3) "DMHAS" means the Department of Mental Health and Addiction Services;

(4) "DPH" means the Department of Public Health;

(5) "Group home" means a privately operated, community-based residential facility that serves sixteen or fewer adult clients, is licensed by the Department of Public Health as either a private freestanding mental health residential living center or a private freestanding community residence pursuant to sections 19a-495-551 or 19a-495-560 of the Regulations of Connecticut State Agencies, is certified by the Department of Mental Health and Addiction Services as a provider of mental health rehabilitation services pursuant to section 17a-485d of the Connecticut General Statutes, and meets the requirements of section 17b-262-760 of the Regulations of Connecticut State Agencies for participation in the Medicaid program as a provider of PNMI rehabilitative services;

(6) "Licensed clinician" means:

(A) a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;

(B) a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;

(C) a marriage and family therapist who is licensed under chapter 383a of the

Connecticut General Statutes;

(D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;

(F) a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field; or

(G) a professional counselor who is licensed under chapter 383c of the Connecticut General Statutes;

(7) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(8) "Medically appropriate" 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;

(9) "Medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring;

(10) "Monthly rate" means the amount the department pays for each PNMI client for PNMI program services for each month of service in which there is a qualifying billable unit of service provided;

(11) "Provider" means an entity that participates in the Medicaid program as a qualified group home provider of PNMI adult rehabilitative services as evidenced by an executed provider agreement with DSS;

(12) "PNMI client" or "client" means a Medicaid-eligible adult who resides in a participating group home and who receives covered PNMI rehabilitative services in accordance with sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies;

(13) "Prior authorization" means approval for the provision of service from the department before the provider actually provides the service;

(14) "Private Non-Medical Institution" or "PNMI" means an entity that is a qualified group home provider of adult rehabilitative services under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies and is not a health insuring organization, hospital, nursing home, or a community health care center;

(15) "Provider agreement" means the signed, written contractual agreement between the department and the provider of PNMI rehabilitative services;

(16) "Qualifying billable unit of service" means forty hours of rehabilitative services during a calendar month or the prorated equivalent based on the number of days the client is in residence at the group home during that month. For purposes of calculation, the forty hours, or the prorated equivalent, may be made up of fifteen minute sub-units, using a

rounding convention to be determined by the department;

(17) "Rehabilitative services" means those services identified in section 17b-262-763 of the Regulations of Connecticut State Agencies when provided by a qualified provider on behalf of a PNMI client;

(18) "Residential rehabilitation plan" means a written plan developed by the performing provider in accordance with section 17b-262-760(5) of the Regulations of Connecticut State Agencies; and

(19) "Under the supervision" means that a licensed clinician provides periodic supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitative services performed by the unlicensed staff.

(Adopted effective December 1, 2005)

Sec. 17b-262-760. Provider participation

In order to participate in the Medicaid program and provide PNMI rehabilitative services that are eligible for Medicaid reimbursement from the department, the provider shall:

(1) Enroll with the department and have on file a valid provider agreement;

(2) Be certified by DMHAS as a group home provider of rehabilitation services;

(3) Comply with all Medicaid record keeping, documentation and other requirements, including, but not limited to, those delineated in the department's administrative manuals, provider agreements and memoranda of understanding;

(4) Follow all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to reimbursement for PNMI rehabilitative services;

(5) Develop an individual residential rehabilitation plan for each PNMI client in accordance with section 19a-495-551(k)(3) of the Regulations of Connecticut State Agencies not later than thirty days after the PNMI client's admission to the program. Such plan shall contain specific behavioral health goals and objectives that are based on each client's mental health diagnosis and diagnostic and functional evaluation and are targeted toward the maximum reduction of a client's behavioral health symptoms, restoration of functioning, and recovery, and shall identify the type, amount, frequency and duration of services to be provided;

(6) Ensure that a licensed clinician employed by, or under contract with, the performing provider reviews and signs the individual residential rehabilitation plan. The first review and signature shall occur not more than thirty days after admission;

(7) Keep current service and progress notes in a permanent case record for each PNMI client in accordance with section 19a-495-551(k)(3)(H) of the Regulations of Connecticut State Agencies;

(8) Cooperate with the department in the rate setting process including, but not limited to, time studies, licensing or any quality assurance reviews or periodic audits to ensure compliance with PNMI program requirements;

(9) Provide an initial orientation, training and periodic supervision to direct service staff related to the provision of rehabilitative services;

(10) Ensure that all group home staff are certified in first aid and cardiopulmonary resuscitation;

(11) Conduct ongoing assessment and service planning;

(12) Promote independent management of medication including the supervision and monitoring of self-administration as appropriate;

(13) Be licensed by the Department of Public Health as either a private freestanding mental health residential living center or a private freestanding community residence pursuant to sections 19a-495-551 or 19a-495-560 of the Regulations of Connecticut State Agencies;

(14) Ensure that the facility director holds a bachelor's degree in a human service discipline and a minimum of three years of experience in a mental health services related position;

(15) Ensure that the facility director (or other manager) is accessible after-hours, by telephone or pager, to staff on duty; and

(16) Ensure that direct service staff hold either a bachelor's degree in a behavioral health related specialty or have two years experience in the provision of mental health services.

(Adopted effective December 1, 2005)

Sec. 17b-262-761. Eligibility

Payment for PNMI rehabilitative services shall be available for services rendered to PNMI clients under the conditions and limitations that are set forth in sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective December 1, 2005)

Sec. 17b-262-762. Need for services

Payment for PNMI rehabilitative services shall be made by the department only if all of the following conditions are met:

(1) For up to thirty days of a PNMI client's initial stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with an initial assessment of need that is completed and signed by a licensed clinician. This assessment shall, for up to thirty days of a PNMI client's initial stay, be utilized as the individual residential rehabilitation plan;

(2) After the first thirty days of a client's stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with a written individual residential rehabilitation plan developed in accordance with section 17b-262-760(5) of the Regulations of Connecticut State Agencies. This plan shall be reviewed and signed by the licensed clinical staff employed by, or under contract with, the performing provider at least every ninety days thereafter;

(3) The group home has provided one qualifying billable unit of service for that month;

(4) The client's mental illness is so serious and disabling as to require care in a group home setting;

(5) The client is sufficiently stable to be able to function outside of a twenty-four hour medically managed setting and participate in community-based treatment services; and

(6) The client has functional disabilities secondary to serious and persistent mental illness and such disabilities are so great as to require that the client reside in a non-medical residential setting with rehabilitative services and supports.

(Adopted effective December 1, 2005)

Sec. 17b-262-763. Covered services

PNMI rehabilitative services are services designed to assist individuals with a serious and persistent mental illness to achieve their highest degree of independent functioning and recovery. These services include the following services, depending upon the particular needs of each client and the individual rehabilitation plan:

(1) Intake and assessment, which means assessing and reassessing the client's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the client, the client's family and through consultation with other professionals;

(2) Development of an individual residential rehabilitation plan in accordance with sections 17b-262-760(5) and 17b-262-762 of the Regulations of Connecticut State Agencies;

(3) Socialization skills development, which means client-centered skills development activities that are provided to support the goals and objectives in the PNMI client's individual residential rehabilitation plan and that are directed at reducing mental disabilities of clients in care, restoring them to their best possible functioning level and assisting clients in becoming responsible for their own actions;

(4) Behavior management training and intervention;

(5) Supportive counseling directed at solving daily problems related to community living and interpersonal relationships;

(6) Psycho-educational groups pertaining to the alleviation and management of psychiatric disorders;

(7) Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem solving;

(8) Assistance in developing skills necessary to support a full and independent life in the community;

(9) Support with connecting individuals to natural community supports;

(10) Orientation to, and assistance with, accessing self help and advocacy resources;

(11) Development of self-advocacy skills;

(12) Health education;

(13) Teaching of recovery skills in order to prevent relapse;

(14) Other rehabilitative support necessary to develop or maintain social relationships, to provide for independent participation in social, interpersonal or community activities and

to achieve full community reintegration; and

(15) Individual, family, and group counseling.

(Adopted effective December 1, 2005)

Sec. 17b-262-764. Limitations

Coverage of PNMI rehabilitative services shall be subject to the following limitations:

(1) PNMI rehabilitative services shall be pre-authorized by the department or its agent based on a written service recommendation.

(2) PNMI rehabilitative services shall be based on the individual residential rehabilitation plan developed pursuant to section 17b-262-760(5) of the Regulations of Connecticut State Agencies and the requirements of sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies, and shall be performed by, or under the supervision of, a licensed clinician employed by, or under contract to, the performing provider.

(3) The department shall not pay for programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.

(4) The department shall not pay for programs, services or components of services that do not relate to the client's diagnosis, symptoms, functional limitations or medical history.

(5) The department shall not pay for programs, services or components of services that are not included in the fee established by the department.

(6) The department shall not pay for programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms.

(7) The department shall not pay for programs, services or components of services designed to provide socialization or recreational activities for clients.

(8) The department shall not pay for time spent by the provider transporting clients.

(9) The department shall not pay for services that are solely, educational or vocational.

(10) The department shall not pay for costs associated with room and board for clients.

(11) The department shall not pay for PNMI rehabilitative services that are provided out-of-state unless the services are pre-authorized and are not available within Connecticut.

(12) The department shall not pay any organization or individual for services covered under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies, if such organization or individual is directly under contract to a provider for services covered under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective December 1, 2005)

Sec. 17b-262-765. Prior authorization

(a) Prior authorization of the need for PNMI adult rehabilitative services is required in order for Medicaid payment to be available for the services. Prior authorization shall be obtained on forms and in the manner specified by the department.

(b) The initial authorization period shall be for up to six months.

(c) If authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be submitted prior to the end of the existing authorization and shall be considered for up to six months per request.

(d) Except in emergency situations, approval shall be received before services are rendered.

(e) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure approval on the next working day for the admission to the PNMI.

(f) In order to receive payment from the department, a provider shall comply with all prior authorization requirements. The department or its agent in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective December 1, 2005)

Sec. 17b-262-766. Documentation and record retention requirements

Providers shall comply with the following documentation and record retention requirements:

(1) An initial residential rehabilitation plan and all updated versions, including the current plan, shall be maintained.

(2) A case record, as required by section 19a-495-551(k) (3) of the Regulations of Connecticut State Agencies, shall be maintained and shall include, at a minimum: identifying information; social and health history; the reason for admission to the PNMI program; copies of the initial and all subsequent orders for PNMI rehabilitative services; the individual residential rehabilitation plan; identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the PNMI client.

(3) Encounter notes shall be maintained for each rehabilitative service provided. The notes shall include the service rendered, actual time the service was rendered, location of service, the goal and objective that is the focus of the intervention, a general description of the content of the intervention to provide evidence that it is a rehabilitative service as described in section 17b-262-763 of the Regulations of Connecticut State Agencies and the client's response to the intervention. Encounter notes shall be signed, dated and indicate the credentials of the staff member who provided the service. Shift notes are not a substitute for encounter notes.

(4) At least monthly, a progress note shall be prepared that describes the services the client has received over the past month, the client's overall response, and the client's specific progress toward the goals and objectives listed on the residential rehabilitation plan. The note shall be signed or co-signed by the program director or the licensed clinician. The note shall discuss any variance between the services listed on the residential rehabilitation plan and the services actually delivered. The note shall also discuss suggested changes, if any,

to the residential rehabilitation plan.

(5) Other documentation and record retention requirements:

(A) The provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified individuals furnishing PNMI rehabilitative services.

(B) The provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.

(C) The provider shall maintain all required records for at least five years or longer as required by statutes or regulation. All required records shall be subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(D) All documentation shall be physically placed into the eligible PNMI client's case record in a complete, prompt and accurate manner. All documents shall be made available to authorized personnel of the department upon request.

(6) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(Adopted effective December 1, 2005)

Sec. 17b-262-767. Billing requirements

(a) Claims for payment of PNMI rehabilitation services shall be on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) All claims submitted to the department for payment of services covered under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the recipient's permanent case record.

(Adopted effective December 1, 2005)

Sec. 17b-262-768. Payment

Payment by the department for PNMI rehabilitative services shall be made in accordance with the following provisions.

(a) The department shall make payments on the basis of monthly rates for PNMI programs.

(b) A statewide capitated monthly rate will be established annually and applied uniformly to all facility providers and to all Medicaid eligible recipients provided with a qualified billable unit of service.

(c) The statewide capitated rate shall be based upon annual audited cost reports filed by licensed and certified service providers to include cost allocations based upon semi-annual time studies of facility staff hours related to rehabilitative services.

(d) The Department shall establish interim PNMI rates for the first and second year of service coverage based upon estimated costs. The interim rates will be replaced based upon

cost report filings for the period and related payment adjustments will be made accordingly.

(e) Prospective rates for subsequent periods will be based upon allowable costs for the cost period ending twelve months prior to the start of the rate period. These rates will be updated, within available appropriations, by the projected increase or decrease in the consumer price index for urban consumers for the twenty-four months between the mid-point of the cost period and the mid-point of the rate year.

(1) Allowable costs for purposes of establishing the statewide capitated rate are the reasonable and necessary costs attributable to the provision of rehabilitative services covered under this regulation but shall exclude any other costs such as transportation, recreation or vocational services that are not part of rehabilitative services. Allowable costs will be determined based on a survey of all group homes covered under this regulation.

(f) The calculation of the PNMI rates shall not include any services that have been reimbursed by Medicaid under other service categories.

(g) The PNMI rates shall exclude payment for non-Medicaid covered services, such as room and board.

(h) Payments shall not be made if the recipient has been absent from the program for the entire calendar month.

(i) The provider shall seek payment from any other resources that are available for payment of rendered services prior to billing the Department.

(j) Claims for payment shall be supported by documentation of required services.

(Adopted effective December 1, 2005)

Sec. 17b-262-769. Audit and compliance review

All supporting accounting and business records, statistical data and all other records relating to the provision of PNMI rehabilitative services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of DPH, DMHAS, and DSS.

(Adopted effective December 1, 2005)

Sec. 17b-262-770. Scope

Sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the establishment by Medicaid entities of policies and procedures for the education of employees regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(Adopted effective August 30, 2007)

Sec. 17b-262-771. Definitions

As used in sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Entity" means a government agency, organization, unit, corporation, partnership,

or other business arrangement, including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists, whether for-profit or not-for profit, which furnishes directly, or otherwise authorizes the furnishing of, the delivery of Medicaid health services where payments made with respect to those services are received, or made, under a State Plan approved under Title XIX, or under any waiver of such plan totaling at least $5,000,000 annually. If an entity furnishes items or services at more than a single location, or under more than one contractual or other payment arrangement, the provisions of sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies apply if the aggregate payments to that entity meet the $5,000,000 annual threshold whether the entity submits claims for payments using one or more provider identification or tax identification numbers. An entity meets the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) of the Social Security Act, P.L. 109-171, § 6032, will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan under Title XIX of the Social Security Act during the preceding federal fiscal year. A government component serving as a provider for which Medicaid payments are made (e.g., a state mental health facility or school district providing school-based health services) is an "entity" as defined in this subsection. A government agency which merely administers the Medicaid program, in whole or in part (e.g., managing the claims processing system or determining beneficiary eligibility), is not an "entity" as defined in this subsection;

(2) "Employee" means any officer or employee of an entity and includes management;

(3) "Contractor" or "agent" means any contractor, subcontractor, agent or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, the delivery of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity;

(4) "Department" means the Department of Social Services or its agent; and

(5) "Medicaid" means the program operated by the Department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time.

(Adopted effective August 30, 2007)

Sec. 17b-262-772. Provider participation

To receive payment from the Department for the provision of goods or services to Medicaid clients, entities shall comply with sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 30, 2007)

Sec. 17b-262-773. Establishment and dissemination of written policies

(a) An entity shall establish and disseminate written policies, which shall also be adopted

by its contractors or agents. Written policies may be on paper or in electronic form, but shall be readily available to all employees, contractors and agents. An entity need not create an employee handbook if none already exists.

(b) An entity shall establish written policies for all employees and for any contractor or agent of the entity, that includes, but is not limited to, detailed information about the federal False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act and detailed information about the entity's policies and procedures for detecting and preventing waste, fraud and abuse. An entity shall include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

(c) In addition to the education requirements concerning the federal laws set forth above, an entity shall reference in its written polices and handbook the following sections of the Connecticut General Statutes: 53a-290 et seq. (Vendor Fraud); 53-440 et seq. (Health Insurance Fraud); 53a-118 et seq. (Larceny); 53a-155 (Tampering with or Fabricating Physical Evidence); 53a-157b (False Statement Intending to Mislead Public Servant); 17b-25a (Toll Free Vendor Fraud Telephone Hotline); 17b-99 (Vendor Fraud); and 17b-102 (Financial Incentive for Reporting Vendor Fraud); 4-61dd (Whistleblowing); 31-51m (Protection of Employee Who Discloses Employer's Illegal Activities or Unethical Practices); and 31-51q (Liability of Employer for Discipline or Discharge of Employee on Account of Employee's Exercise of Certain Constitutional Rights).

(d) An entity shall reference in its written policies and handbook the following sections of the Regulations of Connecticut State Agencies: 17-83k-1 et seq. (Administrative Sanctions); 17b-102-01 et seq. (Financial Incentive for Reporting Vendor Fraud and Requirements for Payment for Reporting Vendor Fraud); and 4-61dd-1 et seq. (Rules of Practice for Contested Case Proceedings under the Whistleblower Protection Act).

(e) The Department shall require that all entities, upon re-enrollment or contract amendment subsequent to January 1, 2007, include an addendum to their Medicaid Provider Agreement or contract which describes the requirements of this section. All entities that met the $5,000,000 threshold in federal fiscal year 2006 and annually thereafter must provide an attestation of their compliance with this section to the Department's Office of Quality Assurance by August 31st of each year. The Department's Office of Quality Assurance shall verify compliance with this section.

(Adopted effective August 30, 2007)

Sec. 17b-262-774—17b-262-778. Reserved

Payment to Chronic Disease Hospitals

Sec. 17b-262-779. Scope

Sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies, set forth the department of social services' requirements for payment to chronic

disease hospitals for services to clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective October 6, 2009)

Sec. 17b-262-780. Definitions

As used in sections 17b-262- 779 to 17b-262- 791, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Applied income" means the amount of income that each client receiving chronic disease hospital services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) "Assessment" means a comprehensive written evaluation of an individual's functional performance in relation to a set of measurable medical or physical criteria;

(3) "Client" means a person eligible for goods or services under the department's Medicaid program;

(4) "Chronic disease" means a disease having one or more of the following characteristics:

(a) is permanent;

(b) leaves residual disability;

(c) is caused by non-reversible pathological alteration;

(d) requires special training of the client for rehabilitation; or

(e) is expected to require a long period of supervision, observation or care;

(5) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(6) "Commissioner" means the commissioner of social services or his or her designee;

(7) "Department" means the department of social services or its agent;

(8) "Durable medical equipment" means equipment that meets all of the following requirements:

(a) can withstand repeated use;

(b) is primarily and customarily used to serve a medical purpose;

(c) is generally not useful to a person in the absence of an illness or injury; and

(d) is non-disposable;

(9) "Institution for mental diseases" means "institution for mental diseases" as defined in 42 CFR 435.1009, as amended from time to time;

(10) "Licensed practitioner" means any person licensed by the state of Connecticut, any other state, the District of Columbia or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(14) "Preadmission assessment" means a clinical assessment of ongoing needs and prognosis as necessary to determine the chronic disease hospital's ability to provide for a client's expected needs;

(15) "Provider" means a chronic disease hospital that is enrolled in Medicaid;

(16) "Provider agreement" means the signed, written, contractual agreement between the department and the provider;

(17) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes;

(18) "Rehabilitation" means any medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental disability and restoration of an individual to his or her best possible functional level;

(19) "Resident" means a client living in a chronic disease hospital;

(20) "Team" means a group of individuals employed by or under contract to the chronic disease hospital and may include physiatrists, specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, respiratory specialists, prosthetists, orthotists, physiatrists or respiratory specialists. Other practitioners, including but not limited to, mental health practitioners, may be part of the team as appropriate;

(21) "Team conference" means a meeting of the team to develop a treatment plan of care;

(22) "Treatment plan of care" means the written description of services designed to meet a resident's medical, nursing and rehabilitation needs that are identified in the resident's assessment. The treatment plan of care shall include measurable objectives and a specific timetable; and

(23) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective October 6, 2009)

Sec. 17b-262-781. Provider participation

(a) To enroll in Medicaid and receive payment from the department, a chronic disease hospital shall comply with the provider participation requirements of sections 17b-262-522

through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) In order to enroll in Medicaid and to receive payment from the department, a chronic disease hospital shall meet the requirements for state licensure described in section 19-13-D5 of the Regulations of Connecticut State Agencies, the requirements for federal certification to participate in the Medicaid program that are described in 42 CFR Part 482, as amended from time to time, and the requirements stated in sections 17b-262-779 to 17b-262-791, inclusive, of these regulations.

(c) In addition to the requirements in subsections (a) and (b) of this section, in order to participate in the Medicaid program, a chronic disease hospital shall be federally certified as either:

(1) a long term care hospital that meets the criteria of 42 CFR 412.23(e);

(2) a rehabilitation hospital that meets the criteria of 42 CFR 412.23(b); or

(3) an acute care hospital with a psychiatric unit excluded from the prospective payment system that meets the criteria of 42 CFR 412.25.

(Adopted effective October 6, 2009)

Sec. 17b-262-782. Eligibility

Payment for chronic disease hospital services is available on behalf of all clients subject to the conditions and limitations that apply to these services.

(Adopted effective October 6, 2009)

Sec. 17b-262-783. Need for service

In order for a client to be approved for admission to a chronic disease hospital, the client shall meet the criteria for admission as either a chronic disease client or a rehabilitation client. All care shall be medically necessary and medically appropriate.

(a) The criteria for admission as a chronic disease client are as follows:

(1) Each chronic disease client shall require services that can be provided safely and effectively at a chronic disease hospital level, shall be ordered by a physician and documented in the client's medical record, and shall include at least a daily physician visit and assessment or the 24-hour availability of medical services and equipment available only in a hospital setting; and

(2) The client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client.

(b) The criteria for admission as a rehabilitation client are as follows:

(1) Each rehabilitation client shall require an intensive rehabilitation program at the level of a chronic disease hospital level of care that includes a multi-disciplinary approach to improve the client's ability to function to his or her maximum potential. Factors shall be present in the client's condition that indicate the potential for functional improvement or freedom from pain. A client who requires therapy solely to maintain function shall not be considered an appropriate rehabilitation candidate;

(2) Each client's medical condition and treatment needs are such that no effective, safe,

less costly alternative placement is available to the client;

(3) A preadmission assessment shall be developed, prior to admission by specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, prosthetists or orthotists;

(4) The treatment plan of care shall be directed by a physician who is board certified or eligible for board certification in an appropriate specialty; and

(5) The treatment plan of care shall be designed to achieve specific goals within a specified timeframe.

(c) Team conferences shall be conducted for each client. The first team conference shall occur not later than seven calendar days after the client's admission.

(d) For rehabilitation clients, subsequent conferences shall occur at least once every fourteen calendar days. All team members, or a designee within the same specialty, shall be in attendance. The purpose of the conference shall be to conduct an assessment of the client's progress, make adjustments to the established goals as indicated or terminate the program when the expected goal has been reached or determined to be no longer attainable.

(e) For chronic disease clients, subsequent conferences shall occur at least once every 90 days. The depth of the periodic review shall be appropriate to the client's clinical status and prognosis.

(f) The department may use nationally recognized guidelines applicable to chronic disease hospitals or inpatient rehabilitation hospitals in determining if the admission is medically necessary and medically appropriate.

(g) The department shall authorize payment for any individual who meets the criteria set forth in subsections (a) or (b) of this section when he or she:

(1) is a client seeking admission to a chronic disease hospital;

(2) is an individual who applies for Medicaid while in the chronic disease hospital; or

(3) is a client seeking an extension of treatment at a chronic disease hospital.

(h) The department shall pay a provider only when the department has authorized the client's admission to that chronic disease hospital and all other requirements for payment are met.

(Adopted effective October 6, 2009)

Sec. 17b-262-784. Services covered

The department shall pay an all-inclusive per diem rate to the provider for each resident for whom payment has been authorized pursuant to section 17b-262-783 of the Regulations of Connecticut State Agencies. This per diem rate represents payment for the following goods and services:

(a) all services as required by section 19-13-D5 of the Regulations of Connecticut State Agencies and 42 CFR Part 482, as amended from time to time, including, but not limited to:

(1) medical direction in accordance with section 19-13- D5(c) of the Regulations of Connecticut State Agencies and 42 CFR 482.22;

(2) nursing services in accordance with section 19-13- D5(e) of the Regulations of Connecticut State Agencies and 42 CFR 482.23, as amended from time to time;

(3) therapeutic recreation in accordance with section 19-13- D5(k) of the Regulations of Connecticut State Agencies;

(4) rehabilitation services in accordance with section 19-13-D5(k) of the Regulations of Connecticut State Agencies and 42 CFR 482.56, as amended from time to time;

(5) room and board in accordance with sections 19-13-D5(h) and (i) of the Regulations of Connecticut State Agencies and 42 CFR 482.28 and 482.41 as amended from time to time;

(6) diagnostic and therapeutic services in accordance with section 19-13-D5(f) of the Regulations of Connecticut State Agencies and 42 CFR 482.26, as amended from time to time;

(7) pharmacy services in accordance with section 19-13-D5(g) and 42 CFR 482.25, as amended from time to time;

(8) laboratory services in accordance with 42 CFR 482.27, as amended from time to time;

(9) respiratory services in accordance with 42 CFR 482.57, as amended from time to time; and

(10) consultation and assistance to residents in obtaining other needed services including, but not limited to, dental services, vision services, hearing services and services to address mental and psychosocial functioning;

(b) all services required as conditions of participation for certification under 42 CFR 412, Subpart B, Subpart O or Subpart P as applicable;

(c) all physical therapy, occupational therapy, speech therapy and respiratory therapy included in the treatment plan of care;

(d) routine personal hygiene items required to meet the needs of the resident including, but not limited to, hair hygiene supplies, soaps and other cleansing agents to treat skin problems, shaving supplies, dental and denture supplies, lotions, incontinence supplies, bathroom supplies and over the counter drugs;

(e) prescription drugs;

(f) durable medical equipment including customized equipment;

(g) supplies used in the care of the resident including, but not limited to:

(1) antiseptics and solutions;

(2) bandages and dressing supplies;

(3) catheters and urinary incontinent supplies;

(4) diabetic supplies;

(5) diapers and underpads;

(6) compression, burn and specialized medical garments;

(7) ostomy supplies;

(8) respiratory and tracheotomy supplies;

(9) enteral and parenteral supplies; and

(10) miscellaneous supplies;

(h) all oxygen supplies including oxygen concentrators; and

(i) transportation services necessary to transport a resident to and from any service included in the per diem rate as described in this section.

(Adopted effective October 6, 2009)

Sec. 17b-262-785. Service limitations

Payment shall be made for the date of admission but not for the date of discharge. Exceptions to this are:

(a) payment shall be made for the date of death when the resident dies in the chronic disease hospital.

(b) in the case of a resident admitted and discharged on the same day, payment shall be made for one day of care.

(Adopted effective October 6, 2009)

Sec. 17b-262-786. Services not covered

(a) The department shall not pay a chronic disease hospital that is characterized as an institution for mental diseases except for services to clients aged 65 and older or under age 22 in accordance with section 17-134d-68 of the Regulations of Connecticut State Agencies and 42 CFR 435.1009.

(b) The department shall not reimburse any provider for any costs incurred before the authorized length-of-stay period or after the expiration of the specified length-of-stay period.

(Adopted effective October 6, 2009)

Sec. 17b-262-787. Authorization process

(a) The department shall pay a provider only when the department has authorized payment for the client's admission to that chronic disease hospital.

(b) The provider shall comply with the authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies and sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary to approve an authorization request. Authorization does not, however, guarantee payment unless all other requirements for payment are met.

(c) An authorization request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the licensed practitioner. For individuals who become clients while in the chronic disease hospital, this authorization request shall include, but not be limited to, a treatment plan of care under the direction of a physician that is designed to achieve specified goals within a specified timeframe and developed by a team.

(d) Initial authorizations for treatment shall be authorized by the department for up to 30 days. Subsequent requests for the extension of authorization for the same client may be

made for up to three months or longer, on a case-by-case basis.

(e) If a safe discharge is not possible from the chronic disease hospital, the department shall authorize a continued stay and payment at the current Medicaid rate for up to three months or longer, on a case by case basis.

(f) The department shall act on prior authorization requests for readmissions to a chronic disease hospital from an acute care hospital within one business day so that clients do not remain at the acute care hospital level longer than necessary.

(g) No chronic disease hospital shall be required to admit a client if such hospital has not received an authorization for treatment from the department.

(h) The department will process a request for authorization for treatment, and deliver a decision on such request within two full business days from the date a chronic disease hospital notifies the department that a client who is a patient of such hospital has exhausted his or her other third party insurance or whose coverage by such insurance has been denied.

(Adopted effective October 6, 2009)

Sec. 17b-262-788. Applied income

(a) A client who receives chronic disease hospital services is responsible for paying applied income to the chronic disease hospital.

(b) The department shall calculate the applied income. The department shall notify the chronic disease hospital of the amount of any applied income that the chronic disease hospital is responsible for collecting. Applied income shall be deducted from what otherwise would have been the department's monthly payment to the chronic disease hospital.

(c) The chronic disease hospital shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(d) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the chronic disease hospital multiplied by the per diem rate.

(e) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(Adopted effective October 6, 2009)

Sec. 17b-262-789. Billing and payment procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The chronic disease hospital is responsible for:

(1) completing the daily admission and discharge forms in accordance with the department's instructions;

(2) notifying the department's caseworker if the chronic disease hospital is aware that

the resident's asset level exceeds the established resource limit. The report shall be made on the form specified by the department;

(3) notifying the department of any and all credits due the department on the form specified by the department; and

(4) exhausting other payment sources of which the chronic disease hospital is aware before billing the department.

(Adopted effective October 6, 2009)

Sec. 17b-262-790. Rates

(a) The per diem rate for a chronic disease hospital is determined annually pursuant to section 17b-239 of the Connecticut General Statutes for freestanding chronic disease hospitals or section 17b-340 of the Connecticut general statutes for chronic disease hospitals associated with chronic and convalescent nursing homes.

(b) the department shall reimburse the chronic disease hospital at the lower of:

(1) the per diem rate minus the applied income; or

(2) the usual and customary charge minus the applied income.

(Adopted effective October 6, 2009)

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)

Sec. 17b-262-792. Scope

Sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to providers of hearing aids and supplies that are medically necessary and that are provided to clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective July 11, 2011)

Sec. 17b-262-793. Definitions

As used in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Actual acquisition cost" means the price paid to a manufacturer by a hearing aid provider for a hearing aid or accessory, as documented on the manufacturer's invoice, less any applicable discounts or rebates. The actual acquisition cost shall be verified by a copy of the manufacturer's invoice;

(2) "Advanced practice registered nurse" means a person who is licensed pursuant to section 20-94a of the Connecticut General Statutes;

(3) "Audiologist" means a person who is licensed under Chapter 399 of Connecticut General Statutes as an audiologist;

(4) "Audiometric report" means a written report that describes the results of measurement of overall performance in hearing, understanding and responding to speech for a general assessment of hearing and an estimate of the degree of practical handicap. The results are recorded on a graph or grid, also called an audiogram, to show the results and the impact of the hearing loss;

(5) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1(b)(2) of the Regulations of Connecticut State Agencies;

(6) "Client" means a person eligible for goods or services under the Medicaid program;

(7) "Commissioner" means the Commissioner of Social Services or his or her designee;

(8) "Department" means the Department of Social Services or its agent;

(9) "Dispensing fee" means a one-time fee pertaining to the selection, orientation, training in proper use, fittings and adjustments required within the first year of service;

(10) "Documented in writing" means handwritten, typed or computer printed;

(11) "Early Periodic Screening, Diagnosis and Treatment special services" or "EPSDT special services" means services that are not otherwise covered under Connecticut's Medicaid program but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to the requirements of 42 U.S.C. 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider, and the service is a type of service that may be covered by a state Medicaid agency and qualify for federal reimbursement under 42 U.S.C. 1396b and 42 U.S.C. 1396d;

(12) "Ear specialist" means any licensed physician who specializes in diseases of the ear and is medically trained to identify the symptoms of deafness in the context of the total health of the patient, and is qualified by special training to diagnose and treat hearing loss. Such physicians are also known as otolaryngologists, otologists and otorhinolaryngologists;

(13) "Hearing aid" means any wearable instrument designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments or accessories, excluding batteries and ear molds;

(14) "Hearing aid dealer" means a "licensed hearing instrument specialist" as defined in section 20-396 of the Connecticut General Statutes or a "hearing aid dealer" as described in section 20-406-1 to 20-406-15, inclusive, of the Regulations of Connecticut State Agencies;

(15) "Hearing aid supplies" means those items purchased by the provider that are necessary for the proper operation of the hearing aid;

(16) "Hearing testing" means the measurement of an individual's level of hearing, as set forth in section 20-406-9(f) of the Regulations of Connecticut State Agencies, for the purpose of determining if a hearing aid is medically necessary;

(17) "Home" means the client's place of residence including, but not limited to, a boarding home, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(18) "Hospital" means a "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(19) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(20) "Licensed practitioner" means a physician, a physician assistant or an advanced practice registered nurse;

(21) "Medicaid" means the program operated by the department pursuant to section 17b-261 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(22) "Medical evaluation" means an examination to ensure that all medically treatable conditions that may affect hearing are identified and treated first and the client is an appropriate candidate for a hearing aid;

(23) "Medical necessity" or "medically necessary" has the same meaning as in section 17b-259b of the Connecticut General Statutes;

(24) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time and licensed according to section 19-13-D8t(b) of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision;

(25) "Physician" means a person licensed pursuant to section 20-10 of the Connecticut General Statutes;

(26) "Physician assistant" means "physician assistant" as defined in section 20-12a(5) of the Connecticut General Statutes;

(27) "Practice of fitting hearing aids" means "practice of fitting hearing aids" as defined in section 20-396 of the Connecticut General Statutes;

(28) "Prescription" means an original, written order documenting medical necessity that is signed and dated by the licensed practitioner who issued the order;

(29) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(30) "Provider" means the vendor or supplier of a hearing aid and supplies who is enrolled with the department as a hearing aid dealer;

(31) "Replacement of a hearing aid" means any occasion in which a new hearing aid is to take the place of a prior hearing aid; and

(32) "Usual and customary charge" means the amount that the provider accepts for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is accepted in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective July 11, 2011)

Sec. 17b-262-794. Provider participation

To enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies and sections 17b-262-522 to 17b-262-532, inclusive, of the

Regulations of Connecticut State Agencies.

(Adopted effective July 11, 2011)

Sec. 17b-262-795. Need for service

(a) The department shall pay for the purchase or repair of a medically necessary hearing aid or supply, subject to the conditions and limitations described in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(b) All clients who have been identified as having a hearing loss, such as through the performance of a hearing screening, shall receive a medical evaluation by a licensed practitioner, preferably an ear specialist, before a hearing aid is considered to ensure that all medically treatable conditions that affect hearing are identified and treated first. The medical evaluation shall have taken place within the six-month period prior to the date in which the client receives the first hearing aid and may, at the licensed practitioner's discretion, be accompanied by a prescription for a hearing aid.

(c) Medical necessity shall be documented by the provider and shall include:

(1) An estimate of the client's ability to benefit from the use of a hearing aid as demonstrated by improvement in speech discrimination or environmental awareness of sound;

(2) test results showing the client's current hearing level and an estimate of improvement in speech discrimination or environmental awareness of sound;

(3) evidence of a medical evaluation signed by a licensed practitioner; and

(4) a written prescription signed by a licensed practitioner or an order by an audiologist or hearing aid dealer.

(d) In addition the provider shall document:

(1) The commitment on the part of the appropriate caregiver to assist the client in the use and care of the hearing aid, if the client is incapable of caring for the hearing aid on his or her own; and

(2) the status of any previous hearing aid used by the client.

(e) The department shall pay for hearing aids and supplies for a client who lives at home or in a nursing facility, ICF/MR, hospital or chronic disease hospital, except as limited by sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(f) All hearing aids dispensed to a child under eighteen years of age shall meet the requirements of section 20-406-10 of the Regulations of Connecticut State Agencies.

(g) Hearing testing shall meet the requirements of section 20-406-9(f) of the Regulations of Connecticut State Agencies.

(h) There shall be a thirty-day trial period for a hearing aid in accordance with section 20-402a of the Connecticut General Statutes; the cancellation fee applies to the total acquisition cost and dispensing fee.

(i) An audiometric report to support medical necessity is required for the purchase of all hearing aids.

(j) A hearing aid shall be replaced only when the prior hearing aid no longer meets the client's needs, has been lost, stolen or damaged beyond repair.

(k) For a hearing aid that has been lost, stolen or damaged beyond repair, the provider shall document:

(1) The disposition of the prior hearing aid and statement of circumstances of loss or damage;

(2) in the case of damage, a statement from the hearing aid dealer or audiologist that the hearing aid cannot be repaired;

(3) the measures to be taken by the client, family or other caregiver, to prevent future loss or damage.

(*l*) For a hearing aid that is no longer meets the client's needs, the provider shall document the significant change in the client's hearing loss to warrant the replacement.

(Adopted effective July 11, 2011)

Sec. 17b-262-796. Eligibility

Payment to a provider for hearing aids and related supplies is available for clients who have a need for such products and services which meets the department's definition of a hearing aid when the items are medically necessary, subject to the conditions and limitations set forth in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective July 11, 2011)

Sec. 17b-262-797. Services covered and limitations

(a) The department shall maintain a fee schedule for hearing aids and supplies, subject to the conditions and limitations set forth in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule is designed to meet the needs of most Medicaid clients.

(b) The department shall pay for the servicing, repair or replacement of hearing aids and supplies, provided that any manufacturer's or dealer's warranty has been exhausted. The provider shall first utilize existing warranties that cover required servicing, repairs and replacement.

(c) The department shall pay for one hearing test provided by either:

(1) A hearing aid provider, who is not an audiologist; or

(2) an audiologist, ear specialist or any other physician under contract to, or employed by a hearing aid provider, who does not separately bill the department for any other hearing test or audiological examination.

(Adopted effective July 11, 2011)

Sec. 17b-262-798. Goods and services not covered

The department shall not pay providers for:

(a) Any hearing aid that is of an unproven, experimental or research nature or for services

in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history;

(b) any hearing aid prescribed and ordered for a client who:

(1) Dies prior to delivery of the item; or

(2) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the item is delivered;

(c) the purchase or repair of a hearing aid necessitated by inappropriate, willful or malicious misuse on the part of the client, as determined by the department;

(d) any hearing aid or supply provided for cosmetic reasons;

(e) a hearing aid for a client in a nursing facility, ICF/MR, chronic disease hospital, hospital or other facility if the hearing aid is included in the facility's per diem Medicaid rate; or

(f) a hearing aid that can be billed to another payer.

(Adopted effective July 11, 2011)

Sec. 17b-262-799. Payment and payment limitations

(a) Fees shall be the same for in-state, border-state and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the provider.

(c) The department shall reimburse a provider when all the requirements of sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies have been met.

(d) The fee for a hearing aid includes an initial one-year manufacturer's warranty against loss, theft or damage.

(e) Hearing aids provided shall be new and guaranteed against all defects in workmanship and materials for at least one year from the date of delivery of the hearing aid to the client.

(f) The department shall pay providers for:

(1) The actual acquisition cost of a hearing aid to the provider up to the maximum amount allowed by the department's fee schedule;

(2) a dispensing fee up to the maximum allowed by the department's fee schedule; and

(3) hearing testing for the purpose of fitting a hearing aid.

(g) The department shall pay for custom ear molds for a client who dies or is not otherwise eligible on the date of delivery provided the client was eligible on the date the item was ordered.

(h) If the cost of repairs to any hearing aid exceeds its replacement cost, the hearing aid

shall be replaced.

(i) The provider shall meet the exact specifications of a hearing aid selected by an audiologist, ear specialist or licensed practitioner.

(Adopted effective July 11, 2011)

Sec. 17b-262-800. Prior authorization

(a) The department shall require PA for:

(1) Any hearing aid that is identified on the department's fee schedule as requiring PA;

(2) EPSDT special services; and

(3) any service or device that is not on the department's fee schedule.

(b) To receive reimbursement from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(c) A PA request, on a form and in the manner specified by the department, shall include documentation of medical necessity and shall be signed by the provider.

(d) A prescription is required from a licensed practitioner for all services and goods provided as EPSDT special services. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(Adopted effective July 11, 2011)

Sec. 17b-262-801. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department in a form and in a manner specified by the department and shall include all information required by the department to process the claim for payment.

(b) A claim submitted for hearing aids and supplies that does not require prior authorization shall include the national provider identifier number of the licensed practitioner or audiologist prescribing the hearing aid, if applicable.

(Adopted effective July 11, 2011)

Sec. 17b-262-802. Documentation

(a) Providers shall maintain all fiscal and medical records related to services and goods rendered or delivered to clients.

(b) All required documentation, including evidence of a medical evaluation for a hearing aid, results of audiometric evaluations, results of any testing to support the need for a hearing aid and expected hearing improvement and notes related to fittings and adjustments shall be maintained for at least five years in the provider's primary place of business and shall be subject to review by the department.

(c) The department shall accept, when feasible, faxed or electronic medical evaluations

and other orders. If evidence indicates that the documentation being reviewed has been falsified or the provider is unable to provide adequate assurance of the medical necessity of the items or services, the department may request additional information, including an original signature, in order to obtain that assurance.

(d) Any documentation, including a medical evaluation, that is electronically submitted to a vendor shall identify the sender and display the sender's fax number and date. The department may request the original medical evaluation and results of the hearing test whenever medical necessity is in question.

(e) In the event of a dispute concerning a service or a hearing aid provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(f) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for the hearing aid or service for which the required documentation is not maintained or provided to the department upon request.

(g) The provider shall have on file the manufacturer's purchase invoice for any hearing aid dispensed to a client, for any repairs or servicing and for any processing charges associated with replacement of a hearing aid under warranty.

(h) Providers shall maintain signed receipts for all goods and services that are provided to a client regardless of whether the item is delivered or picked up by the client or client's representative. The receipt for hearing aids, services and supplies shall at a minimum, contain the following:

(1) The provider's name;

(2) the client's name;

(3) the client's address;

(4) the date of delivery; and

(5) itemization of the hearing aid, service or supplies delivered, including, but not limited to:

(A) Product description;

(B) brand name;

(C) model name and number, if applicable;

(D) serial number, if applicable;

(E) the quantity delivered;

(F) the amount billed per hearing aid; and

(G) any warranty in effect.

(i) A prescription or order for hearing aids and supplies, regardless of the format used, shall, at a minimum, contain the following:

(1) The client's name, address and date of birth; and

(2) the diagnosis for which the hearing aid is required.

(j) Evidence of the medical evaluation shall, at a minimum, include the following:

(1) The client's name, address and date of birth;

(2) the date of the physician's medical evaluation;

(3) the prescribing physician's signature and date of his or her signature; and

(4) a statement that the client's hearing loss has been medically evaluated and that the client may be considered a candidate for a hearing aid.

(k) All required documentation shall be subject to review by authorized department personnel upon the department's request.

(Adopted effective July 11, 2011)

Sec. 17b-262-803. Other

(a) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client, his or her family or a designated representative on the proper use and care of the hearing aid.

(c) The provider shall maintain a written usual and customary price list that details individual product and service charges. This list, including updates along with any required manufacturer's list pricing, shall be available for review by the department.

(d) A hearing aid purchased by the department shall become the property of the client on the date of delivery to the client.

(Adopted effective July 11, 2011)

Requirements for Payment of Services Provided by Psychiatric Residential Treatment Facilities Providers

Sec. 17b-262-804. Scope

Sections 17b-262-804 to 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment for Psychiatric Residential Treatment Facilities (PRTF) services provided to clients who are determined eligible for Connecticut's Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective September 4, 2009)

Sec. 17b-262-805. Definitions

As used in section 17b-262-804 to section 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Active treatment" means "active treatment" as defined in 42 CFR, Part 441, section 44l.l54;

(2) "Acute" means having rapid onset, severe symptoms and a short course;

(3) "Allied Health Professional" or "AHP" means a licensed individual who is qualified by special training, education, skills and experience in behavioral health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, professional counselors and other qualified therapists as defined in Title 20 of the

Connecticut General Statutes;

(4) "Authorization" means the approval of payment for services or goods by the department based on a determination of medical necessity and appropriateness. For elective admissions, authorization also serves as the certification of need as defined in this section;

(5) "CMS" means the Centers for Medicare and Medicaid Services;

(6) "Certification of need" means an evaluation process for clients who are under consideration for admission to a PRTF;

(7) "Client" means a person eligible for goods or services under Medicaid who is under age twenty-one at the time services are received. If a client received services immediately before reaching age twenty-one, payment shall be available for services received before the earlier of the date that the client no longer requires the services or the date that the client reaches age twenty-two;

(8) "Department" means the Department of Social Services or its agent;

(9) "Elective admission" means any admission to a PRTF that is non-emergent, including, but not limited to, transfers from one PRTF to another;

(10) "Independent team" means a team that meets the requirements set forth in 42 CFR, Part 441, section 441.153(a). The independent team may not include anyone who is related, in any way, to the admitting facility, or who is directly responsible for the care of patients whose care is being reviewed or has a financial interest in the admitting facility. The department performs the functions of the independent team;

(11) "Individual plan of care" or "plan of care" means a written plan that meets the criteria set forth in 42 CFR, Part 441, Section 441.155;

(12) "Inpatient" means "inpatient" as defined in 42 CFR, Part 440, section 440.2;

(13) "Interdisciplinary team" means a team that meets the requirements set forth in section 42 CFR, Part 441, section 441.156;

(14) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(16) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or to prevent a medical condition from occurring;

(17) "Medical record" means "medical record" as described in 42 CFR, Part 482, section 482.6l and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies;

(18) "Overnight pass" means a conditional release to the client's proposed residence on discharge of not more than two days duration, after admission and prior to the day of

discharge, in which the client has been permitted by the attending physician to be absent from the facility premises and in accordance with the client's treatment needs and goals as specified in the plan of care;

(19) "Provider" means a PRTF that is enrolled in Medicaid;

(20) "Provider agreement" means the signed, written contractual agreement between the department and the provider;

(21) "Psychiatric emergency" means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a physician emergency certificate are not automatically deemed to qualify as a psychiatric emergency;

(22) "Psychiatric Residential Treatment Facility" or "PRTF" means a facility that meets all the requirements in 42 CFR Part 441, Subpart D and 42 CFR Part 483, Subpart G;

(23) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the condition and the client under treatment;

(24) "Retrospective review" means the review conducted after services are provided to a client, to determine the medical necessity, medical appropriateness and quality of the services provided;

(25) "Transfer" means that a client is discharged from a PRTF and directly admitted to another;

(26) "Under the direction of a physician" means that health services may be provided by allied health professionals or paraprofessionals whether or not the physician is physically present at the time that the services are provided; and

(27) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to a client.

(Adopted effective September 4, 2009)

Sec. 17b-262-806. Provider participation

In order to enroll in Medicaid and receive payment from the department, a provider shall meet the following requirements:

(a) **General:**

(1) meet and maintain all applicable licensing, accreditation and certification requirements;

(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 Medicaid. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for

the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) **Specific:**

(1) be accredited in accordance with 42 CFR 441.151(a)(2);

(2) satisfy all federal and state requirements governing the use of restraint and seclusion including, but not limited to, a written attestation of facility compliance with CMS standards governing the use of restraint and seclusion and filed annually with the department no later than July 1st of each year; and

(3) if located outside of Connecticut, meet all of the provider requirements in subsections (a) and (b) of this section and be an enrolled Medicaid provider in the provider's state of residence, when that state participates in the optional Medicaid of inpatient psychiatric facility services provided for clients.

(Adopted effective September 4, 2009)

Sec. 17b-262-807. Eligibility

Payment for PRTF services shall be available, subject to the conditions and limitations set forth in sections 17b-262-804 to17b-262-816, inclusive, of the Regulations of Connecticut State Agencies, for services rendered to clients.

(Adopted effective September 4, 2009)

Sec. 17b-262-808. Services covered

(a) The department shall pay a per diem rate, which is an inclusive payment for all services that are required to be provided by the facility as a condition for participation as a PRTF, including, but not limited to:

(1) therapeutic services provided by PRTF staff;

(2) active treatment services including, but not limited to, individual, group and family therapy;

(3) diagnostic testing and assessment;

(4) room and board; and

(5) case management, discharge planning.

(b) The department shall pay for authorized PRTF services for clients provided by an enrolled provider.

(Adopted effective September 4, 2009)

Sec. 17b-262-809. Services not covered

The department shall not pay for the following PRTF services that are not covered under Medicaid:

(a) procedures or services of an unproven, educational, social, research, experimental or cosmetic nature or for any diagnostic, therapeutic or treatment procedures in excess of those deemed medically necessary and appropriate by the department to treat the client's

condition;

(b) services or items furnished for which the provider does not usually charge;

(c) services that do not directly relate to the client's diagnosis, symptoms or medical history;

(d) the day of discharge;

(e) a PRTF admission or a day of care that does not meet all the department's requirements for inpatient services;

(f) a day when the client is absent from the PRTF at the midnight census, unless the absence is a medically authorized overnight pass and part of the treatment plan; or

(g) costs associated with the education or vocational training of the client which shall be excluded from Medicaid payments.

(Adopted effective September 4, 2009)

Sec. 17b-262-810. Certification of need requirements

(a) In order to receive payment for PRTF services for an individual, admissions shall have a certification of need as required in 42 CFR 441 Subpart D, as amended from time to time.

(b) The certification of need shall be based on a determination that:

(1) ambulatory care resources available in the community do not meet the treatment needs of the client;

(2) proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) the services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.

(c) When the admission of a client is elective, an independent team shall perform the certification of need. The facility shall maintain written documentation of the independent team's certification of need as evidenced by the signature of a member of the independent team on a certification of need form or letter(s) of authorization by the independent team.

(d) When the admission is of a person who is not Medicaid eligible and who applies for Medicaid while in the PRTF, the certification of need shall be conducted at the time of application for or by the first day of Medicaid eligibility. The interdisciplinary team responsible for the individual plan of care shall perform the certification of need, which shall cover any period prior to application for which Medicaid claims are made. The facility shall maintain written documentation of the certification of need.

(e) For psychiatric emergency admissions, the certification of need shall be performed by the interdisciplinary team responsible for the plan of care not later than fourteen days after the day of admission. The facility shall maintain written documentation of the certification of need as evidenced by the signature of a member of the independent team on a certification of need form.

(f) When the client is admitted from a PRTF to a hospital and, upon discharge, is

readmitted to the PRTF, a new certification of need shall be performed.

(Adopted effective September 4, 2009)

Sec. 17b-262-811. Individual plan of care requirements

(a) PRTF services for clients shall involve active treatment, as documented in the professionally developed and supervised individual plan of care.

(b) A physician shall:

(1) assume professional responsibility for the services provided under the plan of care;

(2) assure that the services are medically appropriate;

(3) certify in writing that the services provided are necessary in the setting in which they will be provided; and

(4) be readily available in person or by phone but not necessarily on the premises.

(c) Not later than seven days after admission, the interdisciplinary team shall establish a written plan of care for each client, designed to achieve the client's discharge from the PRTF at the earliest possible time. This plan shall:

(1) be based on a diagnostic evaluation that includes examinations of the medical, psychological, social, behavioral and developmental aspects of the client's situation and thereby reflect the need for PRTF services;

(2) be developed by the interdisciplinary team of professionals in consultation with the client and his or her parents, legal guardian, or others into whose care he or she will be released after discharge;

(3) state the treatment objectives;

(4) prescribe an integrated program of therapies, activities and experiences designed to meet the treatment objectives;

(5) include, at an appropriate time, post-discharge plans and coordination of PRTF services with partial discharge plans and related community services to ensure continuity of care with the client's family, school and community upon discharge; and

(6) be a recorded document which is maintained in the client's medical record.

(d) The individual plan of care shall be reviewed every thirty days by the interdisciplinary team, starting on the date of admission. The purpose of the review is to determine whether services being provided are currently required, or were required on an inpatient basis, and to recommend any changes to the plan that are indicated by the client's overall progress towards the treatment goals.

(Adopted effective September 4, 2009)

Sec. 17b-262-812. Utilization review program

(a) The department conducts utilization review activities for services delivered by the PRTF for clients where Medicaid has been determined to be the appropriate payer.

(b) To determine whether admission to a PRTF is medically necessary and medically appropriate, the department or the Administrative Service Organization shall:

(1) authorize each PRTF admission, unless the department notifies the providers that a

specific admission or diagnosis does not require such authorization; and

(2) perform retrospective reviews, at the department's discretion, which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the appropriateness, necessity or quality of the health care services provided.

(c) All claims for payment for admission and all days of stay and services that are provided shall be documented. Lack of said documentation may be adequate grounds for the department, in its discretion, to deny or recoup payment for the admission for some or all of the days of stay or services provided.

(d) The department may conduct medical reviews and inspections of care in PRTFs.

(Adopted effective September 4, 2009)

Sec. 17b-262-813. Billing procedures

Claims from providers shall be submitted on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(Adopted effective September 4, 2009)

Sec. 17b-262-814. Documentation and record retention

(a) A provider shall meet the medical record requirements for a PRTF and shall maintain records to support claims made for payment. All documentation shall be made available upon request by and to authorized department, state or federal personnel in accordance with state and federal laws. Documentation shall be retained by the provider for a period of at least five years, except if otherwise required by law or, if any dispute arises concerning a service, until such dispute has been finally resolved.

(b) Failure to maintain all required documentation or to provide it to the department upon request may result in the disallowance and recovery by the department of any amounts paid out for which the required documentation is not maintained or provided.

(Adopted effective September 4, 2009)

Sec. 17b-262-815. Payment

The Department shall reimburse PRTFs at a negotiated per diem rate.

(Adopted effective September 4, 2009)

Sec. 17b-262-816. Audit and compliance review

All supporting accounting and business records, statistical data and all other records relating to the provision of PRTF services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of the department.

(Adopted effective September 4, 2009)

Sec. 17b-262-817—17b-262-828. Reserved

Requirements for Payment of Hospice

Sec. 17b-262-829. Scope

Sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of hospice services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective July 7, 2009)

Sec. 17b-262-830. Definitions

As used in section 17b-262-829 to section 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Advanced practice registered nurse" or "APRN" means an advanced practice registered nurse as defined in section 20-87a of the Connecticut General Statutes;

(2) "Applied income" means the amount of income that each client receiving hospice care is expected to pay each month toward the cost of care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(3) "Attending physician" means a physician who is identified by the client at the time he or she elected to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care;

(4) "Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the client's death to the client and the client's family to assist with issues related to grief, loss and adjustment;

(5) "Client" means a person eligible for goods or services under Medicaid;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Concurrent" means in the same time period covered by the care plan;

(8) "Counseling" means services, including dietary counseling, provided for the purpose of helping the client and caregivers to adjust to the client's approaching death;

(9) "Date of terminal diagnosis" means the date on which a physician first diagnoses the client as terminally ill;

(10) "Department" means the Department of Social Services or its agent;

(11) "Election period" means one of three or more periods of care a client may choose to receive the hospice benefit. The periods consist of an initial 90-day period, a subsequent 90 day period and an unlimited number of subsequent 60-day periods;

(12) "Home" means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. "Home" does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded (ICF/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(13) "Home health aide" means an individual who has completed the homemaker-home health aide services training and competency evaluation program in accordance with Sec.19-13-D69 of the Regulations of Connecticut State Agencies;

(14) "Home health care agency" means "home health care agency" as defined in section 19a-490 of the Connecticut General Statutes and licensed pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(15) "Hospice" means an agency that is primarily engaged in providing care to terminally ill individuals and meets the requirements of section 19-13-D72(b)(2) of the Regulations of Connecticut State Agencies. The hospice model of care is based on a coordinated program of home and inpatient care, employing an interdisciplinary team to meet the special needs of terminally ill individuals;

(16) "Hospice aide and homemaker" means a "hospice aide and homemaker" as defined in 42 CFR 418.76;

(17) "Hospital" means "general hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(18) "Interdisciplinary team" means a group of hospice personnel to include, but not be limited to, a physician, a registered nurse, a pharmacist, a social worker and a counselor that is responsible for providing services to meet the physical, psychosocial, spiritual and emotional needs of a terminally ill client or family members, as delineated in a specific plan of care. The interdisciplinary team is responsible for participating in the establishment of a plan of care for each client, supervising hospice services and reviewing and updating the plan of care as necessary;

(19) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(20) "Legal representative" means an individual who has been authorized under Connecticut state law to direct medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated;

(21) "Licensed practical nurse" or "LPN" means "licensed practical nurse" as defined in section 20-87a of the Connecticut General Statutes;

(22) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(23) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(24) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an

individual in attaining or maintaining an optimal level of health; to diagnose a condition; to prevent a medical condition from occurring; or to alleviate suffering through the palliation of symptoms at the end of life;

(25) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(26) "Nursing care" means the services provided by a registered nurse or a licensed practical nurse;

(27) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time, and licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies;

(28) "Occupational therapy" means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

(29) "Palliative care" means care that addresses physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice;

(30) "Physical therapy" means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

(31) "Physician" means a physician or surgeon licensed pursuant to section 20-10 or 20-12, inclusive, of the Connecticut General Statutes;

(32) "Plan of care" means a comprehensive assessment of the client's needs that identifies the types and frequency of services necessary to manage the client's discomfort and relieve the symptoms of the terminal illness as well as to identify any services necessary to meet the needs of the family that meet the requirements of 42 CFR 418.54;

(33) "Prior authorization" or "PA" means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

(34) "Provider" means a hospice that is certified by Medicare as a hospice, is licensed by the Connecticut Department of Public Health as a hospice and is enrolled with Medicaid;

(35) "Registered nurse" means "registered nurse" as defined in section 20-87a of the Connecticut General Statutes;

(36) "Social worker" means an individual licensed pursuant to section 20-195n of the Connecticut General Statutes;

(37) "Speech therapy" or "speech pathology" means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes; and

(38) "Terminally ill" means a condition in which the patient has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

(Adopted effective July 7, 2009)

Sec. 17b-262-831. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut

State Agencies, shall be certified as a provider of hospice services under the Medicare program as described in 42 CFR 418.50 through 418.100, inclusive, and shall be licensed as a hospice by the State Department of Public Health in accordance with section 19a-122b of the Connecticut General Statutes and section 19-13D72(b)(2) of Regulations of Connecticut State Agencies.

(Adopted effective July 7, 2009)

Sec. 17b-262-832. Eligibility

Payment for hospice services is provided to persons who meet all of the following conditions:

(1) the individual is eligible for Medicaid; and

(2) the individual is certified by a physician as being terminally ill.

(Adopted effective July 7, 2009)

Sec. 17b-262-833. Refusal to serve

No hospice enrolled as a Medicaid provider shall select a service area or refuse to serve any person, based on the geographical location of the service to be provided unless the hospice has a legitimate, non-discriminatory reason for its choice of service area or its refusal to serve as provided in section 17b-262-5 to 17b-262-8, inclusive, of the Regulations of Connecticut State Agencies. Providers shall designate service areas, document any refusals to serve and be subject to the sanctions in section 17b-262-9 of the Regulations of Connecticut State Agencies.

(Adopted effective July 7, 2009)

Sec. 17b-262-834. Certification of terminal illness

(a) The provider shall obtain an initial certification of the client's terminal illness jointly from the medical director of the hospice or a physician member of the hospice interdisciplinary group and the client's attending physician, if an attending physician is identified, prior to the beginning of hospice services.

(b) The initial certification shall state that the client's life expectancy is six months or less and shall include clinical information to support this medical prognosis. The initial certification is valid for the first 90 days of hospice care.

(c) At the end of the first 90-day period, a second 90-day period may be certified by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The certification shall include clinical information to support this medical prognosis;

(d) An unlimited number of 60-day periods may be certified following the first two 90-day periods by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The certification shall include clinical information to support this medical prognosis

(e) An APRN may not certify or recertify a terminally ill diagnosis.

(Adopted effective July 7, 2009)

Sec. 17b-262-835. Plan of care

(a) The interdisciplinary team in conjunction with the attending physician shall establish an initial written plan of care for each client within 48 hours of the client's election of hospice. Services may not be billed until the plan is established.

(b) The interdisciplinary team, in collaboration with the individual's attending physician, if any, must review, revise and document the individualized plan as frequently as the client's condition requires, but no less frequently than every 14 calendar days.

(c) The plan of care shall specify the care and services necessary to meet the client's and family's needs identified in the comprehensive assessment.

(Adopted effective July 7, 2009)

Sec. 17b-262-836. Election of hospice

(a) A client who meets the eligibility requirement of 42 CFR 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her legal representative may file the election statement. The election statement must indicate;

(1) that the individual is electing a hospice benefit and identify which hospice he has chosen;

(2) the effective date of the election;

(3) that the individual understands that hospice services are palliative rather than curative and waives all rights to Medicaid payment for services to cure the terminal illness and related condition. Medicaid shall continue to pay for covered benefits that are not related to the terminal illness; and

(4) that the individual is eligible to receive hospice services only through the provider he has designated.

(b) The election statement shall include the following information:

(1) name of client;

(2) address and telephone number of client;

(3) client's Medicaid number and Medicare number, if applicable;

(4) primary terminal diagnosis;

(5) client's date of birth;

(6) name of parent, guardian or legal representative, if applicable;

(7) sex of client;

(8) name, telephone number and Medicaid number of provider;

(9) name and Medicaid number of attending physician;

(10) date of physician's certification of terminal illness;

(11) date the diagnosis is terminal; and

(12) name and Medicaid number of the nursing facility or ICF/MR, if applicable.

(c) A client may revoke election of hospice services at any time during the election period by signing and dating a statement to this effect. The revocation shall be in writing and shall not be retroactive. When a client revokes the hospice benefit, he resumes coverage for any

services waived when he elected hospice. The client may re-elect hospice at any time for the next 60 or 90 day election period.

(d) A client may change hospice agencies once during any election period by signing and dating a statement to this effect.

(e) A client who is eligible for Medicare in addition to Medicaid shall elect the hospice benefit in both the Medicare and Medicaid programs simultaneously.

(Adopted effective July 7, 2009)

Sec. 17b-262-837. Discharge from hospice

(a) The provider may discharge a client if:

(1) the client moves out of the provider's service area or transfers to another hospice;

(2) the client is no longer terminally ill;

(3) the client revokes the hospice benefit;

(4) the client dies; or

(5) the provider determines that there is just cause because the client or other person living with the client is disruptive, abusive or uncooperative to the extent that delivery of care to the client or the ability of the hospice to operate effectively is seriously impaired. A discharge for just cause shall meet the criteria and follow the process described in 42 CFR 418.26(a)(3).

(b) No client shall be discharged for just cause or if he or she is considered no longer terminally ill without a review by the department. When the hospice advises the client that discharge is being considered either for good cause or because the physician believes the client is no longer terminally ill, a copy of that written communication shall be sent to the department and the attending physician.

(c) The hospice shall obtain a written physician discharge order consistent with 42 CFR 418(b) before discharging a client for any reason other than death.

(d) Upon discharge the client is no longer covered for hospice care for that election period and resumes the Medicaid benefit that had been waived unless the client is immediately transferred to another hospice. As long as the client is still eligible, he or she may re-elect the hospice benefit immediately and by so doing shall enter the next election period.

(e) The provider shall have a discharge planning process in place that is consistent with 42 CFR 418.26(d).

(Adopted effective July 7, 2009)

Sec. 17b-262-838. Services covered

(a) The following documents shall be in place prior to the provision of hospice services:

(1) certification of terminal illness for the applicable election period. The certification may be in writing, electronically transmitted or verbal. A facsimile is acceptable provided the original is available on request. Verbal orders are acceptable provided a written order is received within 48 hours of the verbal order.

(2) a statement signed by the client or his or her legal representative electing the hospice benefit; and

(3) an initial plan of care within 48 hours following election of the hospice benefit.

(b) Subject to the limitations and exclusions identified in sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay an all-inclusive per diem rate to the provider for each Medicaid client. This rate represents payment for the provision of the following goods and services:

(1) Physician services to include: the general supervisory duties of the medical director, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care and establishment of governing policies by the interdisciplinary group;

(2) nursing service provided by or under the supervision of a registered nurse;

(3) home health aide and hospice aide and homemaker services under the supervision of a registered nurse, as ordered by the physician-led interdisciplinary group;

(4) physical therapy, occupational therapy and speech-language pathology to control symptoms or to enable the client to maintain activities of daily living and basic functional skills;

(5) medical equipment, supplies, biologicals and appliances that are a part of the written plan of care and not included in the payment to facilities for room & board;

(6) drugs which are used primarily for the relief of pain and symptom control related to the client's terminal illness and that are included in the provider's formulary, subject to review and approval by the department;

(7) social work services based on the client's psychosocial assessment and the client's and family's needs and acceptance of these services;

(8) dietary counseling, when identified in the plan of care and performed by a qualified individual, including dietitians as well as nutritionists and registered nurses, who are able to address and assure that the dietary needs of the client are met;

(9) spiritual counseling in accordance with the client's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires;

(10) bereavement, grief and loss counseling, to reflect the needs of the bereaved;

(11) short term care inpatient care according to 42 CFR 418.108 for pain control and symptom management;

(12) respite care;

(13) supervision of volunteers; and

(14) any covered medically necessary and reasonable services related to the terminal illness as identified by the interdisciplinary team.

(c) The professional component of physician and APRN services reasonable and necessary for the treatment and management of the hospice client's terminal illness not described in subsection (b)(1) of this section shall be paid in addition to the per diem amount according to the department's fee schedule for physician services.

(d) Hospice services are provided at one of the following four levels of care:

(1) Routine home care is furnished to a client who is at home, in a nursing facility, or ICF/MR; is under the care of a hospice; and is not receiving continuous care.

(2) Continuous home care is furnished during brief periods of crisis as described in 42 CFR 418.204(a) in order to maintain a client at home. A minimum of eight hours of care, of which at least half is direct licensed nursing care, shall be provided in a 24-hour period to qualify for continuous home care to be billed on a hourly basis. The care does not need to be provided in successive blocks of time so long as a need for an aggregate of eight hours is required in a 24-hour period. All direct service hours shall be clearly documented. Services provided by other disciplines, such as social workers or counselors, are expected during periods of crisis but are not counted towards the total hours of continuous care. In addition, documentation of care, modification of the plan of care and supervision of home health aides by a nurse shall not qualify as direct client care.

(3) General inpatient care is furnished in an inpatient facility that meets the requirements in 42 CFR 418.108 when pain control or acute or chronic symptom management cannot be managed in other settings.

(4) Respite care is furnished for each day the client is in an approved inpatient facility in order to give the caregiver a rest. It is available for a maximum of five days in a 60-day period.

(e) The department shall pay a nursing facility or ICF/MR to hold the bed of a client who is hospitalized when the requirements of section 19a-537 of the Connecticut General Statutes are met.

(f) The provider shall routinely provide all nursing services, medical social work services and counseling. The provider may contract for physician services and the services of other personnel consistent with the requirements of 42 CFR 418.64.

(Adopted effective July 7, 2009)

Sec. 17b-262-839. Coordination of hospice and waiver services

(a) For clients who receive waiver services prior to electing the hospice benefit under Medicaid, waiver services shall continue to be available.

(b) It is the responsibility of hospice to develop a plan of care that coordinates the hospice and waiver services. It is the responsibility of the hospice to initiate coordination with the waiver program case manager so that the client receives all of the care and services necessary. The waiver program's case manger is responsible for adjusting the waiver services so there is no duplication of services provider by the hospice or the waiver. These objectives should be accomplished according to the following principles:

(1) The best interest of the client is the key consideration. In circumstances when the hospice and waiver program case managers cannot agree on what is best for the client they shall ask the department for assistance in this determination.

(2) Each program shall provide services consistent with the goals of their respective programs. The goal of hospice care is to keep the client as comfortable as possible while maintaining his or her dignity and quality of life; the goal of the waiver program is to keep

clients out of institutions.

(3) Services related to the terminal diagnosis are the responsibility of the hospice.

(4) Services provided prior to the date of terminal diagnosis are generally considered to be unrelated to the terminal diagnosis.

(5) Services unrelated to the terminal diagnosis may be billed in addition to the hospice reimbursement by the provider rendering the service.

(6) For the purpose of developing a plan of care, the presumption is that waiver services provided prior to the date of the terminal diagnosis should continue to be provided as waiver services. It is presumed that services initiated after the date of the terminal diagnosis are the responsibility of the hospice although this is subject to review and reconsideration by the hospice as approved by the department.

(Adopted effective July 7, 2009)

Sec. 17b-262-840. Volunteers

The provider shall maintain a volunteer program consistent with 42 CFR 418.78.

(Adopted effective July 7, 2009)

Sec. 17b-262-841. Service limitations

(a) The department shall pay only for services listed in its fee schedule.

(b) the department shall not pay separately for any services that are related to the treatment of the terminal condition for which hospice services were elected.

(c) Hospice services are covered in a nursing facility only if the nursing facility has a written agreement with the provider such that the provider takes full responsibility for the professional management of the client's hospice care and the nursing facility agrees to provide room and board to the client. The agreement shall meet the requirements of 42 CFR 418.112.

(d) For a client eligible for both Medicare and Medicaid, the only service payable by Medicaid is the room and board charge for a client in a nursing facility. Room and board means the facility's per diem rate that includes the services described in section 17b-262-705 of the Regulations of Connecticut State Agencies.

(e) The department shall pay for only one level of care on any day.

(f) Respite care is not available for a client who resides in a nursing facility, hospital or ICF/MR.

(g) Bereavement counseling shall be available for the family for up to 13 months following the client's death but is not separately reimbursable.

(h) Home health agency services are not covered unless they are unrelated to the terminal illness and prior authorized by the department.

(Adopted effective July 7, 2009)

Sec. 17b-262-842. Services not covered

(a) When a client elects the hospice benefit, the client waives his or her right to receive

the following services under Medicaid:

(1) treatment intended to cure the terminal illness;

(2) treatment related to the terminal illness except for the treatment provided by the designated hospice;

(3) hospice services provided by a provider other than the one designated by the client on the hospice form submitted to the department. However, the provider may subcontract with another hospice for services as described is section. 17b-262-838(f); and

(4) any services that are duplicative of any service provided by the hospice provider with the exception of services of the client's attending physician.

(b) In order for charges to be billed separately, the provider shall first demonstrate that the service is not related to the terminal illness.

(c) The department shall not pay for services that are not medically necessary and medically appropriate.

(Adopted effective July 7, 2009)

Sec. 17b-262-843. Prior authorization

(a) Prior authorization, on forms and in the manner specified by the department shall be required for:

(1) general inpatient days beyond the fifth day; and

(2) any service which the department indicates on its fee schedule requires prior authorization.

(b) The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective July 7, 2009)

Sec. 17b-262-844. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department, in a form and manner as specified by the department and shall include all information required by the department to process the claim for payment.

(b) The provider is responsible for:

(1) completing any admission and discharge forms consistent with the department's instructions; and

(2) exhausting other payment sources of which the provider is aware before billing the department.

(Adopted effective July 7, 2009)

Sec. 17b-262-845. Payment

(a) The Commissioner shall establish fees that are consistent with section 1902(a)(13)(B) of the Social Security Act.

(b) the Commissioner may increase any fee payable to a hospice upon the application of such an agency evidencing extraordinary costs related to providing escort services. In no case shall any rate or fee exceed the charge to the general public for similar services.

(c) The department shall reimburse the provider at the per diem rate for the appropriate level of care.

(d) The department shall reimburse a provider when all of the requirements of sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies have been met.

(e) The fee for routine, inpatient or respite services represents the per diem reimbursement for the client and is payment for all services provided by the provider on that day. Only one level of care may be billed on any day.

(f) The fee for continuous hospice care is paid on an hourly basis. A minimum of eight hours must be medically necessary in a 24-hour period to qualify for continuous hospice care.

(g) The department shall pay the fee for the routine, inpatient or respite level of care for each day the client is within an election period, regardless of the volume or intensity of services provided on that day.

(h) The department shall pay the same fee for border providers as for in-state providers.

(i) When a client who has elected hospice resides in a nursing facility or ICF/MR, the department shall make a payment equal to the department's rate for the nursing facility or ICF/MR. This payment represents payment for room and board services and is payable to the provider. It is the responsibility of the provider to reimburse the nursing facility or ICF/MR for room and board expenses. Applied income shall be deducted from the room and board payment.

(Adopted effective July 7, 2009)

Sec. 17b-262-846. Payment limitations

(a) It is expected that the provider shall provide bereavement counseling to the client's family after the client's death; however the department shall not pay the provider for such bereavement counseling.

(b) For a twelve month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both general inpatient and respite, shall not exceed twenty percent of the aggregate number of days of hospice care provided to all hospice clients during that same period. At the department's discretion, the days of inpatient care provided to individuals with AIDS may be excluded from the days counted toward the twenty percent limitation.

(c) Payment for inpatient care is limited as follows:

(1) The total payment to the provider for inpatient care, general and respite, is subject to a limitation that total inpatient care days for Medicaid clients not exceed 20 percent of the total days for which these clients had elected hospice care.

(2) At the end of a twelve-month period specified in subsection (b) of this section, the

department calculates a limitation on payment for inpatient care to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid clients. Payments to nursing facilities and ICF/MRs where Medicaid is the secondary payer to Medicare shall be excluded from the calculation.

(3) If the number of days of inpatient care furnished to Medicaid clients is equal to or less than 20 percent of the total days of hospice care to Medicaid clients, no adjustment is necessary. Overall payments to a provider are subject to the cap amount specified in 42 CFR 418.309. Any provider that has received an exemption as specified in 42 CFR 418.108(e) shall be exempt from this provision.

(4) If the number of days of inpatient care furnished to Medicaid clients exceeds 20 percent of the total days of hospice care to Medicaid clients, the total payment for inpatient care is determined in accordance with subsection (c)(5) of this section. That amount is compared to actual payments for inpatient care and any excess reimbursement shall be refunded by the provider or recouped from subsequent claims. Overall payments to the provider are subject to the cap amount specified in 42 CFR 418.309.

(5) If a provider exceeds the number of inpatient care days described in subsection (c)(4) of this section, the total payment for inpatient care is determined as follows:

(A) calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the provider to Medicaid clients;

(B) multiply this ratio by the total reimbursement for inpatient care made by the department;

(C) multiply the number of actual inpatient days in excess of the limitation by the routine home care rate;

(D) add the amounts calculated in subsections (c)(5)(B) and (C) of this section.

(E) compare the amount in section 5(D) of this section with the total reimbursement to the hospice provider for inpatient care during that period. The amount that total reimbursement to the hospice exceeds the amount calculated in section 5(D) of this section is the amount due from the hospice provider.

(d) Applied income shall be calculated and deducted from the department's payment to the provider for a client living in a nursing facility or a hospice facility as follows:

(1) Clients who receive hospice services while residing in a hospice facility or in a nursing facility pursuant to a room and board arrangement with a hospice are responsible for paying applied income to the hospice provider.

(2) The department shall calculate the applied income liability and shall inform the client and the provider of the amount that the client is required to contribute towards the cost of care each month. The client's applied income liability shall be deducted from the amount that the department would otherwise pay to the hospice provider each month.

(3) The provider and the nursing facility may assign responsibility for collecting the client's applied income and may assign the risk of loss for nonpayment in their agreement, depending on the result of their negotiations. In no event shall the department be liable to

a hospice or to a nursing facility in the event that a client fails to pay his or her applied income obligation.

(4) The provider shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(5) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the hospice multiplied by the per diem rate.

(6) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(e) A nursing facility that enters into an agreement with a hospice to provide room and board services for clients shall accept the amount paid by the hospice, if any, pursuant to the contractual agreement between the hospice and the nursing facility as payment in full. In no event may a nursing facility assert a claim against a client, or against the department, in the event that the hospice fails to pay the nursing facility in accordance with their agreement, except that a nursing facility may assert a claim against a client for nonpayment of the client's applied income amount only when the agreement between the hospice and the nursing facility assigns responsibility for collecting the client's applied income liability to the nursing facility.

(Adopted effective July 7, 2009)

Sec. 17b-262-847. Review process

(a) a client or client representative may request a review with the hospice whenever a requested good or service is denied.

(b) **Review Process:**

(1) The hospice shall have a timely and organized review process. The review process shall be available whenever:

(A) the hospice denies a requested good or service; or

(B) the hospice fails to respond to a client's request for goods and services within five working days of such request.

(2) The results of the review shall be in writing and shall include a brief statement of the reasons for the decision and shall state that the client may request review by the department and how to obtain such review.

(3) The hospice's review process shall allow for an expedited review within one business day when the standard time frames for determining a review could jeopardize the comfort of the client.

(c) **Department review:**

(1) A client who is denied a good or service by the hospice provider may request a review by the department in accordance with the following procedures:

(A) The client shall file a written or verbal request for a review within fifteen days from

the date of the hospice denial of the good or service.

(B) The request shall state the reasons the client believes he or she should receive the goods or services and include any additional documentation in support of his or her case.

(C) Within five days of the request, the department shall make a finding based on an evaluation of the evidence submitted and shall notify the client in writing.

(2) If the standard timeframe for the department's review could jeopardize the comfort of the client, an expedited review shall be completed by the department within one business day of the request.

(Adopted effective July 7, 2009)

Sec. 17b-262-848. Documentation

(a) All required documentation shall be maintained for at least five years, or longer, by the provider in accordance with statute or regulation, subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(b) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request.

(c) The following information shall be documented in writing or electronically, consistent with the requirements described in the Provider Enrollment Agreement and maintained on file with the provider for each Medicaid client:

(1) signed and dated physician orders;

(2) initial and subsequent plans of care signed and dated by the licensed practitioner or interdisciplinary team;

(3) Medicaid identification number;

(4) pertinent diagnostic information;

(5) documentation of each service provided and its duration;

(6) dates of services provided;

(7) all election forms signed by the client indicating that he has elected the hospice benefit and which hospice he has elected to provide services;

(8) the initial certification of terminal illness signed by the attending physician and the medical director of the hospice;

(9) subsequent certifications of terminal illness signed by the medical director of the hospice or the physician member of the interdisciplinary team;

(10) forms signed and dated by the client indicating any change in the designation of the hospice, if applicable; and

(11) revocation statements signed and dated by the client, if applicable.

(d) All clinical records shall be maintained in accordance with 42 CFR 418.104.

(e) Each provider shall maintain fiscal and medical records that fully disclose services

and goods rendered or delivered to Medicaid clients.

(f) Providers shall maintain documentation supporting all prior authorization requests.

(Adopted effective July 7, 2009)

Requirements for Payment of Rehabilitation Services for Individuals Under Age 21 with Behavioral Health Disorders

Sec. 17b-262-849. Scope

Sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for Medicaid coverage of rehabilitation services for individuals with behavioral health conditions who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Effective February 2, 2012)

Sec. 17b-262-850. Definitions

As used in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Admission" means an individual's initial participation in a rehabilitation services program;

(2) "Allied health professional" or "AHP" means:

(A) a licensed or certified practitioner performing within his or her scope of practice in any of the professional and occupational license or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes; or

(B) a license or certification-eligible individual whose education, training, skills and experience satisfy the criteria for any of the professional and occupational licensure or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes;

(3) "Authorization" means the approval of payment for services or goods by the department;

(4) "Behavioral health condition" means one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, but excludes mental retardation, dementia and conditions designated with V codes;

(5) "Behavioral health services" means health care that is necessary to diagnose, correct or diminish the adverse effects of a behavioral health condition;

(6) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(7) "Complex behavioral health service needs" means behavioral health needs that require specialized, coordinated behavioral health services across several service systems; for example, school, mental health and court;

(8) "DCF" means the Department of Children and Families or its agent;

(9) "Department" or "DSS" means the Department of Social Services or its agent;

(10) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT services" means the services provided in accordance with the requirements of 42 USC 1396a(a)(43), 42 USC 1396d (r) and 42 USC 1396d(a)(4)(B) and implementing federal regulations found in 42 CFR 441, Subpart B and section 17b-261(i) of the Connecticut General Statutes;

(11) "Emergency" means a psychiatric or substance abuse condition manifesting itself by acute symptoms of sufficient severity, including severe distress, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate psychiatric attention may result in placing the health of the individual in serious jeopardy due to harm to self, harm to others or grave disability;

(12) "Emergency Mobile Psychiatric Services" or "EMPS" means rehabilitation services provided by a DCF-certified provider of such services in the home or other community setting to an individual in response to a psychiatric or substance abuse related crisis in order to reduce disability, restore functioning and achieve full community integration and recovery;

(13) "Extended day treatment program" or "EDT" means "extended day treatment" as defined in section 17a-147-1 of the Regulations of Connecticut State Agencies;

(14) "Home and community-based rehabilitation services" means services provided by a DCF-certified provider of such services in the home or other community setting to an individual with psychiatric or substance abuse needs in order to reduce disability, restore functioning and achieve full community integration and recovery. Services may be provided in settings appropriate to the achievement of the rehabilitation goals and objectives, and as mutually agreed upon with the child and family. For example, service locations may include a local neighborhood community center, police substation, social service office or any other public or private community setting;

(15) "Individual" means a Medicaid-eligible person under age 21 who receives covered rehabilitation services in accordance with sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies;

(16) "Licensed clinician" means:

(A) a doctor of medicine or osteopathy who is licensed under chapter 370 of the Connecticut General Statutes;

(B) a psychologist who is licensed under chapter 383 of the Connecticut General Statues;

(C) a marital and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;

(D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;

(F) a registered nurse who is licensed under chapter 378 of the Connecticut General

Statutes and who has a minimum of one year of experience in the mental health field;

(G) a professional counselor who is licensed under chapter 383c of the Connecticut General Statutes; or

(H) an alcohol and drug counselor who is licensed under chapter 376b of the Connecticut General Statutes;

(17) "Medicaid program" means the program operated by DSS pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(18) "Medical necessity" or "medically necessary" has the same meaning as defined in section 17b-259b of the Connecticut General Statutes;

(19) "Office-based, off-site rehabilitation services" means services provided by a DCF-licensed outpatient psychiatric clinic operating within its scope of practice to an individual in a primary care, school or office setting other than a primary or satellite office as provided for on the clinic's license;

(20) "Prior authorization" means approval for the provision of service from the department before the provider actually provides the service;

(21) "Provider" means a person, entity or organization that meets the requirements for participation specified in section 17b-262-851 of the Regulations of Connecticut State Agencies as a DCF-licensed or DCF-certified entity that provides office-based, off-site rehabilitation services, extended day treatment, emergency mobile psychiatric services or home and community-based rehabilitation services and participates in the Medicaid program as a qualified provider of rehabilitation services as evidenced by an executed provider agreement with the department;

(22) "Provider agreement" means the signed, written contractual agreement between the department and the provider;

(23) "Provider network" means the providers enrolled or contracted with the department;

(24) "Quality management" means the process of reviewing, measuring and continually improving the processes and outcomes of care delivered;

(25) "Registration" means the process of notifying the department of the initiation or continuation of a behavioral health service that includes information regarding the evaluation findings and plan of treatment. Registration may serve in lieu of authorization if a service is designated by the department as requiring registration only;

(26) "Rehabilitation plan" means a written individualized plan of care developed by the performing provider in accordance with the applicable licensing requirements and section 17b-262-851(7) of the Regulations of Connecticut State Agencies;

(27) "Rehabilitation services" means those services identified in section 17b-262-854 of the Regulations of Connecticut State Agencies when provided by a qualified provider to an individual with a behavioral health condition;

(28) "Trainee" means a person enrolled in an educational program or acquiring the supervisory experience necessary to obtain licensure or certification in any of the professional and occupational license or certification categories pertaining to behavioral

health covered in Title 20 of the Connecticut General Statutes;

(29) "Under the direct supervision" means that a licensed clinician operating within his or her scope of practice provides periodic supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitation services performed by the unlicensed staff; and

(30) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity of the allocation of health care resources and services given, or proposed to be given, to an individual.

(Effective February 2, 2012)

Sec. 17b-262-851. Provider participation

In order to participate in the Medicaid program and provide rehabilitation services that are eligible for Medicaid reimbursement from the department, the provider shall:

(1) Enroll with the department and have on file a valid provider agreement;

(2) be licensed by DCF as an Outpatient Psychiatric Clinic for Children, as defined in section 17a-20-11 of the Regulations of Connecticut State Agencies, if providing office-based off-site rehabilitation services;

(3) be licensed by DCF as an extended day treatment program under section 17a-147-1 to 17a-147-36, inclusive, of the Regulations of Connecticut State Agencies, if providing extended day treatment program services;

(4) comply with any applicable DCF certification requirements necessary to be qualified to provide home and community-based rehabilitation services or emergency mobile psychiatric services;

(5) comply with all Medicaid record keeping, documentation and other requirements including, but not limited to, those delineated in the department's administrative manuals, provider agreements and memoranda of understanding;

(6) comply with all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to reimbursement for rehabilitation services;

(7) except as noted below in subdivision (G) of this subsection, develop a written rehabilitation plan for each individual in accordance with section 17a-20-42 of the Regulations of Connecticut State Agencies not later than thirty days after the individual's admission to the program. This rehabilitation plan requirement applies to all providers of Medicaid-funded rehabilitation services for individuals, not just DCF psychiatric clinics, which are the specific subject of section 17a-20-42 of the Regulations of Connecticut State Agencies. Such plan shall be developed by the provider, with input from the individual, the individual's family or the individual's legal representative and shall:

(A) Specify the behavioral health disorder to be addressed;

(B) specify reasonable, individualized behavioral health goals and objectives based on each individual's behavioral health diagnosis and diagnostic and functional evaluation and be targeted toward the reduction of an individual's behavioral health symptoms, restoration of functioning and recovery;

(C) identify the type, amount, frequency and duration of services to be provided;

(D) document that the services provided have been determined to be rehabilitation services consistent with section 17b-262-854 of the Regulations of Connecticut State Agencies;

(E) ensure the active participation of the individual and his or her family or the legal representative of the individual;

(F) contain a timeline, based upon the individual's assessed and anticipated needs, for reevaluation of the plan, which should occur not later than one year after the date of the prior plan; and

(G) providers of EMPS to individuals are not required to develop an individualized rehabilitation plan that meets the requirements of section 17a-20-42 of the Regulations of Connecticut State Agencies unless the services are provided for a period of more than 45 days. The Statewide Uniform Crisis Plan shall serve as the rehabilitation plan for the EMPS until an individual rehabilitation plan for EMPS is developed;

(8) ensure that a licensed clinician operating within his or her scope of practice and employed by or under contract with the provider reviews and signs the individual rehabilitation plan. The first review and signature shall occur not later than thirty days after admission;

(9) ensure that rehabilitation plans are reassessed by a licensed clinician at 90-day intervals, as well as when a significant change in condition or diagnosis occurs. Reassessed rehabilitation plans shall be reviewed and signed by the supervising licensed clinician;

(10) keep current service and progress notes in a permanent case record for each client in accordance with section 17a-20-54 of the Regulations of Connecticut State Agencies;

(11) cooperate with the department in the rate-setting process including, but not limited to, licensing or any quality assurance reviews or periodic audits to ensure compliance with rehabilitation service requirements defined in section 17b-262-849 to section 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies;

(12) provide an initial orientation, training and periodic supervision to direct service staff responsible for the provision of rehabilitation services;

(13) conduct ongoing assessment and service planning;

(14) ensure that the program director is a licensed clinician operating within his or her scope of practice and has a minimum of three years of experience in a behavioral-health-services-related position;

(15) ensure that the program director, or the program director's designee who shall be a licensed clinician, is accessible after hours, by telephone or pager, to staff on duty;

(16) ensure that direct service staff of providers of office-based off-site rehabilitation services are physicians, allied health professionals or trainees;

(17) ensure that direct service staff of providers of extended day treatment meet the minimum requirements established in sections 17a-147-1 to 17a-147-36, inclusive, of the Regulations of Connecticut State Agencies;

(18) ensure that direct service staff of providers of home and community-based

rehabilitation services and EMPS are physicians, allied health professionals or trainees or persons who hold either a bachelor's degree in a behavioral-health-related specialty or have two years of experience in the provision of behavioral health services, provided such individuals meet the minimum requirements of any applicable certification authority;

(19) ensure that all unlicensed staff work under the direct supervision of licensed clinical staff; and

(20) ensure that direct service staff of providers of home and community-based rehabilitation services and EMPS are accessible to clients after hours, whether face-to-face or by telephone.

(Effective February 2, 2012)

Sec. 17b-262-852. Eligibility

Medicaid coverage for the cost of rehabilitation services is available for individuals with behavioral health conditions when the service is medically necessary and is provided by a provider to an individual with a behavioral health condition, subject to all of the qualifications, conditions and limitations contained in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies.

(Effective February 2, 2012)

Sec. 17b-262-853. Need for services

Payment for rehabilitation services shall be made by the department only if all of the following conditions are met:

(1) Medicaid payment for rehabilitation services may be made only to the extent that a covered rehabilitation service is provided by a qualified participating provider of such services and the service is medically necessary for the client. Where a service is subject to prior authorization requirements in accordance with section 17b-262-855 or 17b-262-857 of the Regulations of Connecticut State Agencies, eligibility for Medicaid payment is conditioned upon compliance with such requirements. Furthermore, all Medicaid payments, including payments for services that are prior authorized or for which registration is required, are subject to record keeping and post-payment review and audit requirements, and are subject to subsequent recoupment if it is subsequently determined that the service was not medically necessary or if record keeping or other requirements for payment are not satisfied;

(2) For no more than thirty days after an individual's admission, rehabilitation services shall be provided in accordance with an initial assessment of need that is signed by a licensed clinician operating within his or her scope of practice. This assessment shall, for no more than thirty days after an individual's admission, be utilized as the individual's rehabilitation plan;

(3) Not later than thirty days after an individual's admission, the rehabilitation services shall be provided in accordance with the rehabilitation plan developed in accordance with section 17a-20-42 of the Regulations of Connecticut State Agencies. The rehabilitation plan

shall include a progress note that describes the services that the individual has received to date; the individual's overall response; the individual's specific progress toward the goals and objectives listed in the rehabilitation plan and justification of the need for continued treatment. The progress note shall include discussion of any variance between the services listed on the rehabilitation plan and the services actually delivered. The progress note shall also include discussion of suggested changes, if any, to the rehabilitation plan. The rehabilitation plan shall be reviewed and signed by the licensed clinician employed by or under contract with the provider at least every ninety days thereafter; and

(4) The individual is sufficiently stable to be able to function outside of a twenty-four hour medically managed setting and participate in community-based treatment services.

(Effective February 2, 2012)

Sec. 17b-262-854. Covered services

(a) Rehabilitation services shall be recommended by a physician or other licensed clinician operating within his or her scope of practice.

(b) Rehabilitation services are services designed to assist individuals in reaching an achievable level of independent functioning.

(c) Rehabilitation services include office-based off-site rehabilitation services, home and community-based rehabilitation services and EMPS when provided by a qualified and enrolled provider of such services.

(d) Depending upon the particular needs of each individual and the rehabilitation plan, office-based off-site services may include any of the routine outpatient services listed on the department's fee schedule for behavioral health clinics.

(e) Depending upon the particular needs of each individual and the rehabilitation plan, home and community-based rehabilitation services, extended day treatment program services and EMPS may include the following components:

(1) Intake and assessment, which means assessing and reassessing the individual's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the individual, the individual's family and through consultation with other professionals;

(2) development of an individual rehabilitation plan in accordance with sections 17b-262-851(7) and 17b-262-858 of the Regulations of Connecticut State Agencies;

(3) individual and group psychotherapy or counseling;

(4) family therapy or training;

(5) socialization skills development, which means individual-centered skill development activities that are provided to support the goals and objectives in the rehabilitation plan and that are directed at reducing individuals' psychiatric and substance abuse symptoms, restoring individuals to an achievable functioning level;

(6) behavior modification or management training and intervention;

(7) supportive counseling directed at solving daily problems related to community living and interpersonal relationships;

(8) psycho-educational services pertaining to the alleviation and management of psychiatric or substance abuse disorders;

(9) teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem solving;

(10) therapeutic recreation and other skill development activities directed at reducing disability; restoring individual functioning and achieving independent participation in social, interpersonal or community activities and full community reintegration and independence as identified in the rehabilitation plan;

(11) support with connecting individuals to natural community supports;

(12) orientation to, and assistance with, accessing self-help and advocacy resources;

(13) development of self-advocacy skills;

(14) health education;

(15) teaching of recovery skills in order to prevent relapse;

(16) crisis response services, either face-to-face or telephonic only, when provided as part of a home and community-based rehabilitation service; and

(17) consultation for persons responsible for the development of healthy social relationships and the promotion of successful interpersonal and community experiences.

(Effective February 2, 2012)

Sec. 17b-262-855. Coverage limitations

(a) Coverage of services shall be subject to the following limitations:

(1) Services that do not meet medical necessity requirements or any applicable authorization or certification requirements are not eligible for Medicaid payment.

(2) Services shall be based on the rehabilitation plan developed pursuant to section 17b-262-851(7) of the Regulations of Connecticut State Agencies and the requirements of sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies, and shall be performed by or under the supervision of a licensed clinician employed by or under contract with the provider.

(3) Home and community-based services and EMPS may be provided in a facility, home, hospital or other setting, except as follows:

(A) When an individual resides in a facility or institution, the services may not duplicate services included in the facility's or institution's rate; or

(B) if the provider operates a clinic or practice for the provision of outpatient services, no more than 10 visits may be provided at the site of the outpatient clinic or practice per individual per episode of care, other than the initial assessment, which may occur off-site. The services rendered under this exception are considered reimbursable services only if the services rendered are part of a rehabilitation plan.

(4) EDT programs shall meet the following requirements:

(A) Provide time-limited, active services within a clinic or off-site community setting;

(B) employ an integrated, comprehensive and complementary schedule of treatment approaches;

(C) serve individuals with significant functional impairments resulting from a behavioral health condition in order to avert hospitalization or increase the client's level of independent functioning;

(D) provide an adult escort to support the transportation of individuals under 16 years of age, transported by a Medicaid non-emergency medical transportation provider, unless the parent or guardian of the individual between the ages of 12 to 15 years consents, in writing, to transportation of the individual to the EDT program without an escort; and

(E) provide a minimum of three hours of scheduled, documented programming of which at least two and one half hours are services.

(5) Services may be provided indirectly through counseling of parents, other family members or other persons responsible for the care of the individual, regardless of the Medicaid eligibility of these persons, only to the extent that the provision of such indirect treatment service is necessary and is intended to primarily benefit the individual.

(6) The department shall not pay for the following:

(A) Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;

(B) programs, services or components of services that do not relate to the individual's diagnosis, symptoms, functional limitations or medical history;

(C) programs, services or components of services that are not included in the fee established by the department;

(D) programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms;

(E) programs, services or components of services provided solely for social or recreational purposes not in compliance with section 17b-262-854(e)(5) or 17b-262-854(e)(10) of the Regulations of Connecticut State Agencies;

(F) time spent by the provider solely for the purpose of transporting clients;

(G) services that are solely educational or vocational;

(H) costs associated with room and board for individuals; and

(I) services that are provided out-of-state unless the services are not available within Connecticut.

(b) Notwithstanding subparagraph (a)(3)(B) of this section, services that are provided at the primary or satellite site of a DCF-licensed clinic, as indicated on the clinic's license, do not qualify as rehabilitation services and may be reimbursed by the Medicaid program only to the extent that such services otherwise qualify for Medicaid reimbursement, for example, as covered clinic services.

(Effective February 2, 2012)

Sec. 17b-262-856. Non-billable activities

The following activities are not billable:

(1) Telephone contact with the department for the purpose of requesting or reviewing authorization;

(2) documentation of progress notes or billing documentation;

(3) individual or group supervision, routine case reviews and rounds; ad hoc consultation with supervisors; and discussion or consultation among participants of the rehabilitation team, including those conducted for the purpose of treatment planning;

(4) travel to an appointment with an individual or family; travel to and from collateral appointments (e.g. school planning meeting, court appearance); or transportation of the individual to or from meetings or appointments, unless the provider is also engaged in an activity that otherwise qualifies as a service;

(5) time on-call that does not otherwise qualify as a rehabilitation service;

(6) time spent performing routine services, such as cleaning, cooking, shopping or child care designed to provide relief or respite for the family;

(7) time spent waiting for individuals at their homes when they have a scheduled appointment and the individual has not arrived;

(8) no shows, missed or cancelled appointments;

(9) services of less than eight minutes duration for rehabilitation procedures whose billing codes are defined in 15-minute increments; and

(10) time spent engaged in activities required by a credentialing or oversight entity such as gathering and submitting care plan or service data or other information.

(Effective February 2, 2012)

Sec. 17b-262-857. Authorization

(1) Services are subject to prior authorization or registration requirements to the extent required by this section. Where a service is subject to authorization or registration requirements, Medicaid payment for such service is not available unless the provider complies with such requirements.

(2) Services that require authorization or registration will be designated as such on the provider's fee schedule or authorization and registration schedule published at www.ctdssmap.com.

(3) The following requirements shall apply to all services that require authorization or registration under subdivision (1) or (2) of this subsection:

(A) The initial authorization or registration period shall be based on the needs of the individual.

(B) If authorization or registration is needed beyond the initial or current authorization period, such requests for continued treatment shall be submitted prior to the end of the current authorization period.

(C) Except in emergency situations or for the purpose of initial assessment, providers shall obtain authorization or shall register, as appropriate, before services are rendered.

(D) In order to receive payment from the department, a provider shall comply with all prior authorization and registration requirements. The department or its agent in its sole

discretion determines what information is necessary in order for a provider to register or to approve a prior authorization request. Registration or prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(E) A provider shall present medical or social information adequate for evaluating medical necessity when registering or requesting authorization. The provider shall maintain documentation adequate to support requests for authorization and registration including, but not limited to, medical or social information adequate for evaluating medical necessity.

(F) Registration or requests for authorization for the continuation of services shall include the progress made to date with respect to established treatment goals, the future gains expected from additional treatment and medical or social information adequate for evaluating medical necessity.

(G) The provider shall maintain documentation adequate to support registration or requests for continued authorization including, but not limited to, progress made to date with respect to established treatment goals, the future gains expected from additional treatment, and medical or social information adequate for evaluating medical necessity.

(H) The department may require a review of the discharge plan and actions taken to support the successful implementation of the discharge plan as a condition of registration or authorization.

(I) A provider may register or request authorization from the department after a service has been provided for individuals who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service.

(J) For individuals who are granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall be responsible for initiating this review to enable registration or authorization and payment for services.

(K) The department may deny authorization or registration based on non-compliance by the provider with utilization management policies and procedures.

(Effective February 2, 2012)

Sec. 17b-262-858. Documentation and record retention requirements

(a) Providers shall comply with the following documentation and record retention requirements:

(1) An initial rehabilitation plan and all updated versions, including the current plan, shall be maintained.

(2) All rehabilitation service providers are required to develop a rehabilitation plan that meets the requirements of section 17a-20-42 of the Regulations of Connecticut State Agencies, except as provided for under subsection 17b-262-851(7) of the Regulations of Connecticut State Agencies. The rehabilitation plan shall include a medication plan, if the rehabilitation service includes medication management. The medication plan shall include an order and instructions for administration for each medication prescribed by a provider staff member and a list of other medications that the individual is taking that may be prescribed by non-clinic practitioners.

(3) A case record that meets the requirements of section 17a-20-54 of the Regulations of Connecticut State Agencies, shall be maintained and shall include, at a minimum: identifying information; social and health history; the reason for admission to the rehabilitation program; copies of the initial and all subsequent orders for rehabilitation services; the rehabilitation plan; identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the individual. This case record requirement applies to all providers of rehabilitation services for individuals, not just to DCF-licensed psychiatric clinics that are subject to section 17b-20-54 of the Regulations of Connecticut State Agencies.

(4) Encounter notes shall be maintained for each rehabilitative service provided. The notes shall include the service rendered; actual time the service was rendered; location of service; the goal and objective that is the focus of the intervention; a general description of the content of the intervention to provide evidence that it is a rehabilitative service, as described in section 17b-262-854 of the Regulations of Connecticut State Agencies; and the individual's response to the intervention. Encounter notes shall be signed and dated and shall indicate the credentials of the staff member who provided the service.

(5) For EDT programs the encounter notes shall document the duration of each distinct therapeutic session or activity and progress toward treatment goals.

(6) For the purpose of documenting the supervision of services provided by unlicensed direct care staff, licensed clinical staff shall document in the case record that they have reviewed the encounter notes corresponding to services provided by such unlicensed direct care staff at least once every 30 days. Documentation shall include the signature and credentials of the licensed clinical staff that reviewed the encounter notes.

(b) Other documentation and record retention requirements:

(1) The provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified persons furnishing rehabilitation services.

(2) The provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.

(3) The provider shall maintain all required records for at least five years or longer as required by statutes or regulation. All required records shall be subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(4) All documentation shall be recorded in the eligible individual's case record in a complete, prompt and accurate manner. All documents shall be made available to authorized personnel of the department upon request.

(5) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(Effective February 2, 2012)

Sec. 17b-262-859. Billing requirements

(a) Claims for office-based off-site rehabilitation services shall be billed with routine outpatient procedure codes and an off-site modifier or appropriate place of service code as designated by the department.

(b) For home and community-based rehabilitation services that are delivered by more than one staff member, each staff member may bill for time spent engaged in rehabilitative services, whether the staff members are working together or independently. When more than one staff member is in the home at the same time co-facilitating a family therapy or crisis intervention, each staff member may bill for the time spent engaged in this activity. The staff members may co-sign a single note that documents the rehabilitation service that was conducted by the team. If the staff members worked with different family members, each staff member shall write an encounter note in accordance with section 17b-262-858(a)(4) of the Regulations of Connecticut State Agencies.

(c) A single per diem fee shall be billed for EDT inclusive of all medication evaluation or management services, treatment and rehabilitative services, administrative services and coordination with or linkages to other health care services. The provider may bill separately for medically necessary individual psychotherapy clinic services while the individual continues to receive extended day treatment services, if such services are rendered outside of the EDT program hours of operation, are provided by persons other than EDT program staff and are necessary for the individual's transition or continuity of care.

(d) For EDT if the individual is present for up to half of the program day and attends at least one therapy session, the provider may bill for half of their fee on file. If the individual is present for more than half of the program day but less than a full day and attends at least two therapy sessions, the provider may bill the full day charge on file. If the individual does not attend at least one therapy session the clinic is not entitled to any payment from the department.

(e) Claims for payment of rehabilitation services shall be on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment. All claims submitted to the department for payment of services covered under section 17b-262-854 of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the individual's permanent case record.

(Effective February 2, 2012)

Sec. 17b-262-860. Payment

(a) In order to receive payment from the department, the provider shall be enrolled in the Connecticut Medical Assistance Program and comply with the requirements of sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) The department shall establish rates for rehabilitation services. By enrolling in the program and providing covered rehabilitation services to individuals, the provider agrees

to accept the department's rate as payment in full for rehabilitation services provided to individuals.

(c) Office-based off-site rehabilitation services provided by a provider that is not a Federally Qualified Health Center shall be reimbursed at the same rate applicable to such services when provided at a primary or satellite site as provided for on the clinic's DCF license.

(d) Office-based off-site rehabilitation services provided by Federally Qualified Health Centers shall be reimbursed at the Federally Qualified Health Center's psychiatric encounter rate.

(e) Home and community-based rehabilitation services and EMPS provided by Federally Qualified Health Centers shall be reimbursed at the same rates paid to non-Federally Qualified Health Center providers.

(f) Rates for rehabilitation services include any associated travel costs.

(g) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate; or

(3) the amount in the provider's rate letter or the amount on the applicable fee schedule as published by the department.

(Effective February 2, 2012)

Sec. 17b-262-861. Audit and compliance reviews

All supporting accounting and business records, statistical data and all other records relating to the provision of rehabilitation services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of the department.

(Effective February 2, 2012)

Requirements for Payment of Services Provided by Licensed Behavioral Health Clinicians in Independent Practice

Sec. 17b-262-912. Scope

Sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of services performed by licensed behavioral health clinicians in independent practice for HUSKY C and HUSKY D clients under age twenty-one and HUSKY A clients of any age who are determined eligible to receive services under Connecticut's Medicaid program pursuant to sections 17b-261, 17b-261n and 17b-277 of the Connecticut General Statutes.

(Effective December 28, 2012)

Sec. 17b-262-913. Definitions

As used in sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of

Connecticut State Agencies:

(1) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes;

(2) "Behavioral health clinician services" means preventive, diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed behavioral health clinician within the licensed behavioral health clinician's scope of practice under state law;

(3) "Client" means a person who is eligible for goods or services under Medicaid and is a HUSKY C or HUSKY D member under age twenty-one or a HUSKY A member of any age;

(4) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(5) "Current treatment plan" means a treatment plan that has been reviewed and updated by the provider not more than six months before each treatment session;

(6) "Department" means the Department of Social Services or its agent;

(7) "Early and Periodic Screening, Diagnostic and Treatment Services" or "EPSDT Services" means the services described in 42 USC 1396d(r)(5);

(8) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services that are not covered under the Medicaid State Plan but are covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is (A) medically necessary, (B) the need for the service is identified in an EPSDT screen, (C) the service is provided by a participating provider and (D) the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;

(9) "Federally qualified health center" has the same meaning as provided in 42 USC 1396d(*l*);

(10) "Home" means a client's place of residence, including, but not limited to, a boarding house, community living arrangement, nursing facility or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(11) "HUSKY A" means the Medicaid coverage groups for children, caretaker relatives and pregnant women authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to sections 17b-261 and 17b-277 of the Connecticut General Statutes;

(12) "HUSKY C" means the Medicaid coverage groups for the aged, blind and disabled authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to section 17b-261 of the Connecticut General Statutes;

(13) "HUSKY D" means the Medicaid coverage groups for low-income adults authorized by 42 USC 1396a(a)(10)(A)(i)(VIII) and operated pursuant to section 17b-261n of the Connecticut General Statues, formerly referred to as the State-Administered General Assistance program;

(14) "Licensed alcohol and drug counselor" means an individual licensed pursuant to

section 20-74s of the Connecticut General Statutes;

(15) "Licensed behavioral health clinician" means a licensed alcohol and drug counselor, licensed marital and family therapist, licensed clinical social worker or licensed professional counselor;

(16) "Licensed clinical social worker" means a person licensed pursuant to section 20-195n of the Connecticut General Statutes;

(17) "Licensed marital and family therapist" means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;

(18) "Licensed professional counselor" means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;

(19) "Licensed practitioner" means a physician, APRN or physician assistant;

(20) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(21) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(22) "Physician" means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes;

(23) "Physician assistant" means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;

(24) "Prior authorization" means the department's approval for the provision of a service before a provider actually provides such service, except where section 17b-262-920 of the Regulations of Connecticut State Agencies specifically authorizes the department to grant prior authorization before paying for a service but after the provider has provided such service;

(25) "Provider" means a licensed behavioral health clinician enrolled in Medicaid pursuant to a valid provider agreement with the department;

(26) "Provider agreement" means the signed, written agreement between the department and the provider for enrollment in Medicaid;

(27) "Registration" means the process of notifying the department of the initiation of a behavioral health clinician service, including evaluation findings and plan of care information;

(28) "State Plan" means the current Medicaid coverage and eligibility plan established, submitted and maintained by the department and approved by the Centers for Medicare and Medicaid Services in accordance with 42 CFR 430, Subpart B;

(29) "Treatment plan" means a written individualized plan developed and updated in accordance with section 17b-262-919 of the Regulations of Connecticut State Agencies that contains the type, amount, frequency and duration of services to be provided, and measurable goals and objectives developed in collaboration with the client after evaluation, in order to improve the client's condition to the point that treatment by the licensed behavioral health clinician no longer becomes necessary, aside from occasional follow-up

or maintenance visits; and

(30) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity of services given, or proposed to be given, to a client.

(Effective December 28, 2012)

Sec. 17b-262-914. Provider participation

In order to enroll in Medicaid and receive payment from the department, a provider shall:

(1) Comply with all applicable licensing, accreditation and certification requirements;

(2) comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(3) comply with sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies; and

(4) have a valid provider agreement on file with the department.

(Effective December 28, 2012)

Sec. 17b-262-915. Eligibility

The department shall pay for medically necessary behavioral health clinician services provided to clients eligible for such services, subject to the conditions and limitations that apply to these services.

(Effective December 28, 2012)

Sec. 17b-262-916. Services covered

The department shall pay only for behavioral health clinician services that are:

(1) Within the licensed behavioral health clinician's scope of practice as defined by chapters 376b, 383a, 383b or 383c of the Connecticut General Statutes, as applicable to the behavioral health clinician; and

(2) medically necessary to treat the client's condition.

(Effective December 28, 2012)

Sec. 17b-262-917. Service limitations

The department shall pay for covered services only in accordance with the treatment plan and with the following additional limits:

(1) Only one diagnostic interview in any twelve-month period per licensed behavioral health clinician per client;

(2) only one unit of individual counseling or individual psychotherapy per client, per day;

(3) only one unit of family counseling or family psychotherapy per client, per day;

(4) only one unit of group counseling or group psychotherapy per client, per day;

(5) group psychotherapy sessions shall include a maximum of twelve participants per group session, to the extent clinically appropriate, regardless of each participant's payment source, and the provider shall document the number of participants in each session in the

client's chart;

(6) family, group and multiple-family group psychotherapy sessions shall be at least forty-five minutes in length, and the provider shall document the length of time of each session in the client's chart;

(7) family and multiple-family group psychotherapy shall be reimbursable for one identified family member client per session, without regard to the number of family members in attendance or the presence of behavioral health conditions among other family members in attendance; and

(8) multiple-family group psychotherapy shall include a maximum of twenty-four participants per group regardless of each participant's payment source, shall include members of at least two unrelated families and the provider shall document the number of participants in each session in the client's chart.

(Effective December 28, 2012)

Sec. 17b-262-918. Services not covered

The department shall not pay for the following behavioral health clinician services:

(1) Information or services furnished by the licensed behavioral health clinician to the client electronically or over the telephone, except for case management services provided to clients age eighteen and under;

(2) case management services provided to clients age nineteen and older;

(3) evaluations, diagnostic interviews and therapy services performed in hospital inpatient or outpatient settings;

(4) concurrent services involving the same treatment modalities for the same client by different health professionals;

(5) cancelled office visits or appointments not kept;

(6) services, treatment or items for which the provider does not usually charge;

(7) behavioral health clinician services in excess of those medically necessary to treat the client's condition;

(8) services not directly related to the client's diagnosis, symptoms or medical history;

(9) services provided by anyone other than the provider; and

(10) services that are primarily for vocational or educational guidance.

(Effective December 28, 2012)

Sec. 17b-262-919. Need for service and treatment plan

The department shall pay for medically necessary behavioral health clinician services. The provider shall establish a treatment plan for each client based on the initial diagnostic evaluation before commencing treatment and shall regularly update the treatment plan in accordance with the client's progress as necessary and at least every six months. Notwithstanding section 17b-962-917 of the Regulations of Connecticut State Agencies, the department shall pay for an initial diagnostic evaluation in order to enable the licensed behavioral health clinician to develop the treatment plan. The treatment plan shall specify

the treatment modalities and frequency of care necessary to meet the client's needs, identify measurable outcomes to be achieved and identify any medical providers with whom the licensed behavioral health clinician is coordinating care.

(Effective December 28, 2012)

Sec. 17b-262-920. Prior authorization and registration

(a) Where a service requires prior authorization or registration under this section, the department shall not pay for such service unless the provider complies with this section and all of the department's requirements for prior authorization or registration, as applicable.

(b) The department shall designate services that require prior authorization or registration in the department's fee schedule or on the department's website or by other means accessible to providers, with advance notice given to providers before changing the prior authorization or registration requirements. Registration may serve in lieu of prior authorization only if the department designates a service as requiring registration but not prior authorization. Prior authorization is also required for:

(1) Any service that is not in the department's fee schedule; and

(2) EPSDT Special Services.

(c) The following requirements shall apply to all services that require prior authorization or registration under subsections (a) and (b) of this section:

(1) The initial prior authorization or registration period shall be based on the client's needs;

(2) if prior authorization is needed beyond the initial or current prior authorization period, the provider shall submit a request to the department to extend the prior authorization before the end of the current prior authorization period;

(3) except as provided in subdivision (9) of this subsection or for the purpose of initial assessment, the provider shall receive prior authorization before rendering services or submit complete registration information to the department within the timeframes established by the department and posted on the department's website;

(4) in order to receive payment from the department, a provider shall comply with all prior authorization and registration requirements. The department, in its sole discretion, determines what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met;

(5) a provider shall present medical or social information adequate to evaluate medical necessity when requesting prior authorization. The provider shall maintain documentation adequate to support requests for prior authorization and registration including, but not limited to, medical or social information adequate to evaluate medical necessity;

(6) requests for prior authorization for continued services shall include: progress made to date with respect to established treatment goals; future gains expected from additional treatment; and medical or social information adequate to evaluate medical necessity;

(7) the provider shall maintain documentation adequate to support requests for continued

prior authorization including, but not limited to: progress made to date with respect to established treatment goals; the future gains expected from additional treatment; and medical or social information adequate to evaluate medical necessity;

(8) the department may require a review of the discharge plan and actions taken to support successful implementation of the discharge plan as a condition of prior authorization;

(9) a provider may request retrospective prior authorization from the department before payment has been made but after a service has been provided for clients who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service;

(10) for clients who are granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall initiate this review to enable authorization and payment for services;

(11) for all prior authorization requests for EPSDT Special Services, a provider shall attach a physical or electronic copy of a prescription signed by a licensed practitioner acting within the licensed practitioner's scope of practice under state law or an order signed by a licensed behavioral health clinician acting within the licensed behavioral health clinician's scope of practice under state law. The provider shall keep the original prescription or order on file and subject to the department's review; and

(12) the department may deny prior authorization or registration if the provider does not comply with utilization management policies and procedures.

(Effective December 28, 2012)

Sec. 17b-262-921. Billing procedures

(a) Providers shall submit claims on the department's designated form or by electronic transmission as established by the department and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the licensed behavioral health clinician's usual and customary charge for the services provided.

(c) When a licensed behavioral health clinician is requested to attend a staff conference for a client, the name of the referring practitioner, clinic or agency shall be entered in the appropriate section of the claim form.

(Effective December 28, 2012)

Sec. 17b-262-922. Payment

(a) Licensed behavioral health clinicians who are fully or partially compensated by a Medicaid participating general hospital, public or private institution, freestanding clinic or federally qualified health center shall not receive payment from the department for services rendered at such entities unless the licensed behavioral health clinician maintains an office for private practice at a separate location from the entity referenced above where the licensed behavioral health clinician is employed. The licensed behavioral health clinician shall bill

the department only for a service provided to a client whose overall treatment is provided through the provider's private practice, although each individual service may be provided either at the practice, the client's home or in the community.

(b) Payment for services directly performed by a licensed behavioral health clinician in private practice shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate; or

(3) the amount in the department's applicable fee schedule.

(Effective December 28, 2012)

Sec. 17b-262-923. Payment rate

The commissioner shall establish, update and publish the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Effective December 28, 2012)

Sec. 17b-262-924. Payment limitations

(a) The fees for a diagnostic interview examination, as stipulated in the department's applicable fee schedule, represent one unit of service. The provider shall bill for only one unit of service for a diagnostic interview examination regardless of the number of days it takes to complete.

(b) If a session includes a combination of individual and family psychotherapy, the provider shall bill for the modality that comprises the greater part of the session. The provider shall not bill for both individual and family psychotherapy for the same date of service unless each modality individually meets the minimum time requirement for the modality specified in the department's fee schedule or in section 17b-262-917 of the Regulations of Connecticut State Agencies.

(Effective December 28, 2012)

Sec. 17b-262-925. Documentation

(a) Providers shall maintain (1) a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan signed by the licensed behavioral health clinician and (2) documentation of services provided, including, types of service or modalities, date of service, location of the service and the start and stop time of the service.

(b) For treatment services, the provider shall document the treatment intervention and progress with respect to the client's goals as identified in the treatment plan.

(c) Providers shall maintain all required documentation in its original form for a minimum of five years or longer if required by applicable statutes and regulations, subject to review by the department. In the event of a dispute concerning a service provided, the provider shall maintain documentation until the end of the dispute, five years or the time required by applicable statues and regulations, whichever is greater.

(d) The department may disallow and recover any amounts paid to the provider for which required documentation is not maintained and provided to the department upon request.

(e) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(f) Providers shall make all entries in ink or electronically and shall incorporate all documentation into a client's permanent medical record in a complete, prompt and accurate manner.

(g) Providers shall make all documentation available to the department upon request in accordance with 42 CFR 431.107.

(Effective December 28, 2012)

Requirements for Payment to Birth Centers

Sec. 17b-262-956. Scope

Sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to birth centers that are medically necessary and are provided to clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-261 of the Connecticut General Statutes.

(Effective October 2, 2012)

Sec. 17b-262-957. Definitions

As used in sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Birth center" means a free-standing, separately licensed health care facility that is not a hospital, where a licensed practitioner performs low-risk deliveries;

(2) "Chronic disease hospital" has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;

(3) "Client" means a person eligible for goods or services under Medicaid;

(4) "Commissioner" means the Commissioner of Social Services or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "Early Periodic Screening, Diagnosis and Treatment special services" or "EPSDT special services" means services that are not otherwise covered under Medicaid but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider, and the service is a type of service that may be covered by a state Medicaid agency and qualify for federal reimbursement under 42 USC 1396d;

(7) "Home" means the client's place of residence, including, but not limited to, a

boarding house, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(8) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(9) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(10) "Licensed practitioner" means a physician, physician assistant, nurse practitioner, nurse midwife or such other category of practitioner licensed by the Department of Public Health pursuant to Title 20 of the Connecticut General Statutes and whose scope of practice includes the ante-partum, intra-partum and post-partum care of pregnant women and the care of newborns;

(11) "Low-risk delivery" means a delivery following a low-risk pregnancy that is anticipated to be normal, as determined by the mother's licensed practitioner acting within the licensed practitioner's scope of practice under state law;

(12) "Low-risk pregnancy" means a pregnancy that is anticipated to be normal, as determined by the mother's licensed practitioner acting within the licensed practitioner's scope of practice under state law;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(15) "Nursing facility" has the same meaning as provided in 42 USC 1396r(a) and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision;

(16) "Nurse midwife" means a person licensed pursuant to section 20-86c of the Connecticut General Statutes;

(17) "Nurse practitioner" or "advance practice registered nurse" or "APRN" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;

(18) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;

(19) "Physician assistant" means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;

(20) "Prescription" means an original written order documenting medical necessity issued, signed and dated by a licensed practitioner;

(21) "Prior authorization" means approval from the department for the provision of a

service or the delivery of goods before the provider actually provides the service or delivers the goods;

(22) "Provider" means a birth center enrolled with Medicaid pursuant to a valid provider enrollment agreement with the department; and

(23) "Usual and customary charge" means the amount that the provider accepts for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is accepted in the majority of cases, usual and customary shall mean the median charge. Token charges for charity patients and other exceptional charges shall be excluded when calculating the usual and customary charge.

(Effective October 2, 2012)

Sec. 17b-262-958. Provider participation

(a) To enroll in Medicaid and receive payment from the department, a provider shall comply with sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies and sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies.

(b) A birth center shall:

(1) Be accredited by the Commission for the Accreditation of Birth Centers;

(2) be licensed by the Department of Public Health as a maternity hospital in accordance with section 19-13-D14 of the Regulations of Connecticut State Agencies or be licensed by the Department of Public Health as a birth center in accordance with regulations adopted by the Department of Public Health that specifically regulate birth centers; and

(3) comply with (A) section 19a-505 of the Connecticut General Statutes and (B) section 19-13-D14 of the Regulations of Connecticut State Agencies or such other regulations adopted by the Department of Public Health that specifically regulate birth centers.

(Effective October 2, 2012)

Sec. 17b-262-959. Need for service

Service in a birth center shall be limited to maternal patients who have had a low-risk pregnancy and are likely to have a low-risk delivery, as determined by the maternal patient's licensed practitioner.

(Effective October 2, 2012)

Sec. 17b-262-960. Eligibility

Payment to a provider for birth center services is available for clients who have a need for such products and services when the items are medically necessary, subject to the conditions and limitations set forth in sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies.

(Effective October 2, 2012)

Sec. 17b-262-961. Services covered and limitations

(a) The department shall pay the provider a single all-inclusive fee for a normal, uncomplicated labor and delivery, which covers all services provided by the birth center, including, but not limited to:

(1) Care for, labor, delivery and recovery of the maternal patient;

(2) nursery care and other services provided to the infant patient; and

(3) other ambulatory services within the provider's scope of services established by the Department of Public Health that are offered by the provider and that are otherwise covered by Medicaid.

(b) Surgical procedures at a birth center shall be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair.

(c) No general or regional anesthesia shall be administered at a birth center. Local anesthesia may be administered at a birth center if the administration of the anesthetic is performed within the scope of practice of the licensed practitioner in attendance.

(d) No abortions shall be done at a birth center.

(Effective October 2, 2012)

Sec. 17b-262-962. Payment and payment limitations

(a) The department shall reimburse the provider when the provider has met all the requirements of sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies.

(b) The department's payment to the provider includes all birth center charges, including, but not limited to: charges for labor, delivery, anesthesia, laboratory, radiology, pharmacy, nursing and other clinical staff care. The department shall not pay any other charges to the provider.

(c) The department shall not pay the provider for a delivery at home or in any setting other than the birth center, except for services described in subsection (d) of this section.

(d) If the client is transferred to a hospital prior to the actual delivery, the department shall reimburse the provider for services provided in the birth center prior to such transfer at the lower of billed charges or the reduced fee specified for such services on the department's fee schedule.

(e) If the delivery occurs at the birth center, the department shall pay the provider at the lower of the fee on the department's fee schedule or the provider's usual and customary rate.

(f) Payment to the provider excludes all services provided by a licensed practitioner. Each licensed practitioner shall bill the department for services in accordance with the regulations applicable to the licensed practitioner's provider type.

(Effective October 2, 2012)

Sec. 17b-262-963. Prior authorization

(a) The department shall require prior authorization for:

(1) Any service identified on the department's fee schedule as requiring prior authorization;

(2) EPSDT special services; and

(3) any service that is not identified on the department's fee schedule.

(b) To receive reimbursement from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements are met.

(c) The provider shall submit and sign the prior authorization request, in a form and manner specified by the department, which shall include documentation of medical necessity.

(d) A prescription is required from a licensed practitioner for all services and goods provided as EPSDT special services. The provider may attach a copy of the prescription from the licensed practitioner to the completed prior authorization request in lieu of the actual signature of the licensed practitioner on the prior authorization request form. The provider shall keep the licensed practitioner's original prescription on file and available for review by the department.

(Effective October 2, 2012)

Sec. 17b-262-964. Billing procedure

Providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment.

(Effective October 2, 2012)

Sec. 17b-262-965. Documentation

(a) Providers shall maintain a specific record for all services provided to each client, including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, treatment notes signed by the licensed practitioner, documentation of services provided and the dates the services were provided.

(b) Providers shall maintain all required documentation in its original form for at least five years or longer in accordance with applicable federal and state statutes and regulations, subject to review by authorized department personnel. If there is a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(c) The department may disallow and recover any amounts paid to the provider for which required documentation is not maintained or not provided to the department upon request.

(d) The department may audit all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with regulatory and statutory requirements.

(Effective October 2, 2012)

Sec. 17b-262-966. Reserved