State of Connecticut
Regulation of
Department of Social Services
Concerning
Outpatient Hospital Services

Section 1. The Regulations of the Connecticut State Agencies are amended by adding sections 17b-262-967 to 17b-262-981, inclusive, as follows:

(NEW) Sec. 17b-262-967. Scope

Sections 17b-262-967 to 17b-262-981, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to general hospitals, chronic disease hospitals and psychiatric hospitals for providing outpatient hospital services to Medicaid members.

(NEW) Sec. 17b-262-968. Definitions

As used in sections 17b-262-967 to 17b-262-981, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acute Care" means medical care needed for an illness, episode or injury that requires admission to a hospital for a short period of time;

(2) "Addendum B" means the department's document that lists Healthcare Common Procedural Coding System codes and describes payment information regarding outpatient hospital services;

(3) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes;

(4) "Affiliate" has the same meaning as provided in section 19a-643-201 of the Regulations of Connecticut State Agencies;

(5) "APC" or "Ambulatory Payment Classification" means the classification of clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources and serves as one of the methods of payment under the Outpatient Prospective Payment System;

(6) "APC conversion factor" means a set dollar amount determined by the department that is used as the basis for calculating the payment for outpatient hospital services based on the APC payment methodology;

(7) "APC grouper" means the program that assigns each service on an outpatient claim an APC if appropriate, as well as assigning a status indicator that specifies if and how the provider will be reimbursed for a service;

(8) "APC outlier payment" means a payment that is made in addition to the APC payment when the written criteria established by the department for such a payment are met;

(9) "APC relative weight" means the relative value assigned to each APC;

(10) "Authorization" means approval of payment for services by the department before payment is made. Authorization includes prior authorization, registration and retroactive authorization;

(11) "Autism Spectrum Disorder" has the same meaning as provided in section 17b-262-1052 of the Regulations of Connecticut State Agencies;

(12) "Autism Spectrum Disorder services" has the same meaning as provided in section 17b-262-1052 of the Regulations of Connecticut State Agencies;

(13) "Behavioral health services" means services provided within the scope of the hospital's license that are designed to treat behavioral health conditions as defined by the International Classification of Diseases, but not including conditions classified in the International Classification of Diseases as dementias or intellectual disabilities;

(14) "Border hospital" means an out-of-state hospital that routinely provides services to individuals residing in Connecticut and is deemed a border hospital provider by the department on a case-by-case basis;

(15) "CMS" means the U.S. Centers for Medicare and Medicaid Services;

(16) "Chronic disease hospital" has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;

(17) "Dental services" means any service provided by or under the direct or indirect supervision of a dentist;

(18) "Dentist" means an individual licensed pursuant to sections 20-106 to 20-110, inclusive, of the Connecticut General Statutes, as applicable to such individual;

(19) "Department" means the Department of Social Services or its agents;

(20) "Early and Periodic Screening, Diagnostic, and Treatment special services" or "EPSDT special services" means the services provided in accordance with section 1905(r)(5) of the Social Security Act;

(21) "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 member's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part;

(22) "Emergency department" means an organized department or facility of a hospital that provides unscheduled episodic services to individuals who present to the hospital for immediate medical attention, regardless of whether it is located on or off the main hospital campus;

(23) "Enhanced care clinic" or "ECC" means a behavioral health unit within a hospital that meets specified standards for access, quality and other categories as determined by the department in accordance with subsection (g) of section 17b-262-971 of the Regulations of Connecticut State Agencies;

(24) "Episode of care" means a period of care that ends when the member has been discharged by the provider from receiving outpatient hospital services or when there has been an extended cessation in treatment not less than 120 days from the last time the member was treated at the hospital;

(25) "Formulation" means a clinical assessment of information obtained that is used to provide the framework for developing the appropriate treatment approach for a specific member;

(26) "General hospital" means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries or a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries, but not including a psychiatric hospital, chronic disease hospital or specialty hospital;

(27) "Geographic wage index" means the index published by CMS pursuant to 42 USC 1395ww(d)(3)(E) but not including any adjustments for geographic reclassification of hospitals to other labor market areas;

(28) "Group psychotherapy" means a type of behavioral health care in which individuals meet in groups facilitated for the purpose of discussing their psychiatric or substance use disorders, the impact of these disorders and the barriers that may be overcome in order to progress in their recovery;

(29) "Healthcare Common Procedural Coding System" or "HCPCS" means the coding system for the billing of healthcare procedures as maintained and distributed by the U.S. Department of Health

and Human Services pursuant to 45 CFR 162.1002, as amended from time to time;

(30) "Hospital" means a general hospital, specialty hospital, psychiatric hospital or chronic disease hospital;

(31) "Hysterectomy" has the same meaning as provided in 42 CFR 441.251, as amended from time to time;

(32) "Informed consent" has the same meaning as provided in 42 CFR 441.257, as amended from time to time;

(33) "Inpatient" has the same meaning as provided in 42 CFR 440.2, as amended from time to time;

(34) "Intensive outpatient program" or "IOP" means an integrated set of bundled all-inclusive outpatient psychiatric services provided in the psychiatric unit of a hospital or in a psychiatric hospital that are paid at a daily rate and are designed for more intensive treatment than routine outpatient psychiatric services;

(35) "Intermediate care program" means IOP or partial hospitalization program;

(36) "International Classification of Diseases" or "ICD" means the version of the International Classification of Diseases code set as maintained and distributed by the U.S. Department of Health and Human Services that is required to be used pursuant to 45 CFR 162.1002, as amended from time to time;

(37) "Licensed alcohol and drug counselor" means an individual licensed pursuant to section 20-74s of the Connecticut General Statutes;

(38) "Licensed behavioral health clinician" means a psychologist, licensed alcohol and drug counselor, licensed marital and family therapist, licensed clinical social worker or licensed professional counselor;

(39) "Licensed clinical social worker" or "LCSW" means an individual licensed pursuant to subsection (c) or subsection (e) of section 20-195n of the Connecticut General Statutes;

(40) "Licensed marital and family therapist" or "LMFT" means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;

(41) "Licensed master social worker" or "LMSW" means an individual licensed pursuant to subsection (b) or subsection (d) of section 20-195n of the Connecticut General Statutes;

(42) "Licensed practitioner" means a physician, physician assistant, APRN, dentist, nurse-midwife, podiatrist or any other type of practitioner licensed by the Department of Public Health and whom the department designates in writing as permitted to bill separately for professional services performed in all outpatient hospital settings;

(43) "Licensed professional counselor" means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;

(44) "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;

(45) "Medicaid State Plan" means the plan describing Medicaid eligibility, coverage, benefits and reimbursement that is established by the department and reviewed and approved by the CMS pursuant to 42 CFR 430, Subpart B;

(46) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(47) "Medical record" means the hospital's records of services provided to each member, including, but not limited to identification data, progress notes, orders, services provided and other necessary information, including information required by the Department of Public Health to be included in a medical record;

(48) "Medicare" means the program operated by CMS in accordance with Title XVIII of the Social Security Act;

(49) "Medicare cost report" means a cost report that a hospital is required to prepare and submit to CMS in connection with Medicare;

(50) "Member" means an individual eligible for goods or services under Medicaid;

(51) "National Provider Identifier" or "NPI" means the standard unique health identifier for health care providers that complies with 45 CFR 162.406 and is assigned to a provider pursuant to 45 CFR 162.408;

(52) "Non-patient" means an individual who is not directly receiving outpatient services other than diagnostic testing services from the hospital, but the hospital provides all or part of the required clinical diagnostic testing for such individual;

(53) "Nurse-midwife" means an individual licensed pursuant to section 20-86c of the Connecticut General Statutes;

(54) "Observation" means a period of time used for a prolonged clinical evaluation of a patient and is used to assess, monitor or evaluate a patient's need for hospital admission and ancillary services. Observation services consist of the use of a bed and intermittent monitoring by professional licensed clinical staff and are provided under order of a physician, APRN, physician assistant or nurse-midwife;

(55) "Off-site services" means services that are provided at a location other than the hospital or a satellite location of the hospital;

(56) "Ordering, Prescribing and Referring-only provider" or "OPR-only provider" means an individual health care practitioner who is enrolled in Medicaid solely for the purpose of ordering, prescribing or referring a Medicaid service in accordance with 42 USC 1396a(kk)(7) but is not authorized to be listed on a claim as a billing provider or performing provider;

(57) "Out-of-state hospital" means a hospital that is licensed, certified or accredited in its home state other than Connecticut; is located outside Connecticut and has a business address outside of Connecticut; and is not a border hospital;

(58) "Outpatient" has the same meaning as provided in 42 CFR 440.2, as amended from time to time;

(59) "Outpatient hospital services" means services provided by a hospital to an outpatient that comply with all applicable requirements, including 42 CFR 440.20, as amended from time to time, and sections 17b-262-967 to 17b-262-981, inclusive, of the Regulations of Connecticut State Agencies;

(60) "Outpatient Prospective Payment System" or "OPPS" means the department's outpatient prospective payment system for outpatient hospital services performed by a provider for a member as described in sections 17b-262-976 and 17b-262-977 of the Regulations of Connecticut State Agencies, which is the department's prospectively determined payment system for outpatient hospital services that are reimbursed using APC, fee schedule, daily rate or such other prospective payment methodology as established by the department;

(61) "Partial hospitalization program" or "PHP" has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act;

(62) "Peer group" means a group comprised of one of the following categories of acute care hospitals: privately operated general hospitals, publicly operated general hospitals, or separately licensed children's general hospitals. The category of privately operated general hospitals may be further subdivided into multiple peer groups, as determined by the department;

(63) "Physician" means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes;

(64) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes;

(65) "Plan of Care" means a written individualized plan developed after an evaluation and

diagnosis that contains the diagnosis, type, amount, frequency, and duration of services to be provided and the specific goals and objectives to maximize the effectiveness of services for the member;

(66) "Podiatrist" means an individual licensed pursuant to section 20-54 or section 20-57 of the Connecticut General Statutes;

(67) "Prior authorization" or "prospective review" means the department's approval for a provider to render a service or deliver goods before the provider actually renders the service or delivers the goods;

(68) "Provider" means a hospital, including an in-state hospital, a border hospital or an out-of-state hospital, which is enrolled in Medicaid;

(69) "Provider agreement" means the signed written agreement between the department and the provider;

(70) "Psychiatric hospital" has the same meaning as provided in section 17b-262-500 of the Regulations of Connecticut State Agencies;

(71) "Psychiatrist" means a physician who specializes in the study, diagnosis, treatment, and prevention of mental and social disorders;

(72) "Psycho-educational group" means a type of behavioral health care that is part of an intermediate care program and utilizes a pre-determined and time limited curriculum that focuses on educating members with a common diagnosis about their disorders, specific ways of coping and progressing in their recovery;

(73) "Psychologist" means an individual licensed pursuant to section 20-188 or section 20-190 of the Connecticut General Statutes;

(74) "Qualified neuropsychologist" means a psychologist with special expertise in the applied science of brain-behavior relationships who has met the current minimum requirements for the neuropsychology specialty established by the American Psychological Association;

(75) "Registered nurse" means an individual licensed pursuant to section 20-93 or section 20-94 of the Connecticut General Statutes;

(76) "Registration" means the process of notifying the department of the initiation of a behavioral health outpatient hospital service that includes information regarding the evaluation findings and plan of care;

(77) "Resident" means an individual who has a permit to participate in a resident physician program pursuant to section 20-11a of the Connecticut General Statutes, an individual who has a permit to participate in a resident physician assistant program pursuant to section 20-12h of the Connecticut General Statutes, an individual who is participating in a podiatric residency program pursuant to section 20-54 of the Connecticut General Statutes or an individual who has a permit to participate in an advanced dental education program pursuant to section 20-126b of the Connecticut General Statutes;

(78) "Satellite location" means a facility that operates under a hospital's license; is subject to the fiscal, administrative and clinical management of the hospital; provides services to members solely on an outpatient basis; is not located at the same site as the hospital's inpatient facility; and has obtained provider-based status in accordance with 42 CFR 413.65, as amended from time to time;

(79) "Specialty hospital" means any institution other than a general hospital, psychiatric hospital or chronic disease hospital that provides outpatient hospital services and is separately licensed as a hospital by the Department of Public Health;

(80) "Status indicator" means a payment indicator that is assigned by the APC grouper to a HCPCS code;

(81) "Sterilization" has the same meaning as provided in 42 CFR 441.251, as amended from time to time;

(82) "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 excluded; and

(83) "Utilization review" means the evaluation of the medical necessity, quality and timeliness of the use of applicable covered medical services, equipment, supplies, procedures and facilities. Utilization review may be conducted on a prospective, concurrent or retrospective basis and includes, but is not limited to, prior authorization, registration, concurrent review and retrospective review.

(NEW) Sec. 17b-262-969. Provider Participation

(a) To enroll in Medicaid and receive payment from the department, all hospitals seeking reimbursement for outpatient hospital services shall:

(1) Comply with sections 17b-262-522 to 17b-262-533, inclusive, and 17b-262-967 to 17b-262-981, inclusive, of the Regulations of Connecticut State Agencies;

(2) If located in Connecticut, be licensed by the Department of Public Health pursuant to applicable requirements as a chronic disease hospital, psychiatric hospital, specialty hospital, general hospital or children's general hospital, except to the extent a hospital is exempt from licensure requirements, such as, if applicable, a hospital operated by the Department of Mental Health and Addiction Services, the Department of Children and Families or the Department of Veterans' Affairs;

(3) For any hospital located outside Connecticut, including both border hospitals and out-of-state hospitals, be licensed as a hospital in the state where the hospital is located by the appropriate official state governing body in the state where the hospital is located;

(4) Sign and maintain a valid provider agreement with the department;

(5) Comply with all applicable federal requirements, including, but not limited to, 42 CFR 440.20 and 42 CFR 482, as amended from time to time; and

(6) Provide all services using qualified staff working within the scope of applicable scope of practice requirements. A physician shall authorize the care provided and periodically review the need for continuing care. To the extent applicable, an appropriate licensed practitioner shall sign the initial plan of care and all periodic reviews to the plan of care, assuring that the services are medically necessary, not less than every thirty days or more frequently if medically necessary. For services that require a plan of care, the department pays only for services as outlined in the plan of care, which may be updated as appropriate.

(b) The department shall determine on a case-by-case basis if an out-of-state hospital qualifies for enrollment as a border hospital.

(NEW) Sec. 17b-262-970. Outpatient Hospital Services Covered and Limitations

(a) The department pays hospitals only for medically necessary outpatient hospital services provided to members, including EPSDT special services and other outpatient hospital services.

(b) Organ and Bone Marrow Donors. In connection with a medically necessary organ transplant surgery or bone marrow transplant, the following services provided to an organ or bone marrow donor: harvesting; diagnostic testing; medications; transportation services; and any service related to the actual procedure. The department may also pay for certain organ acquisition costs for transplants, as determined by the department to be medically necessary. Services provided to an organ or bone marrow donor are covered only when a specific Medicaid member has been identified as the recipient of the transplant. Prior authorization is required for the organ recipient's case in order to provide any services related to such organ transplant.

(c) Services to Treat Morbid Obesity. Services to treat morbid obesity only when another medical illness is caused by, or is aggravated by, the obesity, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system.

(d) Observation Services. The department covers observation services with the following limitations:

(1) Services are determined by a physician, APRN, physician assistant or nurse-midwife order and shall be medically necessary.

(2) Documentation in the patient's medical record shall support the medical necessity of the observation service. Observation services shall be provided in a licensed hospital space.

(3) Observation time begins at actual time that the order to admit the member for observation was issued, as such order appears in the applicable hospital medical records.

(4) Observation services shall include not less than eight hours but not greater than forty-eight hours of continuous care. The hospital may bill for ancillary services related to observation only if such services are ordered during the observation stay.

(5) In accordance with subsection (c) of section 17b-262-978 of the Regulations of Connecticut State Agencies, the department shall not separately pay for observation that becomes an inpatient hospital admission.

(e) The department pays for sterilization only if the member is age twenty-one or older and gave informed consent pursuant to 42 CFR 441.250 to 42 CFR 441.259, inclusive, as amended from time to time.

(f) The department pays for hysterectomies and related laboratory and hospital services only if such services are medically necessary and only if the provider has obtained:

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

(2) A physician's certification in accordance with 42 CFR 441.255(d), as amended from time to time.

(g) Abortions.

(1) The department pays for all abortions that a physician certifies as medically necessary 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.

(2) The provider shall maintain all forms required by section 19a-116-1 of the Regulations of Connecticut State Agencies and sections 19a-600 to 19a-609, inclusive, of the Connecticut General Statutes.

(h) Laboratory Services.

(1) In order to ensure accurate payment under the APC reimbursement methodology, laboratory tests that are related to any other outpatient hospital service performed on the same date or dates of service shall be billed by the hospital and shall not be paid to any entity other than the hospital if such laboratory services were performed by: (A) the hospital, (B) an independent laboratory that is an affiliate of the hospital or (C) an independent laboratory that is in the same location as the hospital's main campus or any satellite location of the hospital, even if the laboratory is not an affiliate of the hospital. An independent laboratory that is not an affiliate of the hospital and is in a different location from the hospital's main campus and satellite locations may separately bill for and be reimbursed for such laboratory services, in which case, the hospital shall not bill or be reimbursed for such services.

(2) When a hospital sends a sample to an independent laboratory or to another hospital laboratory for testing that the referring hospital is unable to perform on-site:

(A) The referring hospital shall maintain results of the testing in the member's medical record.

(B) For hospital non-patients, either the referring hospital or the laboratory to which a sample was referred, but not both, may bill for and be reimbursed for such services.

(C) For members other than hospital non-patients, only the hospital that collected the sample and referred it to the other laboratory may bill the department and be reimbursed for such services. The laboratory to which the hospital referred the sample shall not bill for or be reimbursed by the department for such services.

(3) Hospital Non-Patients.

(A) The department shall pay the hospital in accordance with the consolidated laboratory fee schedule for laboratory services provided to hospital non-patients.

(B) A specimen collection fee for hospital non-patients is limited to specimen collection by venipuncture or catheterization.

(4) The hospital and all affiliates of the hospital shall bill for laboratory services as specified in subsection (d) of section 17b-262-976 of the Regulations of Connecticut State Agencies.

(i) Emergency Department Services. This subsection applies to all services provided in a hospital's emergency department, including emergency services and non-emergency services.

(1) The hospital shall follow the department's instructions regarding emergency department services, including instructions regarding appropriate billing for the type of services rendered and the type of facility where the services are performed.

(2) The department's reimbursement for emergency department services varies based on the department's determination of the severity, complexity and amount of hospital resources generally involved in providing a service, as detailed in Addendum B.

(3) The hospital shall maintain sufficient documentation in the medical record to verify the level and method of coding and billing for emergency department services.

(4) The department may establish different reimbursement methodologies, different billing procedures or both for various categories of emergency departments, including emergency departments that are: (A) open twenty-four hours per day, seven days per week; (B) open less than twenty-four hours per day, seven days per week; (C) located on the hospital's main campus; (D) located in a satellite location of the hospital; (E) located as a stand-alone emergency department; or (F) any combination of the attributes described in subparagraphs (A), (B), (C), (D) or (E) of this subdivision.

(j) Individual Tobacco Cessation Counseling.

(1) Individual tobacco cessation counseling services are included and reimbursed as part of an outpatient hospital service, plus related applicable professional claims for licensed practitioners' professional services related to the service. The hospital shall not bill separately and the department shall not reimburse the hospital separately for individual tobacco cessation counseling services.

(2) Individual tobacco cessation counseling services may be provided by any physician, registered nurse, APRN, nurse-midwife, physician assistant or licensed behavioral health clinician.

(3) All individual tobacco cessation counseling services shall be documented accurately in the medical record. The progress note shall include a summary of the discussion and the duration of the counseling session.

(k) Group Tobacco Cessation Counseling.

(1) Group tobacco cessation counseling services are scheduled professional counseling sessions designed to assist a member in ceasing the use of tobacco and shall include:

(A) Education on evidence-based methods for stopping the use of tobacco;

(B) Collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco and to prevent relapse;

(C) A plan for continued care following initial treatment; and

(D) Information and advice on the benefits of nicotine replacement therapy or other appropriate evidence-based pharmaceutical or behavioral adjuncts to quitting tobacco.

(2) A member may receive up to twenty-four group tobacco cessation counseling sessions from a hospital in any 365-day period, which may be exceeded with prior authorization based on medical necessity.

(3) Each group tobacco cessation counseling session shall:

(A) Have not less than three and not more than twelve participants in the group, regardless of each participant's payment source;

(B) Last not less than forty-five minutes; and

(C) Be provided by an individual who complies with subdivision (4) of this subsection.

(4) Provider Qualifications.

(A) Individuals who provide group tobacco cessation counseling shall be trained in the specific counseling model used by the provider and approved by the department.

(B) Supervision of staff and progress notes written by the group facilitator shall comply with applicable licensure and accreditation requirements and other requirements applicable to the hospital.

(5) Documentation. All tobacco cessation counseling services shall be documented accurately in the medical record. The plan of care for group tobacco cessation counseling shall include an order for tobacco cessation services. The progress note for each group participant in group tobacco cessation counseling shall include the date of the group, the duration of the group, the actual start and stop time that the member attended the group, a summary of the content of the group session and the group facilitator's name and credentials.

(*l*) Pharmacy.

(1) Pharmacy items that are included as part of a package of goods and services included in an APC payment shall not be separately reimbursed.

(2) A hospital shall bill for drugs obtained pursuant to section 340B of the Public Health Service Act in accordance with the department's billing guidelines, other written instructions from the department and all applicable requirements.

(m) Dental Services.

(1) The dentist assumes the primary responsibility for all dental procedures performed under such dentist's direct or indirect supervision.

(2) Dental surgery services provided by an outpatient hospital and designated by the department on Addendum B as payable under APCs are provided and reimbursed in accordance with sections 17b-262-967 to 17b-262-981, inclusive, of the Regulations of Connecticut State Agencies.

(3) Except for dental surgery services as provided in subdivision (1) of this subsection, all other dental services provided in an outpatient hospital setting are not reimbursed as outpatient hospital services. Such dental services are provided and reimbursed in accordance with the applicable regulations, policies and reimbursement methodologies for dental services.

(4) Professional fees for dentists' services are paid in accordance with regulations, policies and reimbursement methodologies applicable to the dentist.

(n) Autism Spectrum Disorder Services.

(1) Pursuant to and to the extent authorized by sections 17b-262-1051 to 17b-262-1065, inclusive, of the Regulations of Connecticut State Agencies, a hospital may bill the department for providing autism spectrum disorder services that are performed by individuals employed by or under contract to the hospital.

(2) The hospital shall ensure that all autism spectrum disorder services described in subdivision (1) of this subsection comply with sections 17b-262-1051 to 17b-262-1065, inclusive, of the Regulations of Connecticut State Agencies, including required qualifications for practitioners performing the services.

(3) Individual practitioners shall not bill for or be reimbursed separately for providing autism spectrum disorder services billed by the hospital pursuant to this subsection.

(NEW) Sec. 17b-262-971. Behavioral Health Services: Evaluation, Plan of Care, Limitations and Reimbursement

(a) Evaluation and Plan of Care. When providing behavioral health services, the hospital shall comply with subsections (c), (d), (i) and (j) of section 17b-262-824 of the Regulations of Connecticut State Agencies. In addition, the following requirements also apply:

(1) The initial plan of care shall be signed by a qualified physician, APRN or physician assistant not more than thirty days after the initial evaluation and shall include the types and frequencies of treatment ordered. The physician, APRN or physician assistant shall also sign the plan of care at the time of each periodic review, which shall be not less than every ninety days or more frequently as medically necessary and also when the plan of care is updated to reflect any change in the types of service provided. When a physician, APRN or physician assistant signs off on the plan of care, the signature indicates that the plan of care is valid, conducted properly, based on the evaluation and recommends services that are medically necessary;

(2) If treatment is not recommended, the physician, APRN or physician assistant shall sign the evaluation.

(3) The plan of care shall, at a minimum, meet all applicable state and federal requirements for licensure and conditions of participation.

(b) Services Covered and Limitations: General.

(1) The department pays a hospital for behavioral health services in the outpatient hospital setting, including mental health and substance use services on a routine, intermediate and intensive basis. The department pays only for services included in the plan of care, which shall be updated as necessary.

(2) The hospital shall comply with subdivisions (1), (2), (4), (6) and (7) of subsection (a) of section 17b-262-822 of the Regulations of Connecticut State Agencies.

(3) Only one psychiatric diagnostic interview examination may be provided in a single episode of care, unless:

(A) It is necessary to have a psychologist, psychiatrist, APRN or physician assistant perform an interview to initiate or determine the need for psychological testing or neuropsychological testing; or

(B) A member's presentation requires that a physician, APRN or physician assistant evaluate the need for medication for a member who is in the care of a non-medical practitioner.

(4) Prior authorization is required for each psychological test and each neuropsychological test. A qualified neuropsychologist shall interpret and report on each neuropsychological evaluation and on each neuropsychological test.

(c) Services Provided by Licensed Practitioners. Except as provided in subdivisions (1) and (2) of this subsection, behavioral health professional services provided by physicians, APRNs, physician assistants and licensed behavioral health clinicians in the outpatient hospital setting are included in the department's payment to the hospital. Such practitioners and clinicians shall not separately bill or be reimbursed for such services, except for:

(1) Services in a hospital emergency department other than observation provided by any qualified licensed behavioral health clinician, physician, APRN or physician assistant; or

(2) Electroconvulsive therapy provided by a qualified physician, APRN or physician assistant.

(d) Services Provided by Non-Licensed Individuals.

(1) Except for services that are required to be provided by licensed staff or certified staff, as applicable, the department pays a hospital for behavioral services provided by qualified non-licensed clinical staff, non-certified staff, individuals in training and license-eligible individuals whose

education, training, skills and experience satisfy the criteria for licensure, including accumulation of all supervised service hours, and who have applied for but not yet passed the licensure exam for a category of licensed behavioral health clinician.

(2) An appropriate qualified physician, APRN, physician assistant or licensed behavioral health clinician shall supervise each LMSW, non-licensed clinical staff, non-certified staff, individual in training and licensed-eligible staff not less than weekly and shall supervise certified staff not less than monthly. The supervising physician, APRN, physician assistant or licensed behavioral health clinician shall accept primary responsibility for services performed by LMSWs, unlicensed, non-certified, license-eligible and certified staff; and shall supervise all staff in accordance with applicable scope of practice requirements.

(e) Intermediate Care Programs. Intermediate care programs may include a variety of individual, group or family therapies; medication management; and rehabilitative or psycho-educational services that are integrated into an intensive, coordinated and structured clinical program lasting not fewer than three hours per day. Intermediate care programs shall comply with subdivisions (1) to (8), inclusive, of subsection (d) of section 17b-262-822 of the Regulations of Connecticut State Agencies.

(f) The department shall not cover off-site and certain other services within the outpatient hospital benefit category, including, but not limited to: Emergency mobile psychiatric services; home and community-based rehabilitation services; and extended day treatment, each of which are provided as children's rehabilitation services, as described in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies. Such services are reimbursed within the rehabilitation benefit category pursuant to 42 CFR 440.130(d), as amended from time to time, not within the outpatient hospital benefit category pursuant to 42 CFR 440.20(a), as amended from time to time.

(g) Enhanced Care Clinics. A hospital that operates an ECC shall comply with subsection (h) of section 17b-262-827 of the Regulations of Connecticut State Agencies.

(h) Payment. In addition to section 17b-262-978 of the Regulations of Connecticut State Agencies, for behavioral health services, the hospital shall also comply with subsections (b), (c) and (d) of section 17b-262-827 of the Regulations of Connecticut State Agencies.

(i) Documentation. In addition to section 17b-262-979 of the Regulations of Connecticut State Agencies, for behavioral health services, the hospital shall also:

(1) Comply with subsections (a), (b), (e), (f), (g) and (h) of section 17b-262-828 of the Regulations of Connecticut State Agencies.

(2) Ensure the medical record conforms to applicable federal and state requirements for the hospital, including, but not limited to, as applicable, 42 CFR 482.24, 42 CFR 482.61 and sections 19-13-D3(d), 19-13-D4a(d) or 19-13-D5(d) of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-972. Physical Therapy, Occupational Therapy, Speech and Language Pathology and Audiology Services

(a) Need for Services.

(1) The need for physical therapy, occupational therapy, speech and language pathology, or audiology services shall be established by an evaluation and used in creating the plan of care for each member.

(A) An order for an evaluation shall be signed by the ordering physician, APRN or physician assistant.

(B) Evaluations shall include only the specific evaluation procedures and types of evaluations that are medically necessary to evaluate the member's condition.

(C) If treatment is recommended, the physician, APRN or physician assistant shall review and sign off on the evaluation and issue an order for treatment.

(2) The hospital shall prepare a plan of care for physical therapy, occupational therapy and speech

and language pathology, which shall include the recommended types, frequency and duration of treatment. A plan of care is not required for audiology services.

(3) The need for service shall be reestablished by an evaluation performed not less than every twelve months.

(b) Services Covered and Limitations.

(1) Appropriate licensed or certified staff shall perform physical therapy, occupational therapy, speech and language pathology and audiology services within such individuals' applicable scope of practice under state law. The department pays the hospital for such services performed in the outpatient hospital setting and individual practitioners shall not bill or be reimbursed separately for performing such services.

(2) Physical therapy, occupational therapy, speech and language pathology and audiology services shall be limited to one visit of each type per day per member.

(3) The fee for a physical therapy, occupational therapy and speech and language pathology evaluation shall include all treatment when an evaluation and treatment are provided on the same day.

(4) Audiology evaluations shall include only the specific evaluation procedures and types of evaluations that are medically necessary to evaluate the member's condition as documented in the provider's medical records.

(5) In order for maintenance therapy to be covered for physical therapy, occupational therapy or speech and language pathology services, it shall be designed to do at least one of the following:

(A) Prevent or delay deterioration and sustain function;

(B) Provide interventions, in the case of a chronic or progressive disability, that enables a member to attain or retain capability for independence or self-care; or

(C) Provide treatment interventions for a member who is progressing but not at a rate comparable to the expectations of restorative care.

(c) Prior authorization. Prior authorization is required as specified by the department in writing on its fee schedule, authorization grid or other relevant document that is available to providers.

(NEW) Sec. 17b-262-973. Services Not Covered

The department shall not pay for the following:

1. Any service identified on Addendum B as not covered or not reimbursable;
2. Any service to treat obesity other than those described in section 17b-262-970(c)(9) of the Regulations of Connecticut State Agencies;
3. Infertility treatment or reversal of sterilization procedure;
4. Any sterilization performed on mentally incompetent individuals or institutionalized individuals;
5. A hysterectomy performed during a period of retroactive eligibility as described in 42 CFR 441.255(e);
6. Any service that is unproven or experimental or any service that is solely for a social, research or cosmetic purpose;
7. Any vaccine provided to the hospital through the Vaccines for Children program operated by the Department of Public Health, except that the department reimburses the hospital for the administration of the vaccine using a fixed fee or other reimbursement methodology as determined by the department;
8. Any service that is not medically necessary or that is not directly related to the member's diagnosis, symptoms or medical history;
9. In accordance with 42 USC 1396a(kk)(7) and section 17b-262-979 of the Regulations of Connecticut State Agencies, any service that requires an order or referral from a physician or other licensed practitioner, but is not ordered or referred by a physician or other licensed practitioner

enrolled in Medicaid;

10. Any routine physical examination requested by a third party;

11. Any cancelled service or any good or service that was not actually provided;

12. Any service requiring prior authorization if prior authorization was not obtained before the hospital performed the service; or

13. Any service that does not comply with 42 CFR 440.20 or 42 CFR 482, such as a service provided to an individual who is not an outpatient.

(NEW) Sec. 17b-262-974. Out-of-State and Border Hospitals

The department pays out-of-state hospitals and border hospitals for outpatient hospital services that are provided pursuant to 42 CFR 431.52 and section 17b-262-532 of the Regulations of Connecticut State Agencies, as follows:

(a) For a service that the department determines is available in Connecticut and is reimbursed using the APC methodology, the department pays the hospital using the APC methodology with a statewide conversion factor with no adjustment for geographic wage index, except that if a hospital requests to have the conversion factor adjusted for the hospital's actual geographic wage index, the department may grant such request on a case-by-case basis if the department determines that such adjustment is necessary to ensure access to medically necessary services for a member. In all other respects pays the hospital in accordance with section 17b-262-977 of the Regulations of Connecticut State Agencies.

(b) For a service that the department determines is available in Connecticut and is reimbursed using a methodology other than APC, the department pays the hospital using the same methodology and rate as if the hospital were located in Connecticut.

(c) For a service that the department determines is not available in Connecticut, the department may negotiate payment rates and conditions with such hospital up to but not exceeding the provider's usual and customary charges.

(NEW) Sec. 17b-262-975. Utilization Review

(a) General. The department performs utilization review for outpatient hospital services in order to:

(1) Determine if billed services are medically necessary;

(2) Assure that the quality of service meets accepted and established standards; and

(3) Monitor trends and patterns of utilization.

(b) Prior Authorization.

(1) 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.

(2) Prior authorization is required for:

(A) Any service that the department designates as requiring prior authorization on its fee schedule, authorization grid or another document that is available to providers;

(B) Any service that is not on a fee schedule; and

(C) EPSDT special services.

(3) If prior authorization is required for separately reimbursable professional services associated with an outpatient hospital service and the practitioner has not obtained required prior authorization, the hospital shall not bill for or be reimbursed for the technical component associated with such professional services.

(c) Concurrent Review. The department may perform concurrent review as it deems appropriate. Such concurrent review may evaluate the medical necessity, timeliness, accuracy of coding, quality of services provided or any combination of such these factors.

(d) Retrospective Review. The department may review any selected outpatient hospital service after such service is performed. Such review may focus on such factors as the medical necessity, quality and timeliness of the service provided, the accuracy of coding, patterns of utilization and other factors identified by the department. The department may adjust payments to the provider based on the outcome of such review.

(e) Registration. Registration may serve in lieu of prior authorization or retrospective authorization, as applicable, only if a service is specifically designated by the department as requiring registration

(NEW) Sec. 17b-262-976. Overall Payment Methodology for Outpatient Hospital Services

(a) The department pays hospitals for providing outpatient hospital services in using OPPS in accordance with the Medicaid State Plan. As determined and designated by the department, services are paid using one or more of the following methodologies and in accordance with the department's procedures, instructions, fee schedules and Addendum B:

(1) APC payment as set forth in section 17b-262-977 of the Regulations of Connecticut State Agencies;

(2) A fee on the department's fee schedule for outpatient hospitals;

(3) A daily rate, other fee or reimbursement methodology established by the department; or

(4) A fee on one of the department's fee schedules other than the outpatient hospital fee schedule.

(b) Payment for outpatient hospital services shall comply with applicable federal requirements, including applicable provisions of 42 CFR 447, as amended from time to time.

(c) Reimbursement for outpatient hospital services and other services prior to inpatient hospital admission.

(1) Except as provided in subdivision (2) of this subsection, reimbursement for inpatient hospital services includes payment for all outpatient hospital services provided by the hospital or another hospital that is an affiliate of the hospital at any location, including the hospital's main campus and any satellite location, on the date of admission and the two days prior to the date of admission, which shall not be separately reimbursed by the department and shall be billed as part of the inpatient hospital stay.

(2) The department pays a hospital or an affiliate of the hospital separately for the following services provided on the date of admission, but before the actual admission and the two days prior to the date of admission: Any service clinically unrelated to the admission, maintenance renal dialysis, physical therapy, occupational therapy, speech and language pathology services, audiology services, routine psychotherapy, electroconvulsive therapy (except if the electroconvulsive therapy causes the admission), psychological testing, neuropsychological testing, intermediate care programs and any other category of service specifically designated in writing by the department or on a case-by-case basis. Subdivision (1) of this subsection does not apply to any services described in this subdivision.

(d) Subject to section 17b-262-974 of the Regulations of Connecticut State Agencies, the department shall pay a hospital at the lowest of:

(1) The applicable APC payment, fee schedule payment, per diem payment or other reimbursement methodology established by the department for a service;

(2) The hospital's charges;

(3) Applicable reimbursement from Medicare, except for services designated by the department as being reimbursed at rates higher than Medicare, if any; or

(4) For laboratory services provided by a hospital, the lowest price, including all third party

negotiated discounts, charged or accepted for the same or substantially similar goods or services by the hospital or affiliate of the hospital from any person or entity, except that a billing provider may occasionally charge or accept a lesser amount if the billing provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the hospital and any affiliate of the hospital shall bill for such service at the amount described in this subdivision.

(NEW) Sec. 17b-262-977. Payment Rate and Limitations for Hospitals Reimbursed Using APCs

(a) Effective for services provided on or after July 1, 2016, for applicable services as specified on Addendum B, the department pays for outpatient hospital services on a fully prospective per service basis using an APC payment methodology in accordance with this section.

(b) The department establishes one or more adjusted conversion factors and uses relative weights for each APC.

(c) The department may establish one or more peer groups of hospitals within the reimbursement methodology design of OPPS and the APC payment methodology.

(d) For services specified on Addendum B as being reimbursed using an APC payment methodology:

(1) The department determines the APC service payment based on: (A) one or more applicable APC conversion factor or factors, (B) if applicable, the department's adjustment for the geographic wage index, (C) the APC relative weight, (D) allowed units and (E) if applicable, an APC cost outlier payment.

(2) APCs are assigned using the APC grouper.

(3) An APC outlier payment may be made when the cost for the service exceeds specified criteria established by the department.

(NEW) Sec. 17b-262-978. Services Reimbursed Separately from APC

(a) The department shall not pay a hospital for any service identified as not payable on Addendum B.

(b) The department separately reimburses a hospital using a non-APC payment for the following:

(1) All services designated for separate non-APC payment on Addendum B, including, but not limited to: physical therapy, occupational therapy, speech and language pathology services, behavioral health services, vaccine administration and any other service designated for non-APC payment;

(2) Supplemental payment or other payments for which the hospital may be eligible, if any, such as any disproportionate share hospital (DSH) payments, any upper payment limit (UPL) payments and any other supplemental payment that may be available;

(3) Dental surgery services specified in accordance with subdivision (1) of subsection (l) of section 17b-262-970; and

(4) Laboratory services provided to hospital non-patients, which shall be reimbursed in accordance with the department's consolidated laboratory fee schedule.

(c) Licensed Practitioner Services

(1) Except as provided in subsection (c) of section 17b-262-971 of the Regulations of Connecticut State Agencies concerning behavioral health services, professional services performed by a licensed practitioner in the outpatient hospital setting shall be billed and reimbursed separately from the hospital's facility or technical services. The department's rates, regulations, procedures and policies applicable to the licensed practitioner apply to all professional services performed by the licensed

practitioner in the outpatient hospital setting. Services performed by residents that are reimbursable in accordance with section 17b-262-346 of the Regulations of Connecticut State Agencies shall be paid to the resident's attending or supervising physician, not to the hospital.

(2) Except for practitioners who have obtained advanced written consent from a member to be billed as provided in subparagraph (B) of subdivision (3) of this subsection, the hospital shall ensure that all licensed practitioners who perform professional services in any outpatient hospital setting of such hospital and licensed behavioral health clinicians who perform services in the hospital that are separately billable from the hospital in accordance with subsection (c) of section 17b-262-971 of the Regulations of Connecticut State Agencies are enrolled in Medicaid in a manner specified by the department.

(3) The hospital shall ensure that each licensed practitioner performing professional services in any outpatient hospital setting of such hospital and each licensed behavioral health clinician who performs services in the hospital that are separately billable from the hospital in accordance with subsection (c) of section 17b-262-971 of the Regulations of Connecticut State Agencies does not charge any member in connection with such services, except for:

(A) Medicaid cost-sharing as approved by the department; or

(B) Professional services performed in conjunction with elective outpatient hospital services where each licensed practitioner not enrolled in Medicaid obtains specific written consent from the member that:

(i) Is signed by the member or, if applicable, the member's authorized legal representative, who specifically agrees in writing to be charged for services;

(ii) Is obtained not less than seventy-two hours before the services are initiated;

(iii) Describes the services to be performed and lists the amount estimated to be billed to the member; and

(iv) If it is a service covered by Medicaid, the consent form shall also include the following or comparable statement in clearly readable text: "If you got this care from a different doctor or provider, who is enrolled in Medicaid, then you would not be charged. You might also be charged for follow-up services or prescriptions ordered by a doctor or provider who is not enrolled in Medicaid. For questions, including if you have any questions about co-payments, call the number on your Medicaid card or contact member services."

(4) The department may take such action as necessary to enforce subdivisions (2) and (3) of this subsection, including, but not limited to recouping some or all reimbursement from the hospital for facility charges related to professional charges for which a licensed practitioner bills directly to a member in violation of this subdivision, such as facility charges for services provided to the same member at the same hospital on the same date of service as the professional charges.

(NEW) Sec. 17b-262-979. Billing and Payment Procedures

(a) In a manner specified by the department, the provider shall submit claims on the department's uniform billing form or electronically transmit the claims and shall include all information required by the department to process the claim for payment. The provider shall bill as instructed in writing by the department.

(b) Any applicable third party and Medicare payments to a hospital on behalf of a member receiving outpatient hospital services shall offset allowed payments from the department to the hospital.

(c) Except for any Medicaid cost-sharing approved in writing by the department, the hospital shall not charge or collect payment from a member for:

(1) Cancelled services or appointments;

(2) Not attending an appointment or service, with or without advanced notice;

(3) Any services that are coverable under Medicaid, including any services that would have been covered but for the hospital's failure to comply with applicable requirements for payment;

(4) Any service that are incidental to covered services, including, but not limited to, copying medical records, completing school and camp forms and other forms relating to clients' participation in sports and other activities and completing court forms; or

(5) Any non-coverable service, except as authorized pursuant to subsection (l) of section 17b-262-531 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-980. Documentation and Record Retention

(a) Providers shall maintain specific medical records for all services provided to members, including, but not limited to: name; address; birth date; Medicaid identification number; pertinent diagnostic information; sterilization consent forms, if applicable; documentation of services provided; the dates the services were provided; and, when required, a current plan of care and corresponding treatment notes signed by the appropriate physician or other practitioner.

(b) In accordance with 42 CFR 482.24, all medical records shall be signed and completed not less than thirty days after the service is performed.

(c) Providers shall preserve all required documentation in its original written or electronic form for a period of time not less than five years or the length of time required by statute or regulation, whichever is greater. Such documentation is 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 greater.

(d) In accordance with 42 USC 1396a(kk)(7), the hospital shall:

(1) Maintain appropriate documentation of an order or referral by a physician or other licensed practitioner enrolled in Medicaid for each outpatient hospital service that requires or received an order or referral, including, but not limited to: pharmacy, physical therapy, occupational therapy, speech and language pathology, radiology and any other categories of service designated in writing by the department as requiring an order or referral.

(2) Ensure that, if a resident orders or refers outpatient hospital services, whenever possible, the resident enrolls in Medicaid as an OPR-only provider. If a resident is not enrolled in Medicaid, the resident's order or referral complies with this subdivision if the resident's attending or supervising physician or other applicable licensed practitioner is enrolled in Medicaid. The hospital shall maintain documentation confirming which attending or supervising physicians or other applicable licensed practitioners were responsible for the resident's orders or referrals.

(3) Include the NPI of the ordering physician or other licensed practitioner enrolled in Medicaid on each claim for outpatient hospital services for which an order or referral is issued or required, which may, if appropriate, be the same individual as the attending physician listed on the claim. If a resident orders or refers a service, the hospital may include either the NPI of the resident or the resident's attending or supervising physician or other applicable licensed practitioner on the claim. The medical records shall include the signature of the attending or supervising physician or other applicable licensed practitioner who was responsible for the resident's order or referral.

(e) The department may disallow and recover any amounts paid to the provider for which required documentation is not maintained and not provided to the department upon request.

(f) The department may audit all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with applicable regulatory and statutory requirements.

(g) Upon request, the provider shall make the original medical record or copies of the record available to the department during regular business hours.

(h) Each hospital shall maintain financial and statistical records of the period covered by cost

reports that the hospital has submitted to the department for a period of not less than ten years following the date of submittal of the cost report to the department. These records shall be accurate and shall contain sufficient detail to substantiate the cost data reported. Upon request, the provider shall make such records or copies thereof available to the department. The department may require a hospital to send a Medicare or other cost report, which the hospital shall provide upon request.

(i) In addition to the requirements set forth in subsections (a) to (h), inclusive, of this section, for behavioral health services the hospital shall also retain the documentation specified in subsection (i) of section 17b-262-971 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-981. Reserved

Section 2. Section 17b-262-475 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 17b-262-475. Payment

(a) Except for services provided in a hospital emergency department other than observation, psychologists shall not receive separate payment from the department for providing services to clients in any hospital, including, but not limited to, a general hospital, children's general hospital, psychiatric hospital or chronic disease hospital. Psychologists who are fully or partially [salaried] compensated by a [general hospital,] public or private institution, group practice[,] or clinic shall not receive payment from the department for services rendered at such institution, group practice or clinic 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] The provider's usual and customary charge to the general public;

(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;

(3) [the] The amount in the applicable fee schedule as published by the department; or

(4) [the] 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.]

Section 3. Subsection (a) of section 17b-262-922 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) Except for services provided in a hospital emergency department other than observation, licensed behavioral health clinicians shall not receive separate payment from the department for providing services to clients in any hospital, including, but not limited to, a general hospital, children's general hospital, psychiatric hospital or chronic disease hospital. 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.

Section 4. Section 17b-262-460 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 17b-262-460. Payment

(a) Payment shall be made at the lowest of:
(1) [the] The provider's usual and customary charge to the general public;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] The amount in the applicable fee schedule as published by the department;
(4) [the] The amount billed by the provider; or
(5) For laboratory services provided by the provider, the lowest price, including third party negotiated discounts, charged or accepted for the same of substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

(b) Except for electroconvulsive services or services provided in a hospital emergency department other than observation, a psychiatrist shall not receive separate payment from the department for providing behavioral health services to clients in any outpatient hospital setting, including, but not limited to, a general hospital, children's general hospital, psychiatric hospital or chronic disease hospital. A psychiatrist who is fully or partially [salaried] compensated 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 or other compensation are not entitled to separate 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.

Section 5. Subsection (d) of section 17b-262-346 of the Regulations of Connecticut State Agencies is amended to read as follows:

(d) [The] Except as otherwise provided in subdivision (2) or (3) of this subsection, the department shall not pay for services provided by interns or residents [for their services, nor shall the].
(1) The department shall not pay for assistant surgeons in general hospitals [or chronic disease

hospitals] staffed by [interns and] residents, unless the procedure is sufficiently complicated that it is medically necessary for a [full] second surgeon to act as an assistant, such as for open heart surgery. If the resident or intern performs the surgery and the supervising surgeon assists, the department shall pay only the assistant's fee to the surgeon and shall not pay the regular surgical fee.

(2) The department pays a provider for services provided by residents performed as part of a primary care exception recognized by Medicare in a graduate medical education program, subject to the conditions, billing procedures, documentation and other requirements established in writing by the department.

(3) The department pays a provider for services performed by a resident that are designated for payment by Medicare and are within the resident's competence, so long as the physician is present or performs key parts of the service, as applicable, and subject to the conditions, billing procedures, documentation and other requirements established in writing by the department.

Section 6. Section 17b-262-346 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (g) as follows:

(g) The provider shall not bill and the department shall not pay a provider for performing professional services associated with a facility or technical component performed on the same date or dates of service by a hospital or other facility that requires prior authorization and for which the hospital or other facility did not obtain prior authorization.

Section 7. Section 17b-262-458 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (l) as follows:

(*l*) The provider shall not bill and the department shall not pay a provider for performing professional services associated with a facility or technical component performed on the same date or dates of service by a hospital or other facility that requires prior authorization and for which the hospital or other facility did not obtain prior authorization.

Section 8. Section 17b-262-580 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (h) as follows:

(h) The provider shall not bill and the department shall not pay a provider for performing professional services associated with a facility or technical component performed on the same date or dates of service by a hospital or other facility that requires prior authorization and for which the hospital or other facility did not obtain prior authorization.

Section 9. Section 17b-262-614 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (h) as follows:

(h) The provider shall not bill and the department shall not pay a provider for performing professional services associated with a facility or technical component performed on the same date or dates of service by a hospital or other facility that requires prior authorization and for which the hospital or other facility did not obtain prior authorization.

Section 10. Section 17b-262-626 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (h) as follows:

(h) The provider shall not bill and the department shall not pay a provider for performing professional services associated with a facility or technical component performed on the same date or dates of service by a hospital or other facility that requires prior authorization and for which the hospital or other facility did not obtain prior authorization.

Section 11. Section 17b-262-648 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (e) as follows:

(e) Coordination with Outpatient Hospital Laboratory Services.
(1) When a hospital laboratory refers a specimen to an independent laboratory for testing that it is unable to perform on site:
(A) For a client who is not directly receiving outpatient services other than diagnostic testing services from the hospital, either the referring hospital or the laboratory to which the specimen was referred, but not both, may bill for and be reimbursed for such laboratory services.
(B) For clients other than those specified in subparagraph (A) of this subdivision, only the hospital that collects and refers the specimen may bill the department for such services. The laboratory to which the specimen was referred shall not bill for or be reimbursed by the department for such services.
(2) In order to prevent duplicate payment to the hospital, laboratory services related to any outpatient hospital service that are performed on the same date or dates of service shall be billed only by the hospital that performed the outpatient hospital services. Such services shall not be billed by or paid to any entity other than the hospital if such services were performed by: (A) the hospital, (B) an independent laboratory that is an affiliate of the hospital, in accordance with section 19a-643-201 of the Regulations of Connecticut State Agencies, that performed the other outpatient hospital services or (C) an independent laboratory that is in the same location as the hospital's main campus or any satellite location of the hospital, even if the laboratory is not an affiliate of the hospital, in accordance with section 19a-643-201 of the Regulations of Connecticut State Agencies. An independent laboratory that is not an affiliate of the hospital, in accordance with section 19a-643-201 of the Regulations of Connecticut State Agencies, and is in a different location from the hospital's main campus and satellite locations may separately bill for and be reimbursed for such services.

Section 12. Subsection (a) of section 17b-262-649 of the Regulations of Connecticut State Agencies is amended as follows:

(a) Payment shall be made at the lowest of:
(1) [the] The provider's usual and customary charge to the general public;
(2) [the] The lowest applicable Medicare rate;
(3) [the] The amount in the applicable fee schedule as published by the department;
(4) [the] The amount billed by the provider; or
(5) [the] The lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 13. Section 17b-262-531 of the Regulations of Connecticut State Agencies is amended by adding a new subsection (q) as follows:

(q) Various Prohibitions on Billing Clients.
(1) The provider shall not charge a client for cancelled visits and appointments not kept, regardless of whether the client gives the provider advanced notice.
(2) The provider shall not charge a client for services that are incidental to covered services, including, but not limited to, copying medical records and completing school and camp forms and other forms relating to clients' participation in sports and other activities.
(3) The provider shall not bill clients or any other party for any additional or make-up charge for covered services, excluding any cost sharing approved in writing by the department and as permitted by law, even when the department does not pay for those covered services for technical reasons, such as a claim not timely filed or a billed amount exceeding the amount allowed for reimbursement by the department.

Section 14. Subsection (b) of section 17b-262-617 of the Regulations of Connecticut State Agencies is amended to read as follows:

(b) [Nurse] Except as otherwise provided in writing by the department, nurse practitioner rates for each procedure shall be set at 90% of the department's fees for physician procedure codes.

Section 15. Subsection (b) of section 17b-262-346 of the Regulations of Connecticut State Agencies is amended to read as follows:

(b) Payment shall be made at the lowest of:
(1) The billing provider's usual and customary charge;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] 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] The amount billed by the billing provider[.]; or
(5) For laboratory services provided by the billing provider, the lowest price, including all third party negotiated discounts, charged or accepted for the same of substantially similar goods or services by the provider from any person or entity, except that a billing provider may occasionally charge or accept a lesser amount if the billing provider shows that an individual who received services from such billing provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 16. Subsection (e) of section 17b-262-345 of the Regulations of Connecticut State Agencies is amended to read as follows:

(e) [The department shall pay the billing provider directly for laboratory services performed in the provider's office and the billing provider shall bill the department for such services as separate line items.] When a provider refers a client [to a private laboratory for services, the laboratory shall bill

the department directly and no laboratory charge shall be paid to the provider] for laboratory services that are not performed by the provider, the billing provider shall not bill and the department shall not pay the billing provider for such laboratory services.

Section 17. Subdivision (4) of subsection (m) of section 17b-262-348 of the Regulations of Connecticut State Agencies is amended to read as follows:

(4) The department shall pay the provider only for laboratory physicians' services that are actually provided by the provider and that the provider is authorized to perform [and are performed in the provider's office. The department shall not pay the referring provider for laboratory services performed in a laboratory or in any setting other than the provider's office].

Section 18. Subsection (g) of section 17b-262-827 of the Regulations of Connecticut State Agencies is amended to read as follows:

(g) The department shall pay at the [lower] lowest of:
(1) The amount in the applicable fee schedule;
(2) The amount on the provider's rate letter; [or]
(3) The amount billed by the provider[.];
(4) The provider's usual and customary charge to the public; or
(5) For laboratory services provided by the provider, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 19. Subsection I of section 171.4 of the Department of Social Services Medical Services Policy is amended to read as follows:

I. Payment will be made at the [lower] lowest of:

a. [the] The usual and customary charge to the public[, or];

b. The lowest Medicare rate, [or] except for services designated by the department as being reimbursed at rates higher than Medicare, if any;

c. [the] The fee as contained in the [individual clinic's] applicable fee schedule as published by the Department[, or];

d. [the] The amount billed[.]; or

e.For laboratory services provided by the provider, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 20. Subsection I of section 173 of the Department of Social Services Medical Services Policy is amended to read as follows:

I. Payment

Payment [will be made in accordance with the payment policy established for each provider group.] shall be made at the lowest of:

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

(2)The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;

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

(4)The amount billed by the provider; or

(5)For laboratory services provided by the provider, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 21. Subsection (c) of section 17b-262-628 of the Regulations of Connecticut State Agencies is amended to read as follows:

(c) Payment shall be made at the lowest of:
(1) [the] The podiatrist's usual and customary charge;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] 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] The amount billed by the podiatrist[.]; or
(5) For laboratory services provide by the podiatrist, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 22. Subsection (b) of section 17b-262-616 of the Regulations of Connecticut State Agencies is amended to read as follows:

(b) Payment shall be made at the lowest of:
(1) [the] The provider's usual and customary charge to the general public;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] The amount in the applicable fee schedule as published by the department;
(4) [the] The amount billed by the provider; or
(5) For laboratory services provided by the provider, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 23. Section 17b-262-582 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 17b-262-582. Payment
Payment shall be made at the lowest of:

(a) [the] The provider's usual and customary charge to the general public;
(b) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(c) [the] The amount in the applicable fee schedule as published by the department;
(d) [the] The amount billed by the provider; or
(e) For laboratory services provided by the provider, the lowest price, including all third party

negotiated discounts, charged or accepted for the same or substantially similar goods or services by the provider from any person or entity, except that a provider may occasionally charge or accept a lesser amount if the provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services. If the amount described in this subdivision is the lowest amount described in this subsection for a service, the provider shall bill for such service at the amount described in this subdivision.

Section 24. Subsection (a) of section 17b-262-544 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) Payment shall be made at the lowest of:
(1) [the] The provider's usual and customary charge to the general public;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] The amount in the applicable fee schedule as published by the department; or
(4) [the] 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.]

Section 25. Subsection (b) of section 17b-262-519 of the Regulations of Connecticut State Agencies is amended to read as follows:

(b) The payment rate shall be made at the lowest of:
(1) [the] The provider's usual and customary charge to the general public;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] The amount in the applicable fee schedule as published by the department; or
(4) [the] 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.]

Section 26. Subsection (a) of section 17b-262-556 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) Payment shall be made at the lowest of:
(1) [the] The provider's usual and customary charge to the general public;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] The amount in the applicable fee schedule as published by the department; or
(4) [the] 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.]

Section 27. Subsections (b) and (c) of section 17b-262-638 of the Regulations of Connecticut State Agencies are amended to read as follows:

(b) Payment shall be made at the lowest of:
(1) The provider's usual and customary charge;
(2) [the] The lowest Medicare rate, except for services designated by the department as being reimbursed at rates higher than Medicare, if any;
(3) [the] The amount in the independent therapy fee schedule as published by the department; or
(4) [the] 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.]

Section 28. Sections 17-134d-50, 17-134d-56, 17-134d-63 and 17-134d-86 of the Regulations of Connecticut State Agencies are repealed. Section 150.2 of the Department of Social Services Medical Services Policy is repealed.

Statement of Purpose

The purposes of the regulation are to: (1) update and recodify the department's outpatient hospital medical services policy in regulation form; (2) update and consolidate all of the department's outpatient hospital regulations into one regulation; (3) modernize the outpatient hospital reimbursement system in accordance with section 17b-239 of the Connecticut General Statutes; (4) update and make consistent all regulations regarding the payment of laboratory services; and (5) make various updates and clarifications to various provider regulations.

(A) The problems, issues or circumstances that the regulation proposes to address: Section 17b-239 of the Connecticut General Statutes requires the department to reimburse for outpatient hospital services using an outpatient prospective payment system (OPPS) that uses an ambulatory payment classification (APC) methodology to reimburse for most outpatient hospital services. This payment reform modernizes the department's outpatient hospital reimbursement methodology and is similar to the outpatient hospital reimbursement methodology used by Medicare, with various modifications. Under OPPS, services paid using the APC reimbursement methodology will be paid to hospitals solely for the facility and technical components of hospital services, which means that physicians and certain other licensed practitioners must be reimbursed separately from the hospital for providing professional services associated with hospital services reimbursed under the APC reimbursement methodology. The regulation implements the OPPS both by establishing rules for hospital reimbursement and rate-setting as well as enabling the department to reimburse physicians and certain other licensed practitioners for their professional services separately from the hospital.

In order to improve clarity, this regulation also updates and consolidates all outpatient hospital regulations and repeals regulations that are obsolete or are being consolidated into this regulation, as well as repealing an obsolete clinic regulation. The regulation amends the provider participation regulations to prohibit providers from charging members for cancelled visits or appointments not kept and for providing services incidental to covered services. This regulation amends the independent clinical laboratory regulation to conform to outpatient hospital laboratory provisions being added in this regulation. The regulation also amends the nurse practitioner regulation to add flexibility regarding the rate of reimbursement.

Finally, this regulation also makes several changes to be consistent with the changes being made to payment for laboratory services provided by hospitals. Specifically, the new outpatient hospital regulation aligns with the payment requirement in the independent laboratory regulation, which provides that payment is made at the lowest of several amounts, including any amount charged or accepted by any other person or entity, such as a commercial health insurance plan, which is also known as the "most favored nation" requirement. In order to make this payment rule consistent for laboratory services provided by any provider type, not solely hospitals and independent laboratories, this regulation aligns the payment rules for laboratory services in various other applicable regulations, including the physician, nurse practitioner, nurse-midwife, medical clinic, family planning clinic, psychiatrist, podiatrist and behavioral health clinic regulations. This regulation also clarifies the language in the physician regulation regarding the contexts in which a physician group may be paid for providing laboratory services. Relatedly, this regulation removes the most favored nation payment rule from a variety of other provider regulations, including the naturopath, chiropractor, independent radiology, psychologist, and independent therapist regulations.

(B) The main provisions of the regulation: (1) Establish a new consolidated outpatient hospital regulation that updates provisions from the department's outpatient hospital medical services policy and other regulations regarding coverage, billing, provider enrollment, documentation and related requirements; (2) implement outpatient hospital payment modernization by setting forth specific rules

for reimbursement and rate-setting both for services reimbursed under APCs and non-APC reimbursement methodologies; (3) update and consolidate various other outpatient hospital regulations regarding hospital reimbursement and rate-setting, utilization review and border and out-of-state hospitals; (4) amend various other regulations as necessary to enable the department to reimburse physicians and certain other licensed practitioners separately from the hospital, as required by the services within OPPS that will be reimbursed using the APC reimbursement methodology; (5) update citations in other regulations to regulations that have been renumbered or repealed; (6) make various technical and other updates and revisions; (7) repeal regulations that are obsolete or have been consolidated into the new outpatient hospital regulation, as well as repealing an obsolete clinic regulation; (8) amending the provider participation regulations to prohibit providers from charging members for cancelled visits or appointments not kept and for providing services incidental to covered services; (9) amending the independent clinical laboratory regulation to conform to outpatient hospital laboratory provisions being added in this regulation; (10) amending the nurse practitioner regulation to add flexibility regarding the rate of reimbursement; (11) amending the physician regulation to clarify the contexts in which physician laboratory services are reimbursed; and (12) updating the payment language for various regulations as referenced in paragraph (A) above.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation recodifies and updates the existing outpatient hospital medical services policy in regulation form. The regulation updates and consolidates all outpatient hospital regulations into one regulation. This regulation also amends existing regulations as necessary to enable the department to implement the hospital payment reform project as well as updating cross-references to regulations that are being repealed or renumbered in this regulation. This regulation repeals older outpatient hospital regulations that are obsolete, redundant or have been consolidated into this new regulation, as well as repealing an obsolete clinic regulation. This regulation amends the provider participation regulations to prohibit providers from charging members for cancelled visits or appointments not kept and for providing services incidental to covered services. This regulation amends the independent clinical laboratory regulation to conform to outpatient hospital laboratory provisions being added in this regulation. The regulation also amends the nurse practitioner regulation to add flexibility regarding the rate of reimbursement. The regulation amends the physician regulation to clarify the contexts in which physician laboratory services are reimbursed. Finally, this regulation also updates the payment language in a variety of provider regulations as described in paragraph (A) above.