State of Connecticut
Regulation of Department of Social Services
Concerning
Requirements for Provider Participation in the Connecticut Medical Assistance Program

Section 1. Section 17b-262-523 to 17b-262-532 of the Regulations of Connecticut State Agencies are hereby amended as follows:

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] case-by-case basis;

(3) "Children's Health Insurance Program" or "CHIP" means the federally subsidized program of health care for uninsured, low-income children authorized by Title XXI of the Social Security Act and operated by the department pursuant to sections 17b-289 to 17b-307, inclusive, of the Connecticut General Statutes, also known as HUSKY B;

[(3)] (4) "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)] (5) "Client" means a person eligible for goods or services under the department's Connecticut Medical Assistance Program;

[(5)] (6) "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;

(7) "Connecticut Medical Assistance Program" or "CMAP" means all of the medical assistance programs administered by the department pursuant to state and federal law, including, but not limited to Medicaid, Medicaid waiver programs and CHIP;

[(6)] (8) "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 447.58, inclusive;

[(7)] (9) "Coverable Medical Assistance Program good or service" means any good or service which is payable by the Connecticut Medical Assistance Program under its regulations;

[(8)] (10) "Department" means the Connecticut Department of Social Services or its agent;

(11) "Electronic visit verification" or "EVV" means a telephonic and computer-based in-home scheduling, tracking and billing system that documents the precise time and type of care provided at the point of care;

(12) "Electronic visit verification system" or "EVV system" has the same meaning as provided in 42 USC 1396b(l)(5);

[(9)] (13) "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;

(14) "Explanation of benefits form" means a statement sent by a health insurance company to covered individuals explaining what medical treatments or services were paid for on their behalf;

[(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 17b-134d-11 of the Regulations of Connecticut State Agencies;]

(15) "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;

[(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)] (16) "Medical Assistance Program goods or services" means [medical care or items] goods or services that are furnished to a client [to meet a medical necessity] in accordance with the applicable statutes or regulations that govern the Connecticut 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;]

(17) "Medically necessary" and "medical necessity" have the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(16)] (18) "Medicare" means the federal health care program authorized by Title XVIII of the Social Security Act;

[(17)] (19) "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)] (20) "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)] (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;

[(21)] (22) "Prospective drug utilization review" or "pro-DUR" means a client-specific drug utilization review prior to dispensing;

(23) "Provider" means any individual or entity that furnishes Medical Assistance Program goods or services pursuant to a provider enrollment 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 Connecticut Medical Assistance Program;

[(23)] (24) "Provider enrollment agreement" means the signed, written, contractual agreement between the department and the provider of services or goods and may include, but is not limited to, any addenda, as required by the department;

[(24)] (25) "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 Connecticut Medical Assistance Program;

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

[(26)] (27) "Termination" means precluding CMAP [medical assistance program] participation by providers that have been convicted of a crime involving [medicaid] CHIP, Medicaid or [medicare]

Medicare;

[(27)] (28) "[Third party] 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] has the same meaning as provided in section 17b-265 of the Connecticut General Statutes;

[(28)] (29) "[Third party] Third-party liability" as it applies to CMAP [Medical Assistance Program] claims processing, means payment resources available from both private and public health insurance that can be applied toward CMAP [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] third-party liability; and

[(29)] (30) "Type and specialty" means the department's categorization of CMAP [Medical Assistance Program] providers according to the type and specialty of the goods or services furnished by the provider.

Sec. 17b-262-524. Provider participation

(a) To enroll in the Connecticut Medical Assistance Program and receive payment from the department for the provision of goods or services to CMAP [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 enrollment 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 enrollment 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] the department requires in the event [their] such provider's 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 Connecticut 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 Connecticut 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 Connecticut 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] 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:] only if: (1) the department excludes the professional component of services from applicable payments to the hospital or institution,(2) the provider complies with all regulations, policies and procedures applicable to the provider's enrolled typed and specialty, and (3) any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements, shall be refunded to the department or its fiscal agent within thirty (30) days of receipt of payment.

[(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 CMAP [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 CMAP [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)](h) [Notwithstanding the requirements of subsections (g) and (h) of this section, a] A medical foundation established pursuant to sections 33-182aa to 33-182ff, inclusive, of the Connecticut General Statutes may bill the department for Medical Assistance Program goods or services provided to CMAP [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 (0) of section 17b-262-531of the Regulations of Connecticut State Agencies.

(i) Prior to the initial home visit at which home health care services as defined in 42 USC 1396b (l)(5)(B) or personal care services as defined in 42 USC 1396b (l)(5)(C) are provided to a client, the provider shall

submit to the department the first name, last name and last 5 digits of the social security number of the individual delivering the home health care services or personal care services when using Electronic Visit Verification (EVV).

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, 17-83k-2, 17-83k-3, 17-83k-4a, 17-83k-5, 17-83k-6 and [through] 17-83k-7 of the Regulations of Connecticut State Agencies.

(b) A provider enrollment agreement may be terminated by mutual consent or without cause by either the department or the provider by giving a [thirty day] thirty-day written notification to the affected party, or as otherwise provided by federal or state law.

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 Connecticut 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 42 USC 18116, 45 CFR 80.3 and 45 CFR 80.4[;], and section 46a-71 and 46a-81i of the Connecticut General Statutes;

(2) accept as payment in full either the department's payment or a combination of department, [third party] 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] third-party resources prior to submitting claims to the department for payment; to report any and all [third party] 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] 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 Connecticut Medical Assistance Program payment including, but not limited to: name; address; birth date; CMAP [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 Regulation 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 Connecticut 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 Connecticut 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.

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 CMAP [Medical Assistance Program] clients both before and after making payment for such goods and services.

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.

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 the time frame established by the department but not later than 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. Providers of home health care services as defined in 42 USC 1396b (l)(5)(B) and personal care services as defined in 42 USC 1396b (l)(5)(C) shall submit claims using either the department's EVV system or the provider's claim submission method as approved by the Department.

(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 Connecticut Medical Assistance Program or an applicant for a categorically related program which qualifies the individual for the Connecticut 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 Connecticut 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 payment for Medical Assistance Program [payments for] goods or services, whichever is later; and

(3) when a provider has submitted a claim to a [third party] third-party insurer and has not received a response within a reasonable time, the one year shall begin twelve months from the date of the provider's receipt of the explanation of benefits form. The provider shall be responsible for any follow up to the [third party] third-party insurers.

Sec. 17b-262-530. Payment rates

(a) All schedules of payment for [c]Coverable Medical Assistance Program goods [and] or 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.

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 CMAP [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 Connecticut 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] 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 Connecticut 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 CMAP [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 CMAP [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)*] (l) a provider shall only charge an eligible CMAP [Medical Assistance Program] client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the CMAP [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 CMAP [medical assistance program] shall be in accordance 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*)](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 Connecticut 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.

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 a client[s] while the[y] client is [are out-of-state] 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] 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] 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] 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 Connecticut 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] 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 Connecticut Medical Assistance Program on a case-by-case basis.

(j) The Connecticut 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 CMAP [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.

Statement of Purpose

The purpose of the regulation is to bring the state into compliance with 42 CFR 455.410, which provides that states shall require all physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers. The proposed regulation includes revisions to certain definitions to ensure that all providers rendering services to eligible Medicaid clients under all of the Connecticut Medical Assistance Programs, including Medicaid, Medicaid waiver programs and the Children's Health Insurance Program (CHIP) are enrolled with the agency by signing a provider enrollment agreement. It also revises provider billing requirements to provide for the use of an electronic visit verification system by certain providers and updates the regulation to be consistent with the department's requirement that all claims be filed electronically. Technical changes were necessary to other sections due to the revisions to certain definitions. The proposed amendments require that all providers who provide services to eligible Medicaid clients enroll in the Connecticut Medical Assistance Program and comply with the provider enrollment regulations.