



Connecticut interChange MMIS

Provider Manual

Chapter 7 - Hospital

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**Connecticut Department of Social Services (DSS)
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Hartford, CT 06105**

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Hospital Regulation/Policy
Chapter 7

Medical Services Policy

7.1

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to hospital providers.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Hospital Services

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HOSPITAL INPATIENT SERVICES
150.1. - 150.1A.V.

150 Hospital Services

Section 150.1 Hospital Inpatient is no longer in effect for dates of admission on or after January 1, 2015. Please refer to the draft Regulation Concerning Inpatient Hospital Services available from the menu for Chapter 7 under “Hospital Inpatient: NEW Requirements Eff. 1-1-15”.

Section 150.1 remains in effect for Psychiatric Hospital Inpatient services rendered at State-operated Institutions.

150.1 Hospital Inpatient Services

Inpatient hospital acute care services provide medical treatment under the direction of a physician or dentist to Title XIX eligible hospital inpatient.

A. Legal Bases

- I. Social Security Act: Sections 1902(a), 1903, 1905, 1151, 1152, 1861, 1865
- II. Code of Federal Regulations: 42 CFR Part 405, 42 CFR Part 440, 42 CFR 431.52 (Out-of-state), 42 CFR Part 456, 42 CFR Part 447 (Payments)
- III. Connecticut General Statutes: Sections 19a-630, 17b-225, 17b-238 through 17b-247, 17b-262, 19a-490 through 19a-493, 19a-495
- IV. State Medicaid Plan: 3.1, 3.1A
- V. Regulations of Connecticut State Agencies: Section 19-13-D

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150.1B. - 150.1B.VI.

B. Definitions

- I. Accreditation - The process by which an agency, individual or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined standards. The recognition is called accreditation. Similar assessment of individuals and institutions is called certification. Standards are usually defined in terms of: physical plant, governing body, administration, medical and other staff, and scope and organization of services. Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the Joint Commission on Accreditation of Hospitals). Accreditation standards and individual performance with respect to such standards are not always available to the public. In some situations public governments recognize accreditation in lieu of, accept it as the basis of, or require it as a condition of licensure. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent once obtained or for a specified period of time. Unlike a license, accreditation is not a condition of lawful practice but is intended as an indication of high quality practice, although where payment is effectively conditioned on accreditation it may have the same effect.
- II. Actual Cost - Average cost per inpatient day of care furnished such patients, computed in accordance with accepted principles of hospital cost reimbursement.
- III. Acute Care - Medical care needed for an illness, episode, or injury which requires short term, intense care and hospitalization for a short period of time.
- IV. Acute Disease - A disease which is characterized by a single episode of a fairly short duration from which the patient returns to their normal or previous state and level of activity.
- V. Administratively Necessary Days (ANDs) - ANDs are inpatient hospital days reimbursed by Medicaid for services to a Title XIX eligible patient and to a patient who will eventually be determined eligible. A patient qualifying for ANDs does not require an acute hospital level-of-care. Instead, the patient requires medical services at the skilled nursing or intermediate level-of-care. The patient is forced to remain in the hospital because the appropriate medical level-of-care placement in a skilled nursing facility or intermediate care facility or at home is not available.
- VI. Admission - The formal acceptance by a hospital of a patient who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services.

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150.1B.VII. - 150.1B.XIV.

- VII. Adverse Determination - The initial negative decision by a reviewing body regarding the medical necessity, quality, or appropriateness of health care services provided or proposed to be provided to a patient.
- VIII. AEP - Appropriateness Evaluation Protocol is a technique for determining the medical necessity of admissions and days of care. It is based on objective criteria applicable to all adult medical, surgical, gynecological and non-infant pediatric patients in acute care hospitals. It can be used to identify both the amount of and the reasons for inappropriate hospital use.
- The AEP technique was developed by a team of physicians, nurses and health services researchers at Boston University Medical Center under the direction of Paul M. Gertman, M.D. and Joseph D. Restuccia, Dr. P.H. with the support of the Health Care Financing Administration. The AEP has undergone rigorous testing to establish its reliability and validity.
- IX. Ambulatory - Walking or able to walk; not confined to bed.
- X. Appropriateness of Setting Review - The review of services provided or proposed to be provided to determine if the services could have been delivered safely, effectively and more economically in another setting.
- XI. Average Daily Census (ADC) - The average number of inpatients (other than newborn) each day throughout a given period of time. The census is calculated by dividing the number of patient days during a period by the number of calendar days in the period.
- XII. Average Length of Stay (ALS) - Average number of patient days of services rendered to each inpatient (excluding newborns) during a given period.
- Length is calculated as follows: Total number of days in the facility for all discharges and deaths occurring during a period divided by the number of discharges and deaths during the same period. Average lengths of stay vary and are measured for people with various ages, specific diagnoses, or sources of payment.
- XIII. Border Hospital - When the normal medical service delivery area and nearest hospital for Connecticut Title XIX recipients is adjacent to but outside the State of Connecticut, the hospital is termed a Border Hospital.
- XIV. Chronic Disease - Disease which have one of the following characteristics: are permanent; leave residual disability; are caused by nonreversible pathological alteration; require special training of the patient for rehabilitation; or which may be expected to require a long period of supervision, observation, or care.

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150.1B.XV. - 150.1B.XXII.

- XV. Concurrent Review - Review of the medical necessity of hospital or other health facility admissions upon or within a short period following an admission and the periodic review of services provided during the course of treatment.
- XVI. Criteria - Pre-determined measurement variables on which judgment or comparison of necessity, appropriateness or quality of health services may be made.
- XVII. Department - The State of Connecticut Department of Income Maintenance or its agent.
- XVIII. Department's Manual - The Department's Connecticut Medical Assistance Provider Manual, which contains the Medical Services Policy, as amended from time to time.
- XIX. Diagnosis
 - a. Admitting Diagnosis - The patient's condition which necessitated or prompted the admission to the hospital, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.
 - b. Principal Diagnosis - The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care and coded using International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.
- XX. Emergency - A medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- XXI. Emergency Care - Care for patient with a severe and sudden life-threatening, or potentially disabling condition(s) that requires intervention within minutes or hours.
- XXII. Evaluation - An assessment or examination in which actions and their results are measured against predetermined criteria in order to verify medical necessity, appropriateness, and quality.

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150.1B.XXIII. - 150.1B.XXX.

- XXIII. General Hospital - For purposes of this regulation means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries. It shall also include a border hospital as defined in Section 150.1 of the Department's Manual, as may be amended from time to time.
- XXIV. Inpatient - A recipient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental or other health related services and is present at midnight for the census count.
- XXV. Inpatient Day - For billing purposes a day starts when the patient is present at midnight for the census count.
- XXVI. Inpatient Hospital Services - All items and services which are furnished by a licensed/accredited or formally approved hospital provided under the direction of physicians or dentists for the care of hospital inpatients.
- XXVII. Institutional Health Services - Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions, and by health maintenance organizations; but may also refer to services delivered on an outpatient basis by departments or other organizational units of or sponsored by such institutions.
- XXVIII. ISD Review System - Intensity of service, severity of illness discharge screens were originally published in 1978 in InterQual's publication, Intensification Criteria for Concurrent Utilization Review. The system was conceived by Charles M. Jacobs and Joanne Lamprey, InterQual, and developed by Ms. Lamprey. The Department is using, with permission, the ISD Discharge Screening Criteria, revised in October of 1983.
- XXIX. ICD-9-CM - The International Classification of Diseases, 9th Revision, Clinical Modification.
- XXX. Joint Commission on Accreditation of Hospitals (J.C.A.H.) - A national agency sponsored by the American Medical Association, the American College of Physicians, the American College of Surgeons and the American Hospital Association, which periodically inspects hospitals and which may accord these institutions a degree of accreditation in recognition of satisfactory performances.

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150.1B.XXXI. - 150.1B.XXXIX.

- XXXI. Leave-of-Absence or “Pass” not Medically Approved - A period of time following admission as an inpatient and prior to the day of discharge on which the patient is absent from the hospital for non-medical reasons, without medical order.
- XXXII. Leave-of-Absence or “Pass” with Medical Approval - A period of time following admission as an inpatient and prior to the day of discharge in which the patient has been permitted by the attending physician to be absent from the hospital premises.
- XXXIII. Length-of-Stay (LOS) - The number of days a patient remains in the hospital from admission to discharge.
- XXXIV. Medical Appropriateness - Medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting.
- XXXV. Medical Necessity - Medical care provided to:
- a. Correct or diminish the adverse effects of a medical condition;
 - b. Assist an individual in attaining or maintaining an optimal level of well being;
 - c. Diagnose a condition; or
 - d. Prevent a medical condition from occurring.
- XXXVI. Medical Record - A written record that clearly and sufficiently documents information on each patient, identifies the medical condition, justifies the diagnosis, warrants and describes the treatment, procedures, services and the end results.
- XXXVII. Outpatient - A person receiving medical services in the outpatient department of an approved hospital which is not providing room and board and professional services on a continuous 24-hour-a-day basis.
- XXXVIII. Outpatient Hospital Services - Preventive, diagnostic, therapeutic, rehabilitative or palliative medical services provided to an outpatient by or under the direction of a physician or dentist in an approved hospital outpatient department.
- XXXIX. Override Option - A decision, used in utilization review, when “overriding” circumstances of clinical significance justify changing the conclusion of the objective criteria.

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150.1B.XL. - 150.1B.XLIX.

- XL. PAS Norms - The Professional Activity Study (PAS) of the Commission on Professional and Hospital Activities (CPHA) statistics on hospital length-of-stay.
- XLI. Patient - An individual who receives a health care service from a provider and is also a Medicaid recipient.
- XLII. Patient Days - A measure of institutional use, usually measured as the number of inpatients at a specific time, (e.g., midnight).
- XLIII. Patient Mix - The number and types of patients serviced by a hospital or other health program.
- XLIV. Peer Review - Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered, or performed by other practicing physicians, or other members of the profession whose work is being reviewed (peers).
- XLV. Plan of Care - Before admission to a hospital or before authorization for payment, a physician and/or other personnel involved in the care of the individual must establish a written plan of care for each recipient.
- XLVI. Preadmission Review - A review prior to or in the case of an emergency admission, immediately thereafter, a patient's admission to a hospital to determine the medical necessity, appropriateness, and quality of the health care services proposed to be delivered, or in the case of an emergency, delivered in the hospital.
- XLVII. Principal Procedure - The procedure most closely related to the principal diagnosis, that is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes and/or was necessary to care for a complication, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.
- XLVIII. Prior Authorization - Approval for a service from the Department or the Department's agent before the provider actually provides the service. In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.
- In the case of an emergency admission to a general hospital, prior authorization means approval obtained within two business days of admission.
- XLIX. Proprietary Hospital - A hospital operated for the purpose of making a profit.

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150.1B.L. - 150.1B.LX.

- L. Prospective Payment - Hospital payment programs where rates are set prior to the period during which they apply.
- LI. Quality - the nature, kind or character or something, the degree or grade of excellence measured with respect to individual medical services received by an individual or group of patients, providers, health programs or facilities.
- LII. Quality of Care - The evaluation of medical care to determine if it meets the professionally recognized standard(s) of acceptable medical care for the condition and the patient under treatment.
- LIII. R.C.C. Factor - In rate setting, the ratio of cost-to-charge, or charges-to-charges.
- LIV. Reasonable Cost - Generally the amount which a third party using cost-related reimbursement will actually reimburse. Under Medicare reasonable costs are costs actually incurred in delivering health services excluding any part of such incurred costs found to be unnecessary for the efficient delivery of needed health services. (See Section 1861 of the Social Security Act).
- LV. Recipient - An individual who has been determined eligible for Medicaid.
- LVI. Reliability - A measure of the consistency of a method in producing results. A reliable test gives the same results when applied more than once under the same conditions.
- LVII. Residency, Including Residents and Interns - A prolonged (usually one or more years) period of on the job training which may either be a part of a formal program, sometimes in fulfillment of a requirement for credentialing.
- LVIII. Retrospective Review - The review conducted after services are provided to a patient, to determine the medical necessity, appropriateness, and quality of the services provided.
- LIX. Revenue Center Codes (RCC) - A national coding system used by the Department, where specific codes define specific medical services. It is possible to assign payment by revenue center codes.
- LX. Utilization Review - The evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures and facilities. Utilization review evaluates the medical necessity, and medical appropriateness of admissions, the services performed or to be performed, the length of stay and the discharge practices. It is conducted on a prospective and/or retrospective basis.

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150.1B.LXI. – 150.1E.1.b.

- LXI. Utilization Review Committee (Hospital Based) - A staff committee of an institution responsible for conducting utilization review activities for that institution.
- LXII. Utilization Review Program - The Department's program of Utilization Review for acute care hospitals in the Connecticut Title XIX Program.
- LXIII. Validity - A measure of the extent to which an observed situation reflects the true situation or an indication of medical quality measures what it purports to measure.

C. Provider Participation

Hospitals are required to meet the following conditions to participate in the Connecticut Medical Assistance (Title XIX) program:

- I. Licensure: must have a current and effective hospital license in the State of Connecticut, issued by the Department of Health Services.
- II. Accreditation: must meet both Title XVIII (Medicare) and Title XIX (Medicaid) regulations.

Hospitals are certified by the United States Department of Health Human Services under the Medicare Title XVIII and Medicaid Title XIX programs.

- III. Enrollment: must meet all Departmental enrollment requirements for Title XIX.

D. Eligibility

Payment for inpatient hospital services is available for all persons eligible for Medicaid. Payment is made only for the period where definitive medical treatment is needed and when provided in accordance with the Department's policies, procedures, conditions and limitations.

E. Services Covered and Limitations

- I. Covered Services:
 - a. Medically necessary hospital inpatient acute care, procedures and services as authorized by the responsible physician(s), or dentist, and covered under Department policy and regulations.
 - b. Administratively Necessary Days (ANDs) are covered under the Title XIX program when the following procedures and conditions are met:

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150.1E.I.b.1. - 150.1E.I.b.6.(a)

1. The Medicaid patient is no longer at the acute care level of service but is at a skilled nursing level-of-care or at an intermediate level-of-care;
2. Discharge to a skilled nursing facility or intermediate care facility level-of-care bed is impossible due to the unavailability of a bed;
3. The patient's timely discharge and placement to the appropriate skilled nursing facility or intermediate care facility is planned and arranged by the hospital. Clear evidence of this active and continuous process is documented in the patient's hospital medical record;
4. The hospital places the patient who is on administratively necessary day one (1) through administratively necessary day seven (7) on the active waiting list of five (5) skilled nursing facilities, or intermediate care facilities, whichever is medically appropriate;
5. In cases where additional ANDs are necessary beyond the seventh (7th) day the hospital places the patient on the active waiting list of an additional five (5) facilities. The hospital is required to maintain the patient on the active waiting list of a minimum of ten (10) facilities at all times after the seventh (7th) administratively necessary day.
 - (a) All contacts made by the hospital to facilities must be clearly documented in the patient's medical record with dates of contact and facility name;
 - (b) After the patient is discharged the name of the facility must be recorded in the patient's medical record.
6. The patient receiving ANDs accepts the first available skilled nursing or intermediate care facility placement in the State of Connecticut that is medically appropriate.
 - (a) The Department will not pay for ANDs when the patient refuses to be placed in the first available facility. Payment ceases on the day of refusal.

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150.1E.I.b.6.(b) - 150.1E.I.c.3.

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

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

7. Under the Preadmission Screening and Community Based Services Program (PAS/CBS) the Department will cover ANDs if the Medicaid eligible patients timely discharge to home is delayed due to either the SNF/ICF placement process, or the PAS/CBS process. To receive reimbursement hospitals must comply with all Medical Services Policy on ANDs, meet all PAS/CBS program requirements as stated in Section 17-314b, as amended, of the Connecticut General Statutes and the PAS/CBS Guidelines and Procedures.

8. The revenue center codes designated by the Department for ANDs must be placed on the billing form.

c. Diagnostic Procedures upon Inpatient Admission:

Chest X-rays and other diagnostic procedures performed as part of the admitting procedure to a hospital will be reimbursed by Title XIX as reasonable and necessary only when:

1. The test is specifically ordered by the admitting physician or a hospital staff physician having responsibility for the patient. Note that standing orders do not meet these criteria; and
2. The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
3. The test does not duplicate the same test performed on an outpatient basis prior to admission or performed in connection with a recent admission, unless medically indicated.

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150.1E.I.d. - 150.1E.II.f.

- d. Abortion - Refer to Medical Services Manual 173, Family Planning.
- e. Sterilization - Refer to Medical Services Manual 173, Family Planning.
- f. Dental Services are covered. Please refer to the Medical Service Policy Manual 171.3, Dental Clinics.
- g. Organ Transplantations
 - 1. Organ transplantations are covered under the Medicaid program if they are of demonstrated therapeutic value, medically necessary and medically appropriate, and likely to result in the prolongation and the improvement in the quality of life of the applicant.
 - 2. The following organ transplantations satisfy the Department's criteria: bone, bone marrow, kidney, and cornea. They are covered by the Medicaid program and do not need to be authorized.
 - 3. All other organ transplantations require prior authorization. Prior authorization must be obtained from the Department before the costs associated with an organ transplantation will be covered under Medicaid.

Please refer to Medical Services Policy 150.1 F.viii.C.7 for information on prior authorization for organ transplantation.

II. Services Not Covered

- a. Diagnostic, therapeutic or treatment procedures, and inpatient hospital stays for experimental, cosmetic, research, social or educational purposes;
- b. Any services or items furnished for which the provider does not usually charge;
- c. The day of discharge or transfer;
- d. Leave of Absence (LOA) or Pass without Medical Permission.
- e. Leave of Absence (LOA) or Pass with and without Medical Permission, when the Title XIX patient is out of the hospital at the time of the census count (12 midnight);
- f. Emergency room services provided on the same day as inpatient admission;

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150.1E.II.g. - 150.1E.II.i.

- g. Hospital inpatient stay is not covered when the following procedures or services are performed:
 - 1. Tuboplasty and sterilization reversal
 - 2. Implantation of nuclear-powered pacemaker
 - 3. Nuclear-powered pacemakers
 - 4. Inpatient charges related to autopsy
 - 5. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to the following:
 - lipectomy, hair transplant, rhinoplasty, dermabrasion, chemabrasion.
 - 6. Transsexual surgical procedures for gender change or reassignment or treatment preparatory to transsexual procedures (e.g., hormone therapy and electrolysis).
 - 7. The Department will not pay for a hospital stay, medical services or procedures in the treatment of obesity, including gastric stapling. Although obesity is not itself an illness it may be caused by illnesses such as hypothyroidism, Cushing's disease and hypothalamic lesions. In addition, obesity can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Services in connection with the treatment of obesity could be covered services when such services are an integral and necessary part of course of treatment for one of these illnesses.
- h. With the exception of a CT Scan no Title XIX reimbursement will be made to a hospital for medical services provided to an inpatient outside of the per diem daily rate.
- i. The Department will not pay for drugs included in the Drug Efficiency Study Implementation (DESI) Program that the Food and Drug Administration has proposed to withdraw from the market in a notice of opportunity for hearing. The Drug Efficiency Study Implementation (DESI) Program prohibition against payment includes all generically equivalent drug products and drugs that are less than effective. The Department will notify providers regarding which drugs will not be reimbursed as a result of the DESI program.

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150.1E.II.j. - 150.1F.II.b.l.

- j. New services in hospitals and services previously unauthorized for payment, must obtain approval or they are a non-covered service. (Refer to F.III.e. for prior authorization instructions.)
 - k. Admissions and day(s)-of-care that do not meet established requirements for medically necessary acute care inpatient hospital services.
 - l. Claims involving non-covered services:
 - 1. Non-covered services only. If the hospital stay was for a non-covered service only, then no charges will be paid by Medicaid.
 - 2. Covered and non-covered services. If the hospital stay is a combination of services, some of which are covered and some which are not covered by Medicaid, the Department will pay for the covered services only. The non-covered services will not be paid.
 - m. Weekend admittances (Friday/Saturday) or discharges (Sunday/Monday) unless they are medically necessary. Admissions and discharges on these restricted days must have medical necessity recorded by the attending or performing physician in the patient's medical record.
- F. Need for Service and Authorization Process
- I. Need for Services

Title XIX recipients require inpatient medically necessary acute care when:

 - a. Specific medical care criteria for admission and day(s) of care and discharge are met; and
 - b. The patient's medical record documents that the medical care criteria are met.
 - II. Plan of Care
 - a. Before admission to a hospital a physician and other personnel involved in the care of the individual must establish a written plan of care for each recipient.
 - b. The plan of care must include:
 - 1. Diagnoses, symptoms, complaints and complications indicating the need for admission;

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150.1F.II.b.2. – 150.1F.III.d.5.

2. A description of the functional level of the individual;
3. Any orders for medication, treatment, restorative or rehabilitative services, diet, activities, social services;
4. Plans for discharge, as appropriate;
6. Orders and activities must be developed in accordance with physician's instructions;
7. Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of the individual;
8. A physician and other personnel involved in the recipient's case must review each plan of care at least every sixty (60) days.

III. Medical Records

- a. Medical records must be maintained on each Medicaid patient in accordance with accepted professional principles, Federal and State law, regulation and policy.
- b. Medical records must be preserved in original written form or on microfilm for a period of time not less than five (5) years.
- c. Upon request, the original medical record or copies of the record must be made available to authorized personnel of the Department during regular business hours;
- d. The medical record must fully disclose the medical necessity and the extent of services provided, which includes, but is not limited to, the following:
 1. Diagnoses, symptoms, complaints and complications indicating the need for admission;
 2. Identification data, date of admission, present illness;
 3. Past medical history
 4. Family history
 5. Physical examination report

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150.1F.III.d.6. - 150.1F.IV.

6. Provisional diagnosis;
 7. Clinical laboratory reports;
 8. X-ray reports;
 9. Treatment, medical and surgical
 10. Diagnostic and therapeutic orders and results;
 11. Reports of all procedure tests;
 12. Tissue reports;
 13. Progress notes;
 14. Name of recipient's physician(s); (including attending);
 15. Dates of application for and authorization of Medicaid benefits if application is made after admission;
 16. Plan of care;
 17. Date of operating room reservation, if applicable;
 18. Justification of emergency admission, if applicable;
 19. Initial and subsequent continued stay review dates;
 20. Reasons and plan for continued stay, if the attending physician believes continued stay is necessary;
 21. Evidence of appropriate informed consent;
 22. Conclusions at termination of hospitalization including the provisional diagnosis of reason for admission, the principal diagnosis, the clinical resume or final progress note and;
 23. Disposition of the patient recipient;
 24. Other supporting material as appropriate.
- IV. The medical necessity and need for weekend admittances (Friday/Saturday) or discharges (Sunday/Monday) must be documented in the patient's medical record.

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150.1F.V. - 150.1F.VI.b.1.

V. Prior Authorization Procedures

- a. To obtain prior authorization for medical services, contact:

Connecticut Peer Review Organization (CPRO)
100 Roscommon Drive
Middletown, CT 06457

- b. To obtain prior authorization for dental services:

Refer to Medical Services Policy 171.3, Dental Clinics.

VI. Prior Authorization Requirements:

Prior authorization is required for the following medical services:

- a. Hospital Services Provided in Out-of-State Hospitals:

1. Non-emergency out-of-state hospitalization

All non-emergency, inpatient hospitalization provided outside of Connecticut requires prior authorization.

Designated border hospitals are exempt from this requirement.

(Refer to Section G.I. Bordering Hospitals Policy, and Section G.II. Out-of-state Hospital Policy).

2. Prior Authorization for Non-emergency Situation Occurring Weekends or after hours:

In a non-emergency situation which occurs after working hours or on a weekend or holiday, the hospital must obtain verbal approval on the next working day. This applies only to those services which normally require prior authorization. After securing verbal authorization, the provider has forty-eight (48) hours to submit the written request for authorization on the appropriate forms, with the written notation that verbal approval was granted, by whom, and on what date.

- b. Prior authorization is required for the following:

1. Mastectomy implant and reconstruction surgery after mastectomy;

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2. Reduction mammoplasty and augmentation mammoplasty;
3. Otoplasty for protruding or loop ears;
4. Abdominal plasty;
5. Genitoplasty;
6. Gynecomastia;
7. Organ Transplantation (Refer to 150.1 E.I.g)
 - (a) The final decision as to whether authorization will be granted for a patient to incur Medicaid covered costs associated with an organ transplantation is made by the Department on a case-by-case basis. No such authorization will be granted unless the organ transplantation is of demonstrated therapeutic value, medically necessary, medically appropriate and likely to result in the prolongation and the improvement in the quality of life of the applicant.
 - (b) In order to assist the Department in determining whether a request for prior authorization satisfies these criteria a Transplant Advisory Committee has been established by the Department. The members of the committee are appointed by the Commissioner, provide the Department with technical assistance and expertise in the field of organ transplantation, and are drawn from the medical health and insurance communities.
 - (c) The Transplant Advisory Committee has developed, and continues to review and modify, specific medical criteria as they relate to particular organ transplantation procedures. In addition, the committee may provide technical assistance to the Department in reviewing a particular prior authorization request. In no event, however, are the criteria (guidelines) or recommendations of the committee binding on the Department. A final decision that a prior authorization request fails to satisfy the provisions of 150.1 F.viii.C.7. will not be rendered without considering the medical opinion of a qualified organ transplantation expert(s) in the community.

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- (d) The medical criteria developed by the Transplant Advisory Committee, and any amendments thereto, are on file in the Department and available to all interested parties.
- c. New medical services and medical services not previously billed to Title XIX.

To obtain authorization, provide the following information in writing to the Medical Director for Medicaid at the Department:

Name of the new service(s)
Description of the medical care and services
Objectives of the medical care
Staffing patterns

The Department will notify the hospital in writing regarding the status of the request. If the new service is approved, a rate will be established and a revenue center code assigned. (Refer to Billing Procedures, 150.1H.)

G. Other

I. Border Hospital Policy

Designated Border Hospitals, who treat Connecticut Title XIX recipients, and qualify as Connecticut providers are bound by the same rules and regulations as Connecticut hospitals participating in Title XIX.

II. Out of State Hospital Policy

The Connecticut Title XIX program reimburses for medically necessary services provided in out-of-state hospitals, other than border hospitals under the following conditions:

- a. For emergencies
- b. For non-emergency cases:
 - 1. When medical services are needed because the recipient's health would be endangered if they were required to travel to Connecticut;

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2. On the basis of the attending physician's medical advice that the needed medical services or necessary supplementary resources are more readily available in the other State;
3. When these non-emergency services receive prior approval;

III. Utilization Review Program in General Hospitals

- a. The Department's Utilization Review Program conducts utilization review activities for services delivered to general hospital inpatients, where Medicaid has been determined to be the appropriate payer.
- b. The Department's objectives for performing utilization review include:
 1. To determine the medical necessity and appropriateness of general hospital inpatient services;
 2. To assure that the quality of service meets accepted and established standards;
 3. To safeguard against unnecessary and inappropriate utilization;
 4. To effectively monitor provider patterns of utilization; and
 5. To identify inappropriate patterns and services.
- c. To evaluate services the Department through its staff or its agent, uses utilization review techniques that have withstood tests for validity and reliability. For example: Professional Activity Study (PAS) Norms, Appropriateness Evaluation Protocol (AEP), InterQual ISD Review System (Intensity of service, severity of illness discharge screens).
- d. As part of the Utilization Review process, reviewers may use an override option. The purpose of the override option is to:
 1. Allow the reviewer to indicate that the criteria are not sufficiently comprehensive to meet non-criteria circumstances or factors necessitating admission and/or hospitalization; or

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2. Conversely, to judge that the service which meets the criteria are not justified on clinical grounds.
- e. When the Hospital Utilization Review Program makes an adverse determination on a preadmission review, the provider is notified by telephone and in writing and is given the opportunity to request a second review. The second review to present additional information, can be requested by telephone or in writing within ten (10) calendar days of the adverse determination, unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider by telephone and in writing.
- f. When the Hospital Utilization Review Program makes an adverse determination on a retrospective review providers are sent a written summary of findings by the Department. The provider is given an opportunity to request a second review and present additional information in writing, provided said request is submitted in writing to the Department within twenty (20) calendar days of the date of receipt of notice of adverse determination unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The date of receipt is presumed to be five (5) days after the date on the notice, unless there is reasonably showing to the contrary. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider in writing.
- g. Requirements for Establishment of Medical Necessity
 1. To determine that inpatient general hospital services or admissions are medically necessary, the Department or its agent:
 - a. Shall require prior authorization of each general hospital inpatient admission including emergency admissions unless the Department notifies the providers that a specific diagnosis or procedures does not require such prior authorization. In addition the Department, in its discretion, may perform preadmission review and/or reviews of any or all general hospital inpatient admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such review.

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- b. Shall perform retrospective reviews in the Department's discretion which may be of a random or targeted sample of general hospital admissions and services delivered. The review may be focused on the appropriateness, necessity, and quality of the health care services provided.
 2. If the Department decides to reimpose prior authorization or preadmission review requirements which it has previously notified providers it will no longer require, the Department shall notify all affected providers at least thirty (30) days in advance of the imposition of preadmission review or prior authorization requirements.
 3. All claims for payment for admission and all days of stay and services provided must be documented with the medical records required by Section 150.1F.V. of the Department's Manual. Lack of said documentation itself may be adequate ground for the Department, in its discretion, to deny payment for the admission of some or all of the days of stay or services provided.
- h. Retrospective Review of General Hospital Emergency Admissions
- Payment for an emergency admission where prior authorization was not obtained may be made pursuant to the following:
1. The hospital shall request retrospective review within thirty (30) calendar days of the date the patient was admitted to the hospital. The hospital may request that the Department waive the thirty (30) calendar day time limit if the hospital proves to the satisfaction of the Department that: (a) the failure to make the request within the thirty (30) day time limit was caused by reasons beyond the control of the hospital; and (b) the hospital neither knew nor had any reason to check the eligibility of the individual within the thirty (30) day time period or checked with the Department's eligibility verification unit and was given erroneous information (the "Good Cause Exception"). The total number of Good Cause Exceptions, per hospital fiscal year, shall not exceed the greater of one, or .125% (.00125) of such hospital's Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary- Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS);

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2. The retrospective review shall be done at the hospital's expense at the standard charge of the Department's contractor to hospitals;
3. For each fiscal year commencing October 1, the hospital may request, in total, retrospective reviews up to the maximum number for which it has received authorization pursuant to subsection six (6) below;
4. The patient for whom the retrospective review is requested was an emergency admission (i.e., admitted through the emergency room or transferred from another hospital on an emergency basis due to the original hospital's inability to treat the patient due to the severity or complexity of the illness or injury). No request may be made for consideration of patients admitted directly or via transfer if the admission was not an emergency admission.
5. The retrospective review reveals that all requirements for payment are met except for the failure to obtain prior authorization.
6. In July of each year, the Department shall notify each hospital of the maximum number of retrospective reviews. Said number shall be one percent (1%) of its Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS).

IV. Federal Utilization Review Requirements for Hospitals

- a. Hospitals must implement the Federal Utilization Review Requirements.
- b. The Department's Hospital Utilization Review Program will review individual hospital utilization control requirements for Medicaid Services (Federal) including but not limited to:
 1. Certification and recertification of need for inpatient care;
 2. Plan of care for each individual patient as specified in the UR Plan;

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3. Utilization Review (UR) Plan, including administrative requirements, informational requirements, review of need for admission, review of need for continued stay, and medical care evaluation studies.
4. Utilization Review Committee in Connecticut Hospitals must provide a written notice of any adverse final decision of their own findings to the Department. Send the notice to:

Medical Director-Medicaid
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106

This notice is also sent to: the hospital administrator, the attending physician, the recipient and if possible the next of kin or sponsor.

H. Billing Procedures

- I. Bills for inpatient hospital services are submitted on the Department's Billing Form. Mail the bills to the Department's claim processing agent:

Electronic Data Systems Corporation (EDS)
P.O. Box 2941
Hartford, CT 06104

- II. Submission of Claims

- a. Providers are to submit invoices for goods or services rendered to Title XIX recipients within one year from the date of services rendered or goods delivered to the recipient.
- b. When services are rendered on consecutive dates in hospitals, the date of service pertaining to the one year limitation is the date of discharge.
- c. Exceptions to the one year limitation exist when the delay is not the fault of the provider. Such exceptions include:
 1. Pending Title XIX applications. If the determination of eligibility comes after the last date of services, and eligibility is retroactive, then the one year limitation applies from the date of determination of eligibility, or effective date of award, whichever comes later.
 2. Pending applications for newborns, one year from date of determination of eligibility or effective date whichever is later.

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3. Pending applications delayed by Fair Hearing one year from date of determination of eligibility or effective date whichever is later.
4. Delay in receiving Medicare rejection notice to submit with bill, one year from date of Medicare rejection.
5. Delay in third party liability (TPL) determinations one year from the date of the explanation of benefits (EOB).

III. Resubmission of Claims

An invoice for service initially received by the Department, but which was subsequently resubmitted because of error, disallowance or incompleteness, must be resubmitted correctly within one year from the date returned to the provider.

IV. Medicaid Identification Number

The Medicaid Identification number for each Title XIX eligible client must be placed on the bill. No bill may be submitted without the ID number.

V. Leave of Absence (LOA) or Pass Billings

The Department does not reimburse for LOA or pass days. Separate billing for each day or sequence of days prior and past LOA is required.

VI. Inpatient Stay of Less Than One Day

In cases where it is medically unnecessary for the inpatient to remain in the hospital for the census count, and the patient is discharged, the Department will pay a one day inpatient per diem rate, or the outpatient rates, after utilization review is conducted.

I. Payment for Hospital Inpatient Services

I. Payment for Medicaid Services

- a. Payment by Connecticut Medicaid is only for definitive medical care, treatment and services that are judged to be medically necessary. The Department will not pay for any principal procedure or other procedures or service of an unproven, experimental, social, educational, or research nature or for service(s) in excess of those deemed medically necessary by the Department to treat the patient's condition or for services not directly related to the patient's diagnosis, symptoms or medical history.

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- b. Medical care, treatment and services must be provided to eligible Medicaid recipients in accordance with the Department's policies, procedures, conditions and limitations and bill for in accordance with the billing section of the Department's Manual.
- c. Payment will be denied for hospital inpatient services, and also for physicians' (including physicians in free-standing clinics), dentists', and podiatrists' services provided to hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not comply with the other policies, procedures, conditions, and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided which the Department finds not to meet the medically necessary or utilization review standard.

II. Principles of Cost Reimbursement for Medicaid

The Department of Income Maintenance (hereinafter the Department) will reimburse inpatient acute care services in accordance with the following definitions and rate setting methodology:

- a. Definitions (for this section only).
 - 1. "Admissions" means the same volume of treatment defined as discharges.
 - 2. "Discharge" means any patient who was discharged at a date subsequent to the date admitted to the hospital for treatment as an inpatient, except that it shall also mean such patient was admitted and discharged on the same day where such patient:
 - (a) died, or
 - (b) left against medical advise.
 - 3. "Final adjusted target rate" means the total allowable cost per discharge including routine and ancillary costs as set forth in the Medicare Principles of Reimbursement net of excludable costs which are defined in Section 17-312-105(d) of the regulations.

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4. "Fiscal year" means the hospital fiscal year commencing on October 1 and ending on September 30.
5. "Hospital" means a hospital included within the definition of health care facilities or institutions under section 19a-145 of the General Statutes and licensed as a short-term general hospital by the Department of Health Services but shall not include a short-term children's general hospital. A hospital included within the definition of health care facilities or institutions under said section but licensed as a mental health facility shall be included within the definition of hospital under this subsection at such time as such hospital is covered by the Medicare prospective payment system.
6. "Medicaid" refers to medical assistance provided pursuant to chapters 302 and 308 of the General Statutes and Title XIX of the Social Security Act.
7. "Medicare" refers to Title XVIII of the Social Security Act and to the regulations established pursuant to Title XVIII.
8. "Medicare Principles of Reimbursement" refers to Title 42 of the Code of Federal Regulations (CFR), subchapter B, part 405, subpart D and, as may hereafter be amended.
9. "Rate year" means the fiscal year beginning October 1, for which the hospital's Medicaid reimbursement level is being established.
10. "Prior year" means the most recently completed fiscal year.
11. "TEFRA allowed amounts" means the amounts allowable under the Federal Tax Equity and Fiscal Responsibility Act of 1983.
12. "TEFRA base year" means the hospital's fiscal year ending in calendar year 1982.
13. "Rate period," means the fiscal year that an interim per diem rate is determined.
14. "Interim per diem rate" means the rate as calculated pursuant to 150.11.b.1.

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b. Medicaid interim per diem rate

1. Interim Rate Computation

The Department will reimburse inpatient acute care services based on an interim per diem rate subject to cost settlement as per 150.11.c.2.

2. The interim rate is calculated for each hospital as follows:

The target amount per discharge from the most recently filed cost report will be increased by the estimated TEFRA update factors from the cost report period to the interim rate period. The product will be the rate period estimated target amount per discharge.

The Department will divide the estimated target amount per discharge by the average length of stay as calculated from the most recently filed cost report to determine an interim per diem rate of payment. To this quotient will be added the estimated per diem costs of those items excludable from the TEFRA calculation as defined in 150.11.D.4., Excludable Costs. The sum of this calculation is the Medicaid interim per diem rate.

3. Information Requirements and Notification

(a) All hospitals must provide adequate cost data annually based on financial and statistical records for the year ending September 30. The hospital must submit a cost report each year on forms prescribed by the Department. The Department requires that these reports be completed and filed within 60 days after issuance.

The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. If the filing is not done on a timely basis, the Department may withhold payment to the provider.

(b) Payment to a hospital for inpatient services is made on a "per diem" basis, by the per diem reimbursement rate.

(c) The per diem rates for the specific accommodation cost centers are paid in direct relationship to specific Revenue Center Codes.

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- (d) Revenue Center Codes are assigned according to the medical services that the hospital provides to the patient. The Revenue Center Codes are placed in the appropriate box on the billing form. Each hospital is responsible to accurately assign the Revenue Center Code that identifies the medical services provided to the patient. (Refer to 150.1H., Billing Procedures.)
- c. Determination of TEFRA Reimbursement Level
 - 1. TEFRA Payment Methodology

The Department will determine Medicaid allowable inpatient costs pursuant to TEFRA principles of reimbursement. The components of Medicaid allowable inpatient cost will be determined in the following manner:

- (a) Computation of Target Rates
 - (1) Base Costs for Computing Target Rates

Target rates will be based on the provider's fiscal year ending during the calendar year 1982. The Department will use the appropriate cost and statistical data from the provider's TEFRA base year. The Department will calculate the total Medicaid allowable inpatient cost by applying Medicare Principles of Reimbursement in effect at that time.

The Medicaid allowable inpatient cost is divided by the number of Medicaid discharges to produce the TEFRA base year operating cost per discharge.

Hospital based physicians, capital, direct medical education, malpractice and kidney acquisition costs, as determined by using Medicare principles of reimbursement, will be excluded from this calculation. The methodology for computing the TEFRA Base Year Operating Cost per Discharge (BPOR) is defined as $BPOR = OC/D$ where: OC = Total Title XIX Inpatient Operating Cost for the TEFRA base year net of excludable cost (Form HCFA 2552, Worksheet D-1, Part II, line 56). D = Medicaid discharges for the hospital's TEFRA base year.

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(2) Annual Adjustment Factor

To compute the TEFRA allowed amount, the Department will continue to use the update factor used by Medicare to revise the yearly rates for nonparticipating PPS hospitals and units. The update factor is published annually in the Federal Register.

(3) Computation of Hospital Target Rates

The hospital specific final target rate will be calculated by multiplying the TEFRA Base Year Operating Cost per Discharge by the accumulated update factor from the TEFRA base year to the cost report.

(b) Determination of Allowable Costs for the Cost Report Year

Once the Department determines the costs which are allowable pursuant to the Medicare principles of reimbursement, the Department determines which costs are applicable to the Medicaid program.

Ancillary costs are determined by the ratio of total cost to total charges factor. This ratio is applied to Medicaid charges for the various ancillary cost centers. Routine costs are determined by computing the cost per day. The amount is multiplied by the total number of Medicaid days. The total allowable cost including routine and ancillary costs net of excludable costs is then compared to the final target amount. The total allowable costs are divided by the Medicaid discharges to determine the allowable cost per discharge.

If the hospital's allowable costs per discharge is greater than their hospital specific final target rate then the Department will not consider as Medicaid allowable inpatient costs any costs above the hospital specific final target rate.

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If the hospital's allowable costs per discharge is less than their hospital specific final target rate, the Department will consider the Medicaid allowable inpatient costs to be allowable costs per discharge plus (a) 50% of the difference between the allowable costs per discharge and the hospital specific final target rate, or (b) 5% of the hospital specific final target rate, whichever is less.

(c) Determination of Total TEFRA Allowable Payments

Total TEFRA allowable payments for the year will be based on total allowable costs, as defined to be the sum of:

- (1) allowable Title XIX costs for malpractice, hospital based physicians, capital, medical education, and kidney acquisition, as set forth in 150.II.d.4., Excludable Costs,
- (2) allowable inpatient routine and ancillary costs, and
- (3) the allowable incentive as defined in 150.11.c.1.(b).

2. Allowed Payments under TEFRA for the Medicaid Program - Cost Settlement

The total allowed payment under TEFRA will be the sum of all allowable costs as determined above for each hospital. The total allowed costs will be compared to the interim payments made by the Department plus other payments made on behalf of Title XIX recipients, and the amount owed to the State or to the hospital pursuant to cost settlement will be paid.

d. Other Related Information

1. Rebasing

After the implementation year, the commissioner may in his/her sole discretion, select a new base period using actual cost data from more recent years for prospectively determining the target rate in the event that he/she determines that to do so is appropriate, equitable and does not prejudice the interests of the State.

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2. Allowable and Nonallowable Costs

Allowable costs, nonallowable costs, and reasonableness of costs will be based on Medicare principles of reimbursement.

3. Reporting Year

For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

4. Excludable Costs

The Department will reimburse hospitals for hospital based physicians, capital, direct medical education, malpractice, and kidney acquisition costs attributable to Medicaid based on Medicare principles of reimbursement.

5. Change of Ownership Resulting From a Sale of Lease

When a sale or lease occurs, the provider's target rate basis will remain the same as before the transaction.

6. Retention of Records

Each hospital will maintain financial and statistical records of the period covered by such cost reports for a period of not less than ten years following the date of submittal of the cost report to the Department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records or copies thereof available upon demand to the department, or its representatives.

7. Audits

(a) Desk Audit

Each cost report will be subjected to a review to ensure completeness, appropriateness and accuracy.

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(b) Field Audit

Field audits will be performed on a timetable determined by the Department. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report is accurate, complete and reasonable. The field audits are conducted in conformity with Medicare regulations and are of sufficient scope to determine that only proper items of cost applicable to the services furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost were accurately determined to be reasonable.

Any item not supported by adequate documentation or which is found to be unallowable will be disallowed by field audit. Proper adjustments to future payments will be made to recover amounts determined by field audit to be overpayments.

8. Whenever a Medicare cost report is reopened, the result of the reopening will be applied to the Medicaid cost report.

9. Notwithstanding any of the above provisions, any requirements mandated by changes in Federal law applicable to the Medicaid program shall be hereby incorporated into these regulations and shall supersede any contrary provision of these regulations.

10. Charges to the General Public

The State is not authorized to pay a hospital for services in excess of charges made by such hospital for comparable services to the general public.

11. Hospital Inpatient Per Diem Rate Covers All Inpatient Services

The per diem reimbursement rate is the all inclusive payment in full for all services provided to recipients when they are inpatients. This includes hospital based physician and dental fees. The exception is physicians and dentists that are not providing services as salaried staff by the hospital. These services may be billed by the physician or dentist to the Medicaid program.

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- III. Title XIX Payment Relationship to Title XVIII (Medicare) and other Third Party Insurers: Since Title XIX is the payer of last resort, all other medical insurance resources available to the recipients must be utilized.

For the Department's policies on Third Party Liability refer to Section 127, Medical Services Manual.

- a. Hospitals may bill the Department for unpaid deductibles and/or coinsurances for Medicare covered inpatient stays by following the billing instructions for Medicare crossovers contained in the provider manual. A copy of the Explanation of Medicare Benefits must also accompany all such Medicare crossover billings.
- b. For a Medicare eligible whose inpatient claim has been denied or terminated, the hospital may bill Medicaid for Medicare non-covered days in the usual manner. A copy of the Medicare denial or termination must accompany such a billing.

NOTE: Where a Part A beneficiary, who is also eligible for Part B has exhausted all Part A inpatient benefits during a spell of illness, the hospital must bill the Part B carrier for certain ancillaries which can be covered. Hospitals should refer to their Medicare Manual for detailed instructions.

- c. Payment for inpatient hospital services will be the appropriate Medicaid per diem times the number of medically necessary days minus the other insurance payment.

There are two exceptions:

1. When Medicare coverage is available for inpatient hospital stays, Medicaid will pay the required deductible and coinsurance for Medicaid eligible.
 2. When another insurance pays the full charges for one or more inpatient days, Medicaid liability will not begin until the first day for which less than full charges are paid by the other insurance.
- d. When Medicare benefits are available for any covered service also provided under Medicaid, the only charges payable by Medicaid are the deductibles and coinsurance amounts provided the patient is eligible for Medicaid on the date(s) of service.
 - e. Medicaid will reimburse the provider even if the Medicare "maximum allowable charge" exceeds the Medicaid fee schedule. Conversely, in any instance where the Medicaid fee schedule might exceed the Medicare charge, the Medicare charge becomes the upper limit for payment.

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- f. For hospital inpatient stays where only Part B payment is available for certain ancillaries, Medicaid payment will be available for the unpaid coinsurance and deductibles on the Part B ancillaries through the “piggyback” system. For those inpatient stays, Medicaid will also reimburse the hospital at its Medicaid per diem times the number of days of stay minus the Medicare maximum allowable charge for the Part B ancillaries.

IV. Payment to Hospitals Outside Connecticut

a. Border Hospitals

Payment is at the approved Medicaid rate for that particular hospital established by the State of location.

b. Other Out-of-State Hospitals

Paid at the approved Medicaid rate as established by the State of location.

V. Inpatient Physician Services Included in Hospital Per Diem Rate

- a. When hospital based physician services are included in the inpatient per diem rate, the hospital based physician is thereby paid in full by the hospital and may not bill the State Title XIX program for services.

- b. When the physician services are not included in the inpatient hospital per diem rate the physician submits bills to Title XIX.

VI. Payment to Hospital Based Physicians: Salaried Staff, Residents, Interns

- a. A physician who is fully or partially salaried by a hospital may not receive payment directly from the Department unless the physician maintains an office for private practice at a separate location from the hospital.

- b. Physicians who are solely hospital based, either on a full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients.

- c. A physician who maintains an office for private practice separate from the hospital may bill for services provided at the individual private practice location or for services provided to the physician's patients in the hospital.

- d. The Department does not reimburse interns or residents for their services; they are included in the hospital reimbursement rate.

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150.2. - 150.2.A.V.

150.2 Hospital Outpatient Services

Outpatient hospital services provide medical treatment to outpatients under the direction of physician or dentist in a licensed hospital facility.

A. Legal Bases

- I. Code of Federal Regulations: 42 CFR 440.20(a) (Outpatient); 42 CFR 431.52 (Out-of-State); 42 CFR Part 405 (Medicare); 42 CFR 447.321 (Upper Limits); 42 CFR 447.325 (Upper Limits); 42 CFR 447.53 (Cost Sharing)
- II. Social Security Act: Sections 1902(a) (Federal Participation); 1905 (Medical Assistance); 1903(i); 1833
- III. Connecticut General Statutes: Sections 4-67c (Fees); 17-311 (Payments); 17-312 (Payments); 19a-490 (Licensing); 19a-493 (Licensing)
- IV. State Medicaid Plan: 3.1-A (Amount, Duration, Scope); 4.19-B (Rate Methodology)
- V. Regulations of Connecticut State Agencies: Sections 19-13D; 17-134d-2 (Medical Care); 17-134d-40 (Payments-Clinic); 17-134d-63 (Out-of-State Hospitals); 17-134d-86 (Emergency Room)

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B. Definitions

- I. Ambulatory - means walking or able to walk; not confined to bed.
- II. Ambulatory Care - means all types of health services which are provided on an outpatient "walk-in" basis, in contrast to services provided in the home or to persons who are inpatients. While many patients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day.
- III. Accreditation - The process by which an agency, individual or organization (such as the Joint Commission on Accreditation of Hospitals) evaluates and recognizes a program of study or an institution as meeting certain predetermined standards. The recognition is called accreditation. Similar assessment of individuals and institutions is called certification. Standards are usually defined in terms of: physical plant, governing body, administration, medical and other staff, and scope and organization of services. Accreditation is usually given to a private organization created for the purpose of assuring the public of the quality of the program of study or institution. Accreditation standards and individual performance with respect to such standards are not always available to the public. In some situations public governments recognize accreditation in lieu of, accept it as the basis of, or require it as a condition of licensure. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent once obtained or for a specified period of time. Unlike a license, accreditation is not a condition of lawful practice but is intended as an indication of high quality practice, although where payment is effectively conditioned on accreditation it may have the same effect.
- IV. Border Hospital - means an out-of-state general hospital which has a common medical delivery area with the State of Connecticut and is deemed a border hospital by the Department on a hospital by hospital basis.
- V. Clinical Diagnostic Laboratory Services - means those clinical diagnostic laboratory tests and related specimen collections subject to the statewide Clinical Diagnostic Laboratory Test Fee Schedule established by the State Medicare carrier for outpatient hospital based laboratories effective July 1, 1984 in accordance with §2303 of public Law 98-369. The procedures covered by this definition shall include or exclude any subsequent additions or deletions made by the State Medicare carrier for outpatient hospital-based laboratories. Each test covered is identified and described using the Health Care Financing Administration Common Procedure Coding System (HCPCS) five (5) digit procedure code and terminology or local codes and descriptions assigned by the State Medicare carrier.

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- VI. Connecticut In-State Hospital - means a general hospital located within the boundaries of the State of Connecticut and licensed by the Connecticut State Department of Health Services.
- VII. Department - The State of Connecticut Department of Income Maintenance.
- VIII. Department's Manual - The Department's Connecticut Medical Assistance Provider Manual, which contains the Medical Services Policy, as amended from time to time.
- IX. Emergency - A medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- X. Emergency Room - means a hospital-based department or organized service, certified by the Department of Health Services to provide emergency care, by and under the direction of a physician or dentist.
- XI. Emergency Visit - means an urgent encounter requiring the immediate decision-making and medically necessary action to prevent death or any further disability for patients in health crises (including labor and delivery). Such medical conditions are manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In order to be considered urgent, the encounter must occur within seventy-two (72) hours from the onset of the presenting medical condition.
- XII. General Hospital - means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries.
- XIII. Hospital Based Physician - means a physician who spends the predominant part of practice time within one or more hospitals instead of an office setting, or providing services to one or more hospitals and their patients. Such physicians sometimes have a special financial arrangement with the hospital (salary or percentage of fees collected), and include directors of medical education, pathologists, anesthesiologists and radiologists, cardiologists and psychiatrists, as well as physicians who staff emergency rooms and outpatient departments.

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150.2B.XIV. - 150.2B.XVIII.a.

- XIV. Inpatient - means a patient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental or other health related services and is present at midnight for the census count.
- XV. Medical Necessity/Medically Necessary - means medical care provided to:
- a. Correct or diminish the adverse effects of a medical condition;
 - b. Assist an individual in attaining or maintaining an optimal level of well being;
 - c. Diagnose a condition; or
 - d. Prevent a medical condition from occurring.
- XVI. Non-Emergency Visit - means a medically necessary non-urgent encounter presenting a medical condition which does not meet the requirements for an emergency visit as defined in this section but, rather, requires a routine level of ambulatory health care. Such conditions may be characterized by the fact that they may also be treated in an alternate health care setting, such as: community based physician's office, walk-in clinic, comprehensive health center, neighborhood health center and other free-standing primary health care clinics because such medical conditions do not require the skills, resources and equipment of a hospital emergency room. Such visits may include primary health care or the initial diagnosis and treatment of routine acute or chronic illnesses whether on a scheduled or unscheduled basis.
- XVII. Out-of-State Hospital - means a general hospital located outside the State of Connecticut and is not deemed by the Department to be a border hospital.
- XVIII. Outpatient - A person receiving medical, dental or other health related services in the outpatient department of an approved general hospital which is not providing room and board and professional services on a continuous 24-hour-a-day basis.

There are four classifications of outpatients as follows:

- a. Clinical Outpatient - Patient seen in the clinical service of the outpatient department of the hospital for diagnosis and treatment, on an ambulatory basis in a formally organized unit of a medical or surgical specialty or sub-specialty. Medical staff of the clinic determines services and treatment to be given.

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150.2B.XVIII.b. - 150.2B.XXIII.b.

- b. Emergency Outpatient - One admitted exclusively to the emergency, accident or equivalent service of the hospital, for diagnosis and treatment of a condition that requires immediate physician, dental or allied services.
 - c. Referred Outpatient - (Private) - A patient referred by outside private physician to a special diagnostic or therapeutic facility or service of the hospital for diagnosis or treatment on an appointment basis, as order by patient's private physician.
 - d. Hospital Nonpatient - A person who is not registered on the hospital records as an outpatient or is not directly receiving services from the hospital, but the hospital provides all or part of required clinical diagnostic laboratory testing.
- XIX. Outpatient Clinic Visit Rate - means the rate set by the Department using the methodology as required by subsection 17-312(d) of the General Statutes of the State of Connecticut.
- XX. Outpatient Hospital Services - means preventive, diagnostic, therapeutic, rehabilitative or palliative medical services provided to an outpatient by or under the direction of a physician or dentist in an approved hospital outpatient department.
- XXI. Outpatient Department - means that department or organized service which is part of a hospital licensed under the laws of the State of Connecticut and certified by the Department of Health to provide preventive, diagnostic, therapeutic, rehabilitative or palliative medical services furnished by or under the direction of a physician or dentist for ambulatory patients. Not be confused with examination or treatment in an Emergency Room.
- XXII. Outpatient Surgery (Day Surgery, Ambulatory Surgery) - means the performance of surgical procedures without anticipation of the overnight stay of the patient.
- XXIII. Physician Services - means services provided:
- a. within the scope of the practice of medicine or osteopathy as defined by law; and
 - b. by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

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150.2B.XXIV. - 150.2B.XXXI.

- XXIV. Prior Authorization - means approval for a service from the Department or the Department's agent which may be required by the Department before the provider actually provides the service. Prior Authorization is necessary in order to receive reimbursement from the Department. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.
- XXV. Proprietary - means profit making; owned and operated for the purposes of making a profit, whether made or not made.
- XXVI. Proprietary Hospital - means a hospital operated for the purpose of making a profit.
- XXVII. Rate Year (Clinical Diagnostic Laboratory Fee Schedule) - means beginning January 1, 1987 the Medicaid rate year shall be concurrent with the Medicare rate year.
- XXVIII. Provider Agreement - means the signed written contractual agreement between the Department and the provider of medical services or goods. It is signed by the provider upon application for enrollment and is effective on the approved date of enrollment. The provider is mandated to adhere to the terms and conditions set forth in the provider agreement in order to participate in the program.
- XXIX. R.C.C. Factor - means, in rate setting, the ratio of cost-to-charge, or charges-to-charges.
- XXX. Reasonable Cost - means generally the amount which a third party using cost-related reimbursement will actually reimburse. Under Medicare reasonable costs are costs actually incurred in delivering health services excluding any part of such incurred costs found to be unnecessary for the efficient delivery of needed health services. (See Section 1861 of the Social Security Act).
- XXXI. Residency - means a prolonged (usually one or more years) period of on the job training which may either be a part of a formal educational program or to be undertaken separately after completion of a formal program, sometimes in fulfillment of a requirement for credentialing. In medicine, dentistry, podiatry and some other health professions, residencies are the principal part of graduate medical education, beginning either after graduation (increasingly) or internship (traditionally), lasting two (2) to seven (7) years, and providing specialty training. Residencies are needed for board eligibility.

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150.2B.XXXII. - 150.2D.

XXXII. Staff Privilege (Hospital Privilege) - means the privilege, granted by a hospital, to a physician or other independent practitioner, to join the hospital's medical staff. A practitioner is usually granted privileges after meeting certain standards, acceptance by the medical staff and trustees, and upon agreement to carry out certain duties. It is common for a physician to have staff privileges at more than one hospital.

C. Provider Participation

Hospitals are required to meet the following conditions to participate in the Connecticut Medicaid (Title XIX) program:

I. Connecticut In-State Hospital

- a. Licensure: must be duly licensed by the Department of Health Services as a hospital in the State of Connecticut.
- b. Accreditation: must meet the requirements for participation in Medicare (Title XVIII). Hospitals are certified by the United States Department of Health and Human Services under the Medicare and Medicaid programs.
- c. Enrollment: must meet all Departmental enrollment requirements for Medicaid.

II. Out-of-State and Border Hospitals

- a. Out-of-state and/or border hospitals must submit a copy of a current and effective license or certification as a hospital issued by the appropriate official state governing body within the boundaries of the state in which the hospital is located.
- b. The out-of-state and/or border hospital must enter into a provider agreement with the Department.
- c. The Department shall determine when an out-of-state hospital qualifies for enrollment as a border hospital.

D. Eligibility

Payment for outpatient hospital services is available for all persons eligible for Medicaid when the services are provided in accordance with all applicable Department policies, procedures, conditions and limitations.

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150.2E. - 150.2E.II.e.

E. Services

I. Services Covered

- a. Payment will be made for all medically necessary outpatient services, medical care and procedures ordered under the direction of a physician or dentist when in accordance with all applicable Department policies, procedures, conditions and limitations.
- b. Family planning, abortions and hysterectomies are covered services available to all persons eligible for Medicaid subject to the conditions and limitations which apply to these services. Refer to Medical Services Policy Section 173, Family Planning, for specific requirements.
- c. The HealthTrack Program services are covered for Medicaid eligible persons up to age twenty-one (21). Refer to the Department's Manual, Section III.G. for specific requirements.
- d. Dental treatment is a covered service for all Medicaid eligible persons. Refer to the Medical Services Policy Section 184 for specific dental program requirements.

II. Service Limitations

- a. Hospital outpatient services are limited to one (1) visit per day to the same outpatient clinic.
- b. Chemotherapy is limited to one (1) treatment per day per recipient.
- c. Payment for specimen collections for clinical diagnostic laboratory tests are allowed in circumstances such as drawing blood samples through venipuncture (i.e., inserting into vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.
- d. When a series of specimen collections for clinical diagnostic laboratory test are required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.
- e. Payment for any laboratory service is limited to services provided by hospitals who are in compliance with the provisions of the Clinical Laboratory Improvement Amendment (CLIA) of 1988.

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150.2E.III. - 150.2F.I.

III. Services Not Covered

The Department will not pay for:

- a. Medical services and/or procedures considered to be experimental, cosmetic, social or educational;
- b. Outpatient services requiring prior authorization if authorization has not been obtained or has been denied;
- c. Any services, treatment or items furnished for which the provider does not usually charge;
- d. Examinations and laboratory tests, immunizations, biological products and other products for preventable diseases which are furnished free of charge by the Connecticut State Department of Health Services;
- e. The treatment of obesity;
- f. Tattooing and tattoo removal;
- g. Punch graft hair transplants;
- h. Superficial chemotherapy;
- i. Routine physical examinations requested by third parties, such as employers or insurance companies;
- j. Drugs included in the Drug Efficiency Study Implementation (DESI) Program that the Food and Drug Administration has proposed to withdraw from the market in a notice of opportunity for hearing. The Drug Efficiency Study Implementation (DESI) Program prohibition against payment includes all generically equivalent drug products and drugs that are less than effective;
- k. Canceled or "no-show" appointments;
- l. Telephone contacts.

F. Need for Service

- I. The Department will pay for medically necessary services on an outpatient basis that are ordered by the responsible physician or dentist, and that are within the rules and regulations of the Medicaid program.

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150.2F.II. - 150.2F.IV.a.

II. Clinical Diagnostic Laboratory Services

- a. In order to be eligible for reimbursement for any clinical diagnostic laboratory service performed and for which payment is sought must be reasonable, necessary, and furnished under the direction of a physician for the diagnosis or treatment of a particular illness or injury of the patient upon whom the test was performed.
- b. A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, (e.g., venipuncture or sample by catheterization). A specimen collection fee is not allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. It must be indicated in the nursing facility patient record that no staff is available to draw the sample.

III. New Medical Services

- a. To obtain approval for new medical services and medical services not previously billed to Medicaid the hospital must complete a Revenue Center Request Form obtained from the Department and submit the request along with any other information requested by the Department for consideration of new medical services.
- b. The Department will consider a request to cover a clinical diagnostic laboratory test procedure which is not on the Medicare Fee Schedule only after the hospital documents that it has requested Medicare to add the test, and such request was denied. A copy of the written Medicare decision must accompany such requests.
- c. The Department will notify the hospital in writing regarding the status of the request. If the new service is approved, a rate will be established and a revenue center code assigned.

IV. Out-of-State and Border Hospitals

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

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150.2F.IV.b. - 150.2G.I.b.

- b. The Connecticut Title XIX program reimburses for medically necessary and appropriate services provided in out-of-state hospitals, other than border hospitals, under the following conditions:
 - 1. For emergency cases as defined in this policy and necessitating the use of the most accessible general hospital available that is equipped to furnish the services;
 - 2. For non-emergency cases, when prior authorization is granted by the Department, for the following reasons: medical services are needed because the recipient's health would be endangered if they were required to travel to Connecticut; or on the basis of the attending physician's medical advice that the needed medical services or necessary supplementary resources are more readily available in the other State.

G. Prior Authorization

I. Requesting Prior Authorization

- a. To obtain Prior Authorization for medical services:

Form W-620, "Prior Authorization Request for Professional Services", is used to secure prior authorization. The initial prior authorization can be obtained by phoning the Department. The complete form is submitted after telephone approval, and mailed to:

Department of income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106

Subsequent and additional prior authorization is to be put in writing only.

Forms are obtained from EDS.

- b. To obtain prior authorization for dental services:

Use "EDS Dental Claim Form" available from EDS. The form is submitted to:

Department of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106

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150.2G.I.c. - 150.2G.II.c.

- c. A request for an extension of services authorized should be submitted in writing to the Department thirty (30) days before the current authorization expires. Any request for authorization received for services provided prior to the date the authorization is received by the Department, is subject to denial on that basis.
 - d. Acceptable reasons for late requests for prior authorization as defined in Section (a) of this policy:
 - 1. The patient was pending Title XIX eligibility when the service was provided. The date Title XIX was granted and the effective date must be noted on the prior authorization form.
 - 2. Medicare or other third party payer was billed. A copy of the denial or remittance advice must be attached to the prior authorization form.
 - 3. If delays are encountered in receiving documentation from third party payers, send the prior authorization form to D.I.M. with a copy of Form W-1417 "Third Party Billing Attempt Form". Refer to Section III.D. of the Hospital Manual, Billing Information Section, for detailed instructions.
 - e. In an emergency situation which occurs after working hours or on a weekend or holiday, the hospitals must obtain verbal approval on the next Departmental working day. This applies only to those services which normally require prior authorization. After securing verbal authorization, the provider has forty-eight (48) hours to submit a written request for authorization on the appropriate forms, with the written notation that verbal approval was granted, by whom and on what date.
- II. Prior authorization is required for the following medical services or procedures:
- a. Electroshock therapy;
 - b. Physical therapy or speech, language or hearing therapy in excess of two (2) visits per consecutive seven (7) day period per patient per provider;
 - c. Occupational therapy in excess of one (1) visit per consecutive seven (7) day period per patient per provider;

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- d. Physical therapy, occupational therapy or speech, language or hearing therapy in excess of nine (9) visits per calendar year, per patient per provider, involving the following primary diagnoses:
 - 1. All mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the International Classification of diseases (ICD-9-CM) (9th Revision Clinical Modification) diagnosis code section 290-319, inclusive;
 - 2. Cases involving musculoskeletal system disorders covered by ICD-9-CM diagnosis codes section 722-724, inclusive;
 - 3. Cases involving symptoms concerning nutrition, metabolism and development covered by ICD 9-CM diagnosis code section 783, inclusive.
- e. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to the following:

Genioplasty, lipectomy, gynecomastia, hair transplants, transplant operations, plastic surgery, mastectomy implant, reconstructive surgery including breast reconstruction following mastectomy, otoplasty for protruding ears or loop ears, excisions of keloids, rhinoplasty, silicone or silastic implants, facioplasty, osteoplasty, dermabrasion, chemabrasion, abdominoplasty, mammoplasty and augmentation mammoplasty.
- f. Psychiatric treatment services in excess of thirteen (13) visits in ninety (90) days, twenty-six (26) visits in six (6) months per patient per provider;
- g. Psychiatric evaluations in excess of one (1) per year per patient per provider with justification to warrant;
- h. Partial hospitalization/day treatment programs, from the date of initial treatment.
- i. Psychological Services and Testing

III. Border Hospitals

Prior authorization for outpatient services shall be required for such services in accordance with subsections F.I. through F.IV. of the Section pertaining to Connecticut in-state hospitals.

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150.2G.IV. - 150.2J.I.c.

IV. Out-of-State Hospitals

- a. Prior authorization for outpatient services shall be required for all non-emergency cases as described in subsection (e) (4) (B) of this Policy.
- b. The following services shall not require prior authorization: care in an emergency situation as defined in this policy; newborns and/or deliveries; or outpatient services for a child for whom the State of Connecticut makes adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.

H. Other

All hospital personnel should routinely review the recipient's Medical Identification Cards to verify eligibility. For a complete description of the card and restrictions refer to Section III.A. of the Department's Manual.

I. Billing Procedure

- I. Outpatient services are billed on the UB-82 form. Border hospitals and Out-of-State hospitals also bill on this form. The exceptions are dental services, which bill and receive prior authorization on the EDS Dental Claim Form.
- II. All dental services provided must be billed according to the Department's dental fee schedule using the hospital's dental provider number.

J. Payment

I. Payment to Connecticut-Based Hospitals

The Medicaid Agency must pay the reasonable cost of outpatient hospital services under methods and standards developed by the State of Connecticut. Such methods must:

- a. Be consistent with Section 1122 of the Social Security Act and 42 CFR 447.35 pertaining to Federal Financial Participation (FFP) for capital expenditures;
- b. Adopt the Medicare standards and principles for determining reasonable cost reimbursement (45 CFR 405.402-455);
- c. The Commissioner of Income Maintenance shall establish annually the cost of outpatient services for which payment is to be made;

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- d. All hospitals receiving State aid shall submit cost data to the Commissioner in accordance with established policies and procedures;
- e. Any institution to which payments are to be made which is aggrieved by any decision of the Commissioner of Income Maintenance may make a written request to the Commissioner for a rehearing on all items. (For procedures, refer to General Statute 17-311.)
- f. The rate in effect on the date the service is provided is used to determine the rate of payment.
- g. A physician who is fully or partially salaried by a hospital may not receive payment from the Department unless the physician maintains an office for private practice at a separate location from the hospital;
- h. Physicians who are solely hospital based, either on a full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients;
- i. A physician who maintains an office of private practice separate from the hospital may bill for services provided at the individual private practice location or for services provided to the physician's patients in the hospital;
- j. The Department does not reimburse interns or residents for their services; these services are included in the hospital rate.

II. Connecticut-Based Hospital Outpatient Rate Methodology

a. Outpatient Clinic Visit Rates

Each outpatient clinic visit shall be paid at a reasonable rate to be determined by the reasonable cost of such services, not to exceed one hundred and sixteen percent (116%) of the combined average fee of the general practitioner and specialist for an office visit according to the fee schedule for practitioners of the healing arts approved under §4-67C of the State Statutes. (Refer to Connecticut General Statutes 17-312(d)).

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b. Outpatient Clinic Special Services

The payment rate for ancillary or special services (except for clinical diagnostic laboratory services subject to the Medicare Fee Schedule) provided at the outpatient clinic visit is based on the ratio of cost to charge (R.C.C.). Such R.C.C. factored special services are developed from the annual hospital audited fiscal year end reports.

c. Emergency Room Rate

1. The Department shall pay all non-emergency visits to a general hospital emergency room at the hospital's outpatient clinic visit rate but not to exceed the charges made by such hospital for comparable services to the general public.

2. The rate for an emergency room visit is calculated by the Department effective July 1st of each year.

3. Payment for emergency visits to the emergency room shall be calculated as follows:

Hospital emergency room costs must be submitted in writing under oath by each hospital by June 1st annually on forms acceptable to the Department. Each hospital's cost is adjusted by the lesser of the percent of change in its own emergency room costs over the last four years; or the percent of change in the emergency room costs for all hospitals for the same period. The rate authorized by the Department shall be the lower of the hospital's adjusted cost, as set forth above, or the rate calculated at the 66-2/3 percentile of the statewide adjusted cost for all hospitals, ranked in ascending order.

4. A hospital emergency room visit includes a facility cost component and a professional cost component.

5. Each hospital may annually elect to have the rate for its facility component and professional component determined separately or with the components combined. Said election shall be made at the time the emergency room costs are filed with the Department in accordance with the provisions of this Section.

6. The Department shall pay general hospital for each emergency room visit at the rate authorized herein not to exceed the charges made by such hospital for comparable services to the general public.

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III. Out-of-State and Border Hospital Rate Methodology

Pursuant to Section 17-134d-63 of the Regulations of Connecticut State Agencies, effective July 1, 1990, the following payment methodology shall apply to out-of-state and border hospitals:

- a. For outpatient services rendered on and after the effective date of the regulation, the Department shall pay out-of-state and border hospitals, at a fixed percentage of each out-of-state and border hospital's usual and customary charge. The standard methodology to be employed shall be the fixed percentage calculated in accordance with Subsection b. of this section.
- b. For outpatient services the standard fixed percentage shall be calculated by the Department based on the ratio between the aggregates of the amount paid by the Department and the amount billed to the Department for all Connecticut in-state hospital outpatient services. The amount billed represents the hospital's usual and customary charges for outpatient services and the Department's payment represents the amount paid up to the amount allowed in accordance with the Department's current outpatient fee schedule for each Connecticut in-state hospital and as may be amended from time to time. The amount paid by the Department to Connecticut in-state hospitals shall include amounts paid in accordance with limits of payments as may be required by Federal law. The fixed percentage shall be determined by the Department utilizing data taken from its most recent and deemed the most complete twelve (12) month period as reported in its Medicaid Management Information System.
- c. The Department shall pay out-of-state and border hospitals utilizing the methodology as set forth in subsection b. of this section unless a different methodology is required by Federal law, in which case, the required Federal methodology shall be employed.
- d. Upon the effective date of the regulation establishing the payment methodology described in subsection b. of this section and annually thereafter and at the beginning of the rate year, meaning the twelve (12) month period beginning on October 1st of each year, the Department shall notify each out-of-state and border hospital enrolled in the Connecticut Medicaid Program as to the standard fixed percentages for that rate year.
- e. Upon the effective date of said regulation, the fixed percentages set in accordance with subsection b. of this section shall expire at the end of the rate year as defined in subsection d. of this section.

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IV. Payment for Clinical Diagnostic Laboratory Services

- a. Pursuant to §2303 (g) (2) and (j) (2) of Public Law 98-369 enacted effective July 18, 1984, clinical diagnostic laboratory service provided to hospital outpatients and nonpatients and performed on and after July 1, 1984 and paid on or after October 1, 1984 shall be reimbursed no more than the statewide fee schedule for clinical diagnostic laboratory tests, including amounts for specimen collections as permitted in this policy, established by the State Medicare carrier for outpatient/nonpatient hospital based laboratories; or the amount of the charges billed for the tests.
- b. Effective for outpatient clinical laboratory services rendered on or after July 1, 1986, the rate shall be the lesser of: the amount determined under such Medicare fee schedule; the limitation amount for that test pursuant to §9303(b) of the Public Law 99-272 enacted effective July 1, 1986; or the amount of the charges billed for the tests.
- c. In order to remain in compliance with §2303 (g) (2) and (j) (2) of Public Law 98-369 for the rate period July 1, 1985 through June 30, 1986 and §9303 (b) of the Public Law 99-272 enacted effective July 1, 1986 for the rate period July 1, 1986 through December 31, 1986 and January 1, 1987 through December 31, 1987 and all subsequent Medicare rate years, the rate for clinical diagnostic laboratory services as defined in this policy shall be reimbursed as follows:
 1. For the Medicare rate period July 1, 1985 through June 30, 1986, payments by the Department shall be made in accordance with the Medicare Fee Schedule as it existed on July 1, 1985. The rates established by the Department shall be the lesser of the Medicare Fee Schedule for such period or the amount of the charges billed for the tests;
 2. For the Medicare rate period July 1, 1986 through December 31, 1986, the rates established by the Department shall be the lesser of the Medicare Fee Schedule in effect on July 1, 1985, the limitation amount pursuant to §9303 (b) of the Public Law 99-272 or the amount of the charges billed for the tests;
 3. For the Medicare rate period beginning on and after January 1, 1987, the rates of payment shall be based upon the lesser of the amount of the Medicare Fee Schedule, the limitation amount pursuant to §9303 (b) or the Public Law 99-272 or the amount of the charges billed for the tests;

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4. Any subsequent changes mandated by Congress or of the United States Department of Health and Human Services shall be implemented by the Department as soon as practicable retroactive to the effective date of said mandatory change.
- d. The payment rate for clinical diagnostic laboratory service as stipulated in subsection I.III. of this policy shall be the lesser of:
 1. Medicare Fee Schedule Amount
 2. National limitation amount
 3. Amount of charges billed
- e. The payment rate for clinical diagnostic laboratory specimen collections shall be the lesser of:
 1. Medicare Fee Schedule rate
 2. Medicaid prevailing rate
 3. Hospital's usual and customary charge
- f. Services Not Subject to the Clinical Diagnostic Laboratory Fee Schedule include:
 1. Laboratory tests furnished to a hospital inpatient as defined in Section (b). of this policy.
 2. Those laboratory tests furnished by hospital based end-stage renal dialysis (ESRD) facilities the cost of which are included in the ESRD composite rate payment;
 3. Laboratory tests and services as identified by the State Medicare carrier to be performed by a physician; and
 4. Certain blood tests and tests primarily associated with the provision of blood products as identified by the State Medicare carrier.

V. Payment Limitations

- a. The amount paid by the Department for the clinical diagnostic laboratory services including amounts for specimen collections as permitted in this policy constitutes payment in full to the provider hospital.

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- b. There is no payment of Medicare coinsurance and deductible for clinical diagnostic laboratory tests subject to the Medicare Fee Schedule.
- c. When the hospital obtains laboratory tests for outpatients or nonpatients under arrangements with independent laboratories or other hospital laboratories, either the originating hospital (or hospital laboratory) may receive payment for all tests, or the originating hospital and the reference laboratories may receive payment for the tests they perform. The hospital may not receive payment for tests under arrangement if it does not operate a laboratory.
- d. Pursuant to said §2303 (g) (2) and (j) (2) of Public Law 98-369, it will be necessary to verify that any amounts expended by the Department between October 1, 1984 and January 31, 1986 inclusive, for clinical diagnostic laboratory tests, did not exceed the amount that would be recognized under the Social Security Act by Medicare. If any such payments are found to exceed the amount permitted by Federal Law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.
- e. Should any claims for clinical diagnostic laboratory services rendered prior to February 1, 1986 be submitted after the date that any overpayment has been calculated, the ratio used (the methodology of which is contained in §17-134d-40 of the Department's regulations) in determining the hospital's overpayment shall be applied in calculating the amount of reimbursement for said services.
- f. Pursuant to said §9303 (b) of the Public Law 99-272, it will be necessary to verify that any amounts expended by the Department - for dates of service on and after July 1, 1986 and received for payment on or before November 30, 1986, for clinical diagnostic laboratory tests - did not exceed the amount that would be recognized under said Section. If any such payment are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.
- g. The amount allowed by the Department for drawing or collecting a specimen at the laboratory facility covers the specimen drawing service and materials and supplies used.
- h. The amount allowed for drawings done in the recipient's home or in a nursing home covers the travel expenses of the technician, specimen drawing service, and materials and supplies used.

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150.2J.V.i. - 150.2J.V.n.

- i. Payment for drawing or collecting specimen is allowed for those hospitals who have an established rate and routinely charge for specimen collections.
- j. A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal (such as throat culture, a routine capillary puncture for clotting, or bleeding time).
- k. Payment will be made only in those cases in which the hospital has drawn or collected the specimen from the patient.
- l. Only one (1) collection fee is allowed for each type of specimen (e.g., blood, urine, etc.) for the same patient encounter regardless of the number of specimens drawn or collected.
- m. Papanicolaou Test

The Papanicolaou test fee includes the reading and interpretation of the test. There is no additional fee payable to any physician.
- n. There is no payment for emergency room services provided on the same day as an inpatient admission for the same recipient.

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173. – 173A.III.

173 Family Planning, Abortions and Hysterectomies

This section contains policies and procedures which must be followed when providers request payment for family planning, abortion and hysterectomy procedures and services provided to Title XIX patients.

A. Legal Bases

- I. Code of Federal Regulations: 42 CFR 441.20; 42 CFR 441.200 through 42 CFR 441.208; 42 CFR 441.250 through 441.259
- II. Connecticut General Statutes: Section 17-134d

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173B. - 173B.III.

B. Definitions

I. Family Planning Services

Family Planning Services include any medically approved diagnostic procedures, treatment, counseling, drugs, supplies or devices which are prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

II. Informed Consent

For the purposes of this section, Informed Consent means the knowing, voluntary assent from the individual on whom the sterilization is to be performed after he or she has been given, as evidenced by the document signed by the individual, the following information:

- a. an objective explanation of the procedures to be followed;
- b. a description of the attendant discomforts and risks;
- c. a description of the benefits to be expected;
- d. counseling concerning appropriate alternative methods and the result of the sterilization including the fact that it must be considered an irreversible procedure;
- e. instruction that the individual is free to withhold or withdraw his or her consent anytime prior to the sterilization without prejudicing future care and without loss of any other program benefits to which the individual might otherwise be entitled; and
- f. answers to any inquiries concerning the procedure.

III. Institutionalized Individual

For the purposes of this section, Institutionalized Individual means an individual who is (a) voluntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or (b) confined under voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

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173B.IV. – 173E.II.a.

IV. Mentally Incompetent Individual

Mentally Incompetent Individual means an individual who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

V. Shortly Before

For the purposes of this section, the phrase “shortly before” as used in the Physician’s Statement section of the Sterilization Consent Form means seven (7) days or less. This applies to the requirement that the physician performing the sterilization explain the procedure to the patient shortly before the operation is performed.

VI. Sterilization

Sterilization means any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

C. Provider Participation

In order to participate in the Medicaid program, providers must meet all applicable State licensing and certification requirements. Providers must also meet all Departmental enrollment requirements.

D. Eligibility

Payment for family planning services, abortions and hysterectomies is available to all persons eligible for Medicaid, subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

I. Family Planning

The Department will pay for family planning services for individuals of childbearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

II. Sterilizations

a. The Department will not pay for sterilizations for patients who are under the age twenty one (21) or who are under the age twenty-one (21) at the time of consent.

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173E.II.b. - 173F.II.

- b. The Department will not pay for sterilizations performed on mentally incompetent individuals.
- c. The Department will not pay for sterilizations performed on institutionalized individuals.

III. Hysterectomies

The Department will not pay for hysterectomies when:

- a. The hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- b. If there was more than one purpose to the procedure, the hysterectomy would not have been performed, but for the purpose of rendering the individual permanently incapable of reproducing.

IV. Abortions

The Department will pay for an abortion only when:

- a. The attending physician has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term, or
- b. Effective October 9, 1981, the attending physician has certified in writing that the abortion is medically necessary for the patient's health.

- V. Services covered are limited to those listed in the Department's fee schedules.

F. Need for Service and Authorization Process

I. Need for Service

Medicaid recipients of child-bearing age who indicate a need for family planning services must be free from coercion or mental pressure and free to choose the method of family planning to be used.

II. Prior Authorization

None of the services covered in this section require prior authorization.

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173G. - 173G.I.a.7.

G. Other

I. Requirements for Sterilizations

a. Informed Consent

Informed consent has been given only if the person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure and provided a copy of the consent form to the individual to be sterilized.

The person obtaining consent has met the informed consent requirements if all of the following information or advice was provided orally (unless otherwise indicated):

1. The individual has been advised that he or she is free to withhold or withdraw consent to this procedure at any time before sterilization. This decision would not affect the individual's right to future care or treatment nor would it cause the loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
2. The individual has been given a description of available alternative methods of family planning and birth control.
3. The individual has been advised that the sterilization procedure is considered to be irreversible.
4. The individual has been given a thorough explanation of the specific sterilization procedure to be performed, verbally and in writing.
5. The individual has been advised of the discomforts and risks that may accompany or follow performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
6. The individual has been given a full description of the benefits or advantages that may be expected as a result of the sterilization.
7. The individual has been advised that the sterilization will not be performed for at least thirty (30) days, except in the circumstances specified under Premature Delivery or Emergency Abdominal Surgery.

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173G.I.a.8. - 173G.I.c.1.

8. In the case of a blind, deaf or otherwise handicapped individual, suitable arrangements were made to ensure that the information listed above, under Informed Consent, was effectively communicated.
9. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.
10. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.
11. The requirements of Form W-612, "Consent Form" (Sterilization) were met.

b. Restrictions on Obtaining Informed Consent

Informed consent may not be obtained from an individual under the following conditions:

1. The individual is in labor or childbirth.
2. The individual is seeking to obtain or is obtaining an abortion.
3. The individual is under the influence of alcohol or other substances that effect the individual's state of awareness.

c. Consent Form

1. The Department must receive a completed original of Form W-612, "Consent Form" (Sterilization) before payment for any sterilization procedure can be made. The form must be fully and accurately completed in all areas. Forms must be clearly written and legible. Form W-612 is the only acceptable form that can be submitted. The only reproduction of this form allowed for the purpose of obtaining consent is by photocopy. All other facsimiles, even with identical wording will be denied for payment.

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173G.I.d. - 173G.II.b.

d. Premature Delivery

In the case of a premature delivery, Form W-612 must be signed and dated by the patient at least seventy-two (72) hours prior to sterilization and at least thirty (30) days prior to the expected date of delivery. The physician must include the patient's expected date of delivery as part of the Physician's Statement in cases of sterilization with premature delivery.

e. Emergency Abdominal Surgery

Form W-612 must be completed and signed by the patient at least seventy-two (72) hours prior to surgery in cases where sterilization is performed in conjunction with emergency abdominal surgery.

f. Submission of Consent Form

Providers should submit Form W-612 along with their standard billing form. When two or more providers will bill for services rendered in connection with the same sterilization, only one provider is required to submit the original completed Consent Form. It is suggested that hospitals submit the original Form W-612 with their bill since hospitals frequently bill earlier than physicians. This is not mandatory. An original Form W-612 must be on file before any provider will be paid.

II. Requirements for Hysterectomies

a. Medical Necessity

The Department will pay only for hysterectomies which are medically necessary. The diagnosis must be clearly written on the face of the claim. The Department reserves the right to review the medical necessity of all hysterectomies for which reimbursement is being requested.

b. Hysterectomy Acknowledgment Requirement

The Department will pay for a medically necessary hysterectomy which was performed for a reason other than sterilization only when:

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173G.II.b.1. - 173G.II.c.1.

1. The person who secured authorization to perform the hysterectomy informed the patient and her representative, if any, both orally and in writing prior to the surgery that the hysterectomy would make the patient permanently incapable of reproducing. The patient or her representative, if any, must sign and date Form W-613, "Hysterectomy Information Form," acknowledging receipt of this information.

For dates of service on or after July 1, 1983, the patient or her representative must sign and date Form W-613 before or after the surgery is performed provided that the person who secured authorization for the surgery informed the patient and her representative, if any, both orally and in writing prior to the hysterectomy;

2. The physician certifies in writing that the patient was already sterile at the time of the hysterectomy and states the cause of sterility. Form W-613 must be completed by the physician when this situation applies. The patient or her representative is not required to complete Form W-613 when the patient was already sterile at the time of the hysterectomy; or
3. The physician certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The physician must include a description of the nature of the emergency. Form W-613 must be completed by the physician when this situation applies.

A completed Form W-613 must be submitted with the billing form in order for payment to be made.

c. Retroactive Eligibility

For dates of service on or after July 1, 1983, the Department will pay for a medically necessary hysterectomy which was performed during a period of retroactive eligibility if the physician who performed the hysterectomy certifies in writing that:

1. The patient was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;

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173G.II.c.2. - 173G.V.

2. The patient was already sterile at the time of the hysterectomy and the physician states the cause of sterility; or
3. The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The physician must include a description of the nature of the emergency.

Form W-613A, "Physician Hysterectomy Certification Form - Retroactive Eligibility" must be completed by the physician and submitted with the billing form in order for payment to be made.

III. Requirements for Abortions

a. Medical Necessity

The Department will pay for an abortion only when:

1. The attending physician has certified in writing on Form W-484, "Physician's Certification for Abortion (Title XIX)," that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term, or
2. The attending physician has certified in writing on Form W-484 that the abortion is medically necessary for the patient's health.

b. Submission of Certification

Form W-484 must be filled out completely including the name and address of the patient. An original Form W-484 must be on file with the Department before any provider will be paid. Providers should submit Form W-484 along with their standard billing form for the services provided.

IV. The Department must have an accurate original certification form on file before any provider will be paid for a sterilization, hysterectomy or abortion. The first certification form submitted by a provider for a particular claim will be the one which is reviewed for payment purposes.

V. The Department will not pay for canceled office visits, for appointments not kept, or for information provided by telephone.

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173G.VI. - 173I.

VI. Obtaining Consent, Information and Certification Forms

Providers may obtain forms Form W-612, "Consent Form" (Sterilization); W-613, "Hysterectomy Information Form"; W-613A, "Physician Hysterectomy Certification Form - Retroactive Eligibility"; and Form W-484, "Physician's Certification for Abortion (Title XIX)", by sending a written request to:

Supervisor
Duplicating
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106

H. Billing

- I. Providers should use the standard billing form for their provider group when billing for family planning services, abortions and hysterectomies (e.g., physicians use the HCFA 1500). All family planning procedures should be indicated as such on the billing form using the method appropriate for the billing form.

NOTE: Abortions and hysterectomies should not be listed as family planning services.

- II. Providers of family planning services, abortions and hysterectomies should submit claims to the Department's fiscal agent:

Electronic Data Systems Corporation (EDS)
Hartford, Connecticut 06104

Providers should use the post office box number appropriate for their provider type.

I. Payment

Payment will be made in accordance with the payment policy established for each provider group.

Requirements for Payment of Inpatient Psychiatric Hospital Services

Sec. 17b-262-499 Scope

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

Sec. 17b-262-500 Definitions

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

- (1) "**Active Treatment**" means the definition contained in 42 Code of Federal Regulations (CFR), Part 441, section 441.154.
- (2) "**Acute**" means having rapid onset, severe symptoms, and a short course.
- (3) "**Acute Care**" means medical care needed for an illness, episode, or injury which requires short-term, intense care, and hospitalization for a short period of time.
- (4) "**Allied Health Professional (AHP)**" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in mental health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, and other qualified therapists.
- (5) "**Certification of Need Review**" means an evaluation process for clients under the age of twenty-one who are requesting inpatient admission to a psychiatric hospital. This evaluation is conducted by the department acting as the independent team.
- (6) "**Client**" means a person eligible for goods or services under the department's Medical Assistance Program.
- (7) "**Client Age Sixty-Five or Over**" means the definition contained in 42 CFR, Part 441, section 441.100.
- (8) "**Client Under Age Twenty-One**" means the definition contained in 42 CFR, Part 441, section 441.151.
- (9) "**Department**" means the Department of Social Services or its agent.
- (10) "**Elective Admission**" means any psychiatric admission to a psychiatric hospital or psychiatric facility that is nonemergency, including urgent admissions and transfers from one facility to another.
- (11) "**HealthTrack Services**" means the services described in subsection (r) of section 1905 of the Social Security Act.
- (12) "**HealthTrack Special Services**" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

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

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

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

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

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

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

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

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

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

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

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

(22) "**Medical Record**" means the definitions contained in 42 CFR, Part 482, section 482.61, and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

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

- (24) "**Preadmission Review**" means a review prior to, or, in the case of an emergency admission, within fourteen days after a client's admission to an inpatient psychiatric facility with the purpose of determining the medical necessity, appropriateness, and quality of the health care services to be delivered, or in the case of an emergency, delivered in the hospital.
- (25) "**Prior Authorization**" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.
- (26) "**Provider**" means a psychiatric hospital or psychiatric facility.
- (27) "**Provider Agreement**" means the signed, written, contractual agreement between the department and the provider of services or goods.
- (28) "**Psychiatric Emergency**" means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability, or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a Physician Emergency Certificate are not automatically deemed to qualify as a psychiatric emergency.
- (29) "**Psychiatric Facility**" means an institution which is not a hospital and is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHO), to provide inpatient psychiatric services under the direction of a physician to clients who are under the age of twenty-one or age sixty-five or over, and meets specific conditions contained at 42 CFR, Part 435, section 435.1009.
- (30) "**Psychiatric Hospital**" means an accredited or state licensed institution which is engaged in providing hospital level psychiatric services, under the supervision of a physician, for the diagnosis and treatment of mentally ill persons. Specific conditions for psychiatric hospital contained at 42 CFR, Part 482, sections 482.60 through 482.62, and at 42 CFR, Part 435, section 435.1009, shall be implemented. Psychiatric units or beds in a general, acute care hospital are not included in this definition.
- (31) "**Quality of Care**" means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the condition and the client under treatment.
- (32) "**Retrospective Review**" means the review conducted after services are provided to a client, to determine the medical necessity, appropriateness, and quality of the services provided.
- (33) "**State Plan**" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations.
- (34) "**Transfer**" means that an individual is discharged from the hospital or facility and directly admitted to another.
- (35) "**Under the Direction of a Physician**" means that health services may be provided by allied health professionals whether or not the physician is physically present at the time that the services are provided. The physician shall:

- (A) assume professional responsibility for the services provided;
 - (B) assure that the services are medically appropriate; and
 - (C) be readily available within five minutes but not necessarily on the premises.
- (36) "**Urgent Admission**" means an elective, nonemergency admission.
- (37) "**Utilization Review**" means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures, and facilities. Utilization Review evaluates the medical necessity and medical appropriateness of admissions, the services performed or to be performed, the length of stay, and the discharge practices. It is conducted on a concurrent, prospective, or retrospective basis.

Sec. 17b-262-501 Provider Participation

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

(a) General:

- (1) meet and maintain all applicable licensing, accreditation, and certification requirements;
- (2) meet and maintain all departmental enrollment requirements; and
- (3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) Specific:

- (1) providers of inpatient psychiatric services shall be licensed, when appropriate, by the state and accredited as a psychiatric hospital by the Joint Commission on Accreditation of Healthcare Organizations, and
- (2) psychiatric hospitals outside of Connecticut shall meet all of the above provider requirements. They shall also be an enrolled Medical Assistance Program provider in their state of residence, when that state participates in the optional program of Medical Assistance Program psychiatric inpatient services provided to clients age twenty-one and under and age sixty-five and over.

Sec. 17b-262-502 Eligibility

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

Sec. 17b-262-503 Services Covered

The department shall pay for the following:

- (a) medically necessary and medically appropriate inpatient psychiatric services for clients under age twenty-one or age sixty-five or over when the need for services as stated in section 17b-262-499 through section 17b-262-511 are met and provided by an enrolled Medical Assistance Program provider;
- (b) inpatient hospital tests when the tests are specifically ordered by the attending physician or other licensed practitioner who is responsible for the diagnosis and treatment of the client, and who is acting within the scope of practice as defined under state law;

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

Sec. 17b-262-504 Services Not Covered

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

- (a) procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature or for any diagnostic, therapeutic, or treatment procedures in excess of those deemed medically necessary and appropriate by the department to treat the client's condition;
- (b) services that do not directly relate to the client's diagnosis, symptoms, or medical history;
- (c) services or items furnished for which the provider does not usually charge;
- (d) the day of discharge or transfer;
- (e) an inpatient psychiatric hospital admission or a day of care that does not meet all the department's requirements for inpatient services;
- (f) an inpatient psychiatric hospital admission or a day of care that is denied by the hospital's Utilization Review Committee;
- (g) a day when the client, who is age sixty-five or over, is absent from the psychiatric hospital at the midnight census, even though the leave or transfer is medically authorized and part of the treatment plan;
- (h) a day when the client, who is under age twenty-one, is absent from the psychiatric hospital at the midnight census, even though the leave or transfer is medically authorized and part of the treatment plan; or
- (i) costs associated with the education or vocational training of the client which shall be excluded from Medical Assistance Program payments.

Sec. 17b-262-505 Certification of Need Review Requirements for Inpatient Psychiatric Services for a Client Under Age Twenty-One in a Psychiatric Hospital

- (a) In order to receive payment for inpatient psychiatric hospital services for individuals under age twenty-one, each individual admission, including elective and emergency admissions, shall have a certification of need review.
- (b) The certification of need review shall be a part of the client's medical record, with written documentation certifying that:
 - (1) ambulatory care resources available in the community do not meet the treatment needs of the client;
 - (2) proper treatment of the client's psychiatric condition requires inpatient care under the direction of a physician; and
 - (3) the services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.
- (c) When the admission of a Medical Assistance Program client is elective, an independent team is responsible to perform the certification of need review. The department shall act as the independent team.

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

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

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

Sec. 17b-262-506 Individual Plan of Care Requirements for Inpatient Psychiatric Services for a Client Under Age Twenty-One in a Psychiatric Hospital

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

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

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

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

(3) state the treatment objective;

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

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

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

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

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

Sec. 17b-262-507 Individual Plan of Care for a Client Age Sixty-Five or Over in a Psychiatric Hospital

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

- (1) an initial review of the client's medical, psychiatric, and social needs;
- (2) periodic review of the client's medical, psychiatric, and social needs;
- (3) a determination, at least every ninety days, of the client's need for continuing institutional care and for alternative care arrangements;
- (4) appropriate medical treatment in the institution; and
- (5) appropriate social services.

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

Sec. 17b-262-508 Utilization Review Program for Inpatient Psychiatric Services for Clients Under Age Twenty-One Or Age Sixty-Five or Over

(a) The department's Utilization Review Program conducts utilization review activities for services delivered by the inpatient psychiatric hospital to clients where the Medical Assistance Program has been determined to be the appropriate payer.

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

- (1) require preadmission review or prior authorization of each inpatient psychiatric hospital admission, including a certificate of need review, for clients under age twenty-one, unless the department notifies the providers that a specific admission, diagnosis, or procedure does not require such authorization; and
- (2) perform retrospective reviews at the department's discretion which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the appropriateness, necessity, or quality of the health care services provided.

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

(d) All claims for payment for admission and all days of stay and services that are provided shall be documented. Lack of said documentation itself may be adequate ground for the

department, in its discretion, to deny or recoup payment for the admission for some or all of the days of stay or services provided.

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

Sec. 17b-262-509 Billing Procedures

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

Sec. 17b-262-510 Documentation and Record Retention

(a) A provider shall meet the special medical record requirements for a psychiatric hospital and shall maintain records to support claims made for payment. All documentation shall be made available upon request by and to authorized department, state, or federal personnel in accordance with state and federal laws.

Documentation shall be retained by the provider for a period of five years, or if any dispute arises concerning a service, until such dispute has been finally resolved.

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