



# Connecticut interChange MMIS

Provider Manual

Chapter 7 - Physician and Psychiatrist

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**CONNECTICUT MEDICAL ASSISTANCE PROGRAM**  
**Physician and Psychiatrist Regulation/Policy**  
**Chapter 7**

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

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.

Physicians

**Requirements for the Payment of Physicians' Services**

Requirements for the Payment of Physicians' Services.....17b-262-337  
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Psychiatrists

**Requirements for the Payment of Psychiatrists' Services**

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## DEPARTMENT OF SOCIAL SERVICES

### REGULATIONS CONCERNING PHYSICIANS' SERVICES

#### **Sec. 17b-262-337. Scope**

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

#### **Sec. 17b-262-338. Definitions**

For the purposes of sections 17b-262-337 to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) "Acute" means symptoms that are severe and have rapid onset and a short course;
- (2) "Admission" means the formal acceptance by a hospital of a client who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services;
- (3) "Advanced practice registered nurse" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;
- (4) "Allied Health Professional" or "AHP" means a licensed individual other than a physician who: (A) Is qualified by special training, education, skills and experience in health care and treatment, (B) is licensed by the Department of Public Health as one or more of the following: Psychologist, licensed clinical social worker, advanced practice registered nurse, nurse-midwife, physician assistant, licensed professional counselor, licensed marital and family therapist, licensed alcohol and drug counselor, physical therapist, occupational therapist, speech pathologist, audiologist, optician, optometrist, respiratory care practitioner or such other category of licensed health care professional that the department permits to enroll individually as a Medicaid provider, (C) acts within the AHP's scope of practice under state law and (D) complies with all requirements in 42 CFR 440 applicable to the AHP;
- (5) "Audiologist" means a person licensed to practice audiology pursuant to section 20-395c of the Connecticut General Statutes;
- (6) "Billing provider" means a physician, physician group or other entity enrolled in Medicaid that bills the department for physicians' services;
- (7) "Border provider" means a provider located in a state bordering Connecticut, in an area that allows the provider to generally serve Connecticut residents, and that is enrolled as and treated as a Medicaid provider. Such providers are certified, accredited or licensed by the applicable agency in their state and are deemed border providers by the department on a case-by-case basis;

- (8) “Child” means a person who is under twenty-one years of age;
- (9) “Chronic disease hospital” has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;
- (10) “Client” means a person eligible for goods or services under Medicaid;
- (11) “Commissioner” means the Commissioner of Social Services;
- (12) “Consultation” means those services rendered by a physician whose opinion or advice is requested by the client’s physician or agency in the evaluation or treatment of the client’s illness;
- (13) “Department” means the Department of Social Services or its agent;
- (14) “Early and Periodic Screening, Diagnostic and Treatment services” or “EPSDT services” means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;
- (15) “Emergency” means an event involving a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (A) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (B) serious impairment to bodily functions or (C) serious dysfunction of any bodily organ or part;
- (16) “Family planning services” means any medically approved diagnostic procedure, treatment, counseling, drug, supply or device that a provider prescribes or furnishes to individuals of childbearing age for the purpose of enabling such individuals to freely plan the number and spacing of their children;
- (17) “Fees” means the payments for services, treatments and drugs administered by physicians which the commissioner shall establish and include in the department’s fee schedules;
- (18) “General hospital” has the same meaning as provided in section 17-134d-80 of the Regulations of Connecticut State Agencies;
- (19) “Home” means the client’s place of residence, which includes a boarding home, community living arrangement or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;
- (20) “Hysterectomy” has the same meaning as provided in 42 CFR 441.251;
- (21) “Informed consent” has the same meaning as provided in 42 CFR 441.257;

- (22) “Intermediate care facility for the mentally retarded” or “ICF/MR” means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;
- (23) “ICD” means the International Classification of Diseases established by the World Health Organization or such other disease classification system that the department currently requires providers to use when submitting Medicaid claims;
- (24) “Institutionalized individual” has the same meaning as provided in 42 CFR 441.251;
- (25) “Legend Device” has the same meaning as provided in section 20-571 of the Connecticut General Statutes;
- (26) “Legend Drug” has the same meaning as provided in section 20-571 of the Connecticut General Statutes;
- (27) “Licensed alcohol and drug counselor” means an individual licensed pursuant to section 20-74s of the Connecticut General Statutes;
- (28) “Licensed clinical social worker” means an individual licensed pursuant to section 20-195n of the Connecticut General Statutes;
- (29) “Licensed marital and family therapist” means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;
- (30) “Licensed professional counselor” means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;
- (31) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- (32) “Medical necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (33) “Medical record” has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;
- (34) “Mentally incompetent individual” has the same meaning as provided in 42 CFR 441.251;
- (35) “Nurse-midwife” has the same meaning as provided in section 20-86a of the Connecticut General Statutes;
- (36) “Nursing facility” has the same meaning as provided in 42 USC 1396r(a);
- (37) “Occupational therapist” means an individual licensed pursuant to section 20-74b or section 20-74c of the Connecticut General Statutes;

- (38) “Optician” means a person licensed pursuant to section 20-146 of the Connecticut General Statutes;
- (39) “Optometrist” means a person licensed pursuant to section 20-130 of the Connecticut General Statutes;
- (40) “Out-of-state provider” means a provider that is located outside Connecticut and is not a border provider;
- (41) “Panel or Profile Tests” means specified groups of tests performed on a single specimen or material derived from the human body that are related to a condition, disorder or family of disorders, and when combined mathematically or otherwise, comprise a finished identifiable laboratory study or studies;
- (42) “Performing provider” means the physician or AHP who actually performs the service;
- (43) “Physical therapist” means an individual licensed pursuant to 20-70 or 20-71 of the Connecticut General Statutes;
- (44) “Physician” means a person who is: (A) Licensed pursuant to section 20-13 of the Connecticut General Statutes and (B) acting within the physician’s scope of practice under state law;
- (45) “Physician assistant” means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes;
- (46) “Physicians’ services” means services that are billed by the billing provider and are provided:
- (A) By an individual physician who is also the billing provider;
  - (B) by a physician who is employed by or affiliated with the billing provider; or
  - (C) by an AHP working under the personal supervision of a physician who is employed by or affiliated with the billing provider;
- (47) “Prior authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;
- (48) “Provider” means (A) a physician or a physician group enrolled in Medicaid or (B) an AHP who is providing physicians’ services;
- (49) “Psychologist” means a person licensed pursuant to sections 20-188 or 20-190 of the Connecticut General Statutes
- (50) “Quality of care” means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the client’s condition;
- (51) “Respiratory care practitioner” means an individual licensed pursuant to section 20-162o of the Connecticut General Statutes;

- (52) “Speech pathologist” means an individual licensed pursuant to section 20-411 of the Connecticut General Statutes;
- (53) “Sterilization” has the same meaning as provided in 42 CFR 441.251;
- (54) “Under the personal supervision” means the administrative and clinical responsibility personally assumed by the physician for the AHP’s services within the AHP’s scope of practice;
- (55) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary charge” means the median charge. Token charges for charity patients and other exceptional charges shall be excluded when calculating the usual and customary charge; and
- (56) “Utilization review” has the same meaning as provided in section 17-134d-80 of the Regulations of Connecticut State Agencies.

**Sec. 17b-262-339. Provider participation**

- (a) In order to enroll in Medicaid and for billing providers to receive payment from the department, performing providers and billing providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies and shall maintain their enrollment status pursuant to valid provider enrollment agreements on file with the department.
- (b) Performing providers shall enroll in Medicaid as performing providers.
- (c) Billing providers shall enroll in Medicaid as billing providers.

**Sec. 17b-262-340. Eligibility**

Payment to a billing provider for physicians’ services billed by the billing provider shall be available on behalf of clients who have a need for such services, provided such services are medically necessary, subject to the conditions and limitations that apply to such services.

**Sec. 17b-262-341. Goods and services covered and limitations**

The department shall pay billing providers for the following physicians’ services:

- (1) Those procedures that are medically necessary to treat the client’s condition;
- (2) physicians’ services provided in an office, a general hospital, the client’s home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;
- (3) laboratory services provided by a provider in compliance with 42 USC 263a to 42 USC 263a-7, inclusive;

- (4) medical and surgical supplies for out-of-office use by the client;
- (5) drugs and devices administered by a provider;
- (6) a second opinion for surgery or any other treatment when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation;
- (7) family planning, abortion and hysterectomy services as described in section 17b-262-348(r) of the Regulations of Connecticut State Agencies;
- (8) Early and Periodic Screening, Diagnostic and Treatment services, including treatment services which are indicated following screening not otherwise covered, provided that prior authorization is obtained;
- (9) surgical services necessary to treat morbid obesity as defined by the ICD that causes or aggravates another medical illness, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system;
- (10) family planning services for clients of childbearing age, including minors who can be considered sexually active, and who desire the services;
- (11) sterilization for clients who are at least 21 years of age at the time of informed consent; and
- (12) a hysterectomy performed during a period of retroactive eligibility as described in 42 CFR 441.255(e).

**Sec. 17b-262-341a. Physician Assistants**

- (a) The department shall pay the billing provider for physicians' services provided by a physician assistant who:
  - (1) Provides services under the personal supervision of a physician;
  - (2) acts within the physician assistant's scope of practice under state law and performs only functions delegated by the supervising physician in compliance with sections 20-12c and 20-12d of the Connecticut General Statutes and all applicable requirements of the Department of Public Health; and
  - (3) is employed by or affiliated with the billing provider.
- (b) All relevant payment limits described in section 17b-262-348 of the Regulations of Connecticut State Agencies apply to physicians' services provided by a physician assistant.
- (c) Physician assistants shall enroll individually in Medicaid as performing providers.



**Sec. 17b-262-342. Goods and services not covered**

The department shall not pay for the following goods or services or goods or services related to the following:

- (1) Transsexual surgery or for a procedure that is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis;
- (2) immunizations, biological products and other products available to providers free of charge;
- (3) examinations and laboratory tests for preventable diseases that are furnished free of charge;
- (4) information or services provided to a client by a provider electronically or over the telephone;
- (5) cosmetic surgery;
- (6) an office visit for the sole purpose of the client obtaining a prescription where the provider previously determined the need for the prescription;
- (7) cancelled services and appointments not kept;
- (8) services provided in a general hospital if the department determines the admission does not, or retrospectively did not, comply with the department's utilization review requirements in section 17-134d-80 of the Regulations of Connecticut State Agencies;
- (9) infertility treatment;
- (10) sterilizations performed on mentally incompetent individuals or institutionalized individuals;
- (11) more than one visit per day to the same provider by a client;
- (12) services to treat obesity other than those described in section 17b-262-341(9) of the Regulations of Connecticut State Agencies; and
- (13) any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary by the department to treat the client's condition; or services not directly related to the client's diagnosis, symptoms or medical history.

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

Payment is available to billing providers for an initial office visit and continuing services that are medically necessary, provided that:

- (a) The services are within the provider's scope of practice; and
- (b) the provider documents the services in the client's medical record.

**Sec. 17b-262-344. Prior authorization**

- (a) Prior authorization, on forms and in the manner specified by the department, is required in order for payment to be available for the following physicians' services. Prior authorization is also required for services designated by the department and published on its website or by other means accessible to providers.
  - (1) Electrolysis epilation;
  - (2) physical therapy services in excess of two visits per calendar week per client per provider;
  - (3) physical therapy services in excess of nine visits per calendar year per client per provider, when the therapy being prescribed is for the treatment of:
    - (A) All mental disorders, including diagnoses related to mental retardation and specific delays in development covered by the ICD;
    - (B) musculoskeletal system disorders of the spine covered by the ICD; and
    - (C) symptoms related to nutrition, metabolism and development covered by the ICD;
  - (4) reconstructive surgery, including breast reconstruction following mastectomy;
  - (5) plastic surgery;
  - (6) transplant procedures;
  - (7) Early and Periodic Screening, Diagnostic and Treatment services that are identified during a periodic screening as medically necessary and that are not payable pursuant to the physician fee schedule; and
  - (8) any service or device that is not on the department's fee schedule.
- (b) Prior authorization is required for all hospital admissions pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies.
- (c) The department shall make payment available to the billing provider only if the provider initiates the authorized procedure or course of treatment not more than six months after the date of authorization.
- (d) The initial authorization period shall not exceed six months.
- (e) If prior authorization is needed beyond the initial authorization period, the department shall consider requests for continued treatment beyond the initial authorization period for up to an additional six-month period per request or longer as determined by the department on a case-by-case basis.

- (f) Except in emergency situations, the provider shall receive prior authorization before rendering services.
- (g) In an emergency situation involving services that require prior authorization that occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval from the department on the next working day for the services provided.
- (h) In order to receive payment from the department, a billing provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met.

**Sec. 17b-262-345. Billing procedures**

- (a) Billing providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment, including, but not limited to, identifying the performing provider on each claim.
- (b) The amount billed to the department shall represent the billing provider's usual and customary charge for the services delivered.
- (c) When a client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's name on all applicable claims.
- (d) When billing for anesthesia services, anesthesiologists shall include the name of the primary surgeon on the claim.
- (e) The department shall pay the billing provider directly for laboratory services performed in the provider's office and the billing provider shall bill the department for such services as separate line items. When a provider refers a client to a private laboratory for services, the laboratory shall bill the department directly and no laboratory charge shall be paid to the provider.
- (f) When more than one member of a billing provider provides services, the billing provider shall submit prior authorization requests prior to billing in accordance with the billing instructions in the department's provider manual.

**Sec. 17b-262-346. Payment**

- (a) Fees shall be the same for in-state, border and out-of-state providers.
- (b) Payment shall be made at the lowest of:
  - (1) The billing provider's usual and customary charge;
  - (2) the lowest Medicare rate;

- (3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or
  - (4) the amount billed by the billing provider.
- (c) Notwithstanding the provisions of the Regulations of Connecticut State Agencies or any provisions of the department's Medical Services Policy, the department shall not pay any billing provider under sections 17b-262-337 to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies for a client seen at a freestanding clinic enrolled in Medicaid. Only the clinic may bill for such services, except that (1) a provider may bill for covered services for a client seen at an outpatient dialysis clinic or at an outpatient surgical facility and (2) a billing provider enrolled with Medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.
- (d) The department shall not pay interns or residents for their services, nor shall the department pay for assistant surgeons in general hospitals or chronic disease hospitals staffed by interns and residents, unless the procedure is sufficiently complicated that it is medically necessary for a full surgeon to act as an assistant, such as for open heart surgery. If the resident or intern performs the surgery and the supervising surgeon assists, the department shall pay only the assistant's fee to the surgeon and shall not pay the regular surgical fee.
- (e) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, the department shall not pay any fee to the surgeon even if the surgeon was on call during the surgery.
- (f) When an AHP provides physicians' services, the department shall pay the billing provider that employs or is affiliated with the AHP for such services at the rates applicable to the AHP's provider type, including any percentage adjustment to the physician fee schedule for the AHP's provider type.

**Sec. 17b-262-347. Payment rate**

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

**Sec. 17b-262-348. Payment limitations**

- (a) The department shall pay only for physicians' services performed by or under the personal supervision of a physician.
- (b) The department shall pay the fee for an initial visit by a provider in an office, home, ICF/MR or nursing facility only once per client. Initial visits refer to the provider's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the provider-client relationship has been discontinued for three or more years and is then reinstated.
- (c) The department shall pay non-hospital-based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.

- (d) The department shall pay fees to a consultant provider only when another provider or other appropriate referral source requests the opinions and advice of the consultant provider. The consultant provider shall document such provider's opinion and any services ordered or performed by the consulting provider in the client's medical record and submit a written report describing such opinion and services to the requesting physician or other appropriate referral source. The referring provider remains responsible for carrying out the plan of care after seeking a consultation.
- (e) If a client is referred to a provider for treatment of a condition that the referring provider does not usually treat, the department shall pay the treating provider the fee for an office visit rather than the fee for a consultation.
- (f) When the consultant provider assumes the continuing care of the client, the department shall pay the consultant provider for any subsequent service according to the fee listed for the procedure.
- (g) If a client's medical condition necessitates the concurrent services and skills of two or more providers, the department shall pay each provider the listed fee for the service that each provider provides.
- (h) When a provider examines a Medicaid applicant for the purpose of substantiating whether a medical condition exists that would enable the department to determine eligibility for Medicaid disability, the department shall pay the billing provider only for the tests required to establish eligibility as requested by the department. The department shall not pay the billing provider for any other procedures.
- (i) **Surgery**
  - (1) When a billing provider submits a claim for multiple surgical procedures performed on the same date, the department shall pay the listed fee for the primary surgical procedure. The department shall pay for additional surgical procedures performed on that day at 50% of the listed fee.
  - (2) When an assistant surgeon, in addition to staff provided by the general hospital or chronic disease hospital, is required, the department shall pay the assistant surgeon 20% of the listed fee for the surgery.
  - (3) The department shall not pay for related evaluation and management encounters on the same day of surgery.
  - (4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care provided to clients in a general hospital or chronic disease hospital. The department shall pay for follow-up visits after a client is discharged from the general hospital or chronic disease hospital as office visits.
  - (5) The listed fees for surgery on the musculoskeletal system includes payment for the application of the first cast or traction device.

(j) **Anesthesia**

- (1) The listed fees for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and blood incident to the anesthesia or surgery.
- (2) The department shall pay the listed fees for anesthesia services only when the anesthesia is administered by or under the supervision of a provider who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia services.
- (3) The department shall not pay for local infiltration or digital block administered by the operating surgeon.

(k) **Radiology**

- (1) The listed fees for all diagnostic radiology procedures, including nuclear medicine, magnetic resonance imaging, computerized axial tomography and diagnostic ultrasound, include consultation and a written report to the referring provider.
- (2) The listed fees for all diagnostic radiology procedures shall apply only when the provider's own equipment is used. If a general hospital or chronic disease hospital or a related entity directly or indirectly owns the equipment used to perform the procedure, or if a hospital includes the operating expenses of the equipment in its cost reports, the department shall not pay the billing provider for the technical component of the listed fee.

(l) **Radiotherapy**

- (1) The provider fee for radiological treatment includes one year of follow-up care unless otherwise specified.
- (2) The provider fee for treatment includes the concomitant office visits, but does not include surgical, radiological or laboratory procedures performed on the same day.
- (3) The fees listed for therapeutic procedures involving the use of radium and radioisotopes do not include the radioactive drug used or preliminary and follow-up diagnostic tests. Radioactive drugs may be billed separately.
- (4) The fees listed for diagnostic procedures involving the use of radium and radioisotopes do not include the radioactive drugs used. Radioactive drugs may be billed separately.

(m) **Laboratory**

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

- (3) The department shall pay for panel or profile tests according to the listed fees for panel tests and not according to the fee for each separate test included in the panel or profile.
- (4) The department shall pay only for laboratory physicians' services that the provider is authorized to perform and are performed in the provider's office. The department shall not pay the referring provider for laboratory services performed in a laboratory or in any setting other than the provider's office.

(n) **Drugs**

- (1) The department shall pay up to the actual acquisition costs for oral medications incident to an office visit as billed by the provider.
- (2) The department shall pay for injectables, legend drugs and legend devices administered by the provider based on a fee schedule determined by the department.
- (3) The department shall not pay for drugs provided free of charge.

(o) **Newborn Care**

- (1) The provider fee for routine care of a normal newborn infant in the general hospital includes history and examination of the infant, initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby and conferences with the parents. The department pays per day for subsequent hospital care for evaluation and management of a normal newborn.
- (2) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care and the routine or subsequent newborn care for the same child.
- (3) The provider may bill for newborn resuscitation in addition to billing for routine care or critical care of a newborn.

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

- (1) The department shall pay providers for evaluation and management only when performed in a nursing facility, ICF/MR or chronic disease hospital.
- (2) The department shall pay for a maximum of one annual assessment per client per year.

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

If the department determines either prospectively or retrospectively pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies, that a general hospital admission was not medically necessary or did not fulfill the accepted professional criteria for appropriateness of setting or quality of care, the department shall not pay for the admitting provider's services in a general hospital.

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

- (1) The department shall pay the provider for sterilization only if the client is at least age 21 and has given informed consent in accordance with 42 CFR 441.257 and 42 CFR 441.258, as amended from time to time.
- (2) The department shall pay for hysterectomies and related laboratory and hospital services that are medically necessary only if the client is at least age 21 and the physician or physician's representative has obtained:
  - (A) A consent form that complies with 42 CFR 441.257 and 42 CFR 441.258, as amended from time to time, or
  - (B) a physician's certification that complies with 42 CFR 441.255(d), as amended from time to time.
- (3) The department shall pay the billing provider for all abortions that a physician certifies as medically necessary whether or not the woman's life would be endangered by carrying the fetus to term and whether or not the pregnancy is the result of rape or incest. For the purposes of abortion coverage and payment, a physician determines medical necessity.
- (4) The provider shall maintain all forms required by section 19a-116-1 of the Regulations of Connecticut State Agencies and section 19a-601 of the Connecticut General Statutes.

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

- (a) Providers shall maintain a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, treatment notes signed by the provider, documentation of services provided and the dates the services were provided.
- (b) The provider shall maintain all required documentation in its original form for at least five years or longer in accordance with statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.
- (c) The department may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.
- (d) The department may audit all relevant records and documentation and may take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.
- (e) If the provider bills for a service based on the time spent during the encounter, the provider shall document the length of the encounter.



## REQUIREMENTS FOR PAYMENT OF PSYCHIATRISTS' SERVICES

### Sec. 17b-262-452. Scope

Sections 17b-262-452 through 17b-262-463 inclusive set forth the Department of Social Services requirements for payment of: (a) medical and clinical services provided by licensed psychiatrists in private or group practice, and (b) clinical procedures performed by allied health professionals in the employ of the psychiatrist in private or group practice for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

### Sec. 17b-262-453. Definitions

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

- (1) "Acute" means having rapid onset, severe symptoms, and a short course.
- (2) "Acute Care" means medical care needed for an illness, episode, or injury which requires short-term, intense care, and hospitalization for a short period of time.
- (3) "Allied Health Professional (AHP)" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in mental health care and treatment and shall include, but is not limited to: psychologists, social workers, psychiatric nurses, and other qualified therapists.
- (4) "By or Under the Supervision" means the psychiatrist shall assume professional responsibility for the service performed by the allied health professional, overseeing or participating in the work of the allied health professional including, but not limited to:
  - (A) availability of the psychiatrist to the allied health professional in person and within five minutes;
  - (B) availability of the psychiatrist on a regularly scheduled basis to review the practice, charts, and records of the allied health professional and to support the allied health professional in the performance of services; and
  - (C) a predetermined plan for emergency situations, including the designation of an alternate psychiatrist in the absence of the regular psychiatrist.
- (5) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.
- (6) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.
- (7) "Consultation" means those services rendered by a psychiatrist whose opinion or advice is requested by another physician or an agency in the evaluation and treatment of a client's illness.

- (8) “Department” means the Department of Social Services or its agent.
- (9) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- (10) “Estimated Acquisition Cost (EAC)” means the department’s best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer.
- (11) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.
- (12) “HealthTrack Special Services” means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:
  - (A) services not covered under the State Plan or contained in a fee schedule published by the department; or
  - (B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.
- (13) “Home” means the client’s place of residence which includes a boarding home or home for the aged. Home does not include a hospital or long-term care facility; long-term care facility includes a nursing facility, chronic disease hospital, and intermediate care facility for the mentally retarded (ICF/MR).
- (14) “Interperiodic Encounter” means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician’s office visits, clinic visits, and other primary care visits.
- (15) “Legend Drug” means the definition contained in section 20-571 of the Connecticut General Statutes.
- (16) “Licensed Practitioner of the Healing Arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).
- (17) “Long-Term Care Facility” means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

- (A) nursing facilities,
  - (B) chronic disease hospitals—inpatient, and
  - (C) intermediate care facilities for the mentally retarded (ICFs/MR).
- (18) “Medical Appropriateness or Medically Appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.
- (19) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.
- (20) “Medical Necessity or Medically Necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.
- (21) “Medical Record” means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.
- (22) “Prior Authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.
- (23) “Provider” means a psychiatrist.
- (24) “Provider Agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.
- (25) “Psychiatric Services” means services provided to individuals, groups, and families, by or under the supervision of a licensed psychiatrist in private or group practice. In such a setting the psychiatrist retains the primary medical and clinical responsibility for work up of the initial evaluation, diagnosis, and prescription of the treatment plan, rehabilitation, and discharge of the client. Such services include the diagnosis of specific mental and social problems which disrupt an individual’s daily functioning and provide treatment to reduce the symptoms and signs associated with these disturbances.
- (26) “Psychiatrist” means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who specializes in the study, diagnosis, treatment, and prevention of mental and social disorders.
- (27) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

**Sec. 17b-262-454. Provider participation**

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

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

**Sec. 17b-262-455. Eligibility**

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

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

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

- (a) The department shall pay for:
  - (1) psychiatric evaluation;
  - (2) psychotherapy, including: individual, group, family, hypnosis, and electroshock;
  - (3) psychiatric consultation;
  - (4) drugs, as limited in subsection (b) of section 17b-262-456;
  - (5) all admitting and inpatient services performed by the admitting psychiatrist in an acute care hospital after the psychiatrist has received prior authorization for the admission pursuant to the department's utilization review program as delineated in section 17-134d-80 of the Regulations of Connecticut State Agencies; and
  - (5) HealthTrack Services and HealthTrack Special Services.
- (b) Limitations on covered services shall be as follows:

- (1) a psychiatric evaluation shall be limited to one evaluation in any twelve month period per client per provider;
- (2) only one unit of therapy of the same type shall be paid for on the same day;
- (3) group psychiatric sessions shall be limited in size to a maximum of eight persons per group session regardless of the payment source of each participant;
- (4) services covered shall be limited to those listed in the department's applicable fee schedule; and
- (5) hypnosis and electroshock therapy shall be personally provided by a psychiatrist.

(c) **Services Not Covered**

The department shall not pay for the following psychiatric services:

- (1) information or services furnished by the provider to the client over the telephone;
- (2) concurrent services for the same client involving the same services or procedure;
- (3) office visits to obtain a prescription, the need for which has already been ascertained;
- (4) procedures performed in the process of preparing an individual for transsexual surgery; and
- (5) cancelled office visits or appointments not kept.

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

The department shall pay for medically necessary and medically appropriate psychiatric services for Medical Assistance Program eligible clients which are provided by a licensed physician who specializes in the study, diagnosis, treatment, and prevention of mental and social diseases.

**Sec. 17b-262-458. Prior authorization**

- (a) Prior authorization, on forms and in a manner as specified by the department, is required for all clients, including clients originally referred by another state agency for:
  - (1) treatment services in excess of thirteen visits in a calendar quarter;
  - (2) treatment services to hospitalized clients from the date of admission; and
  - (3) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:
    - (i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her

- respective scope of practice as defined under state law, justifying the need for the item or service requested;
- (ii) a description of the outcomes of any alternative measures tried; and
  - (iii) if applicable and requested by the department, any other documentation required in order to render a decision.
- (b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization. The form shall include the progress made to date and the future gains expected through additional treatment.
  - (c) Initial authorization for outpatient services shall be up to six months.
  - (d) Initial authorization for hospital inpatient services shall be authorized for up to forty-two days from the date of initial admission for a specific episode of illness.
  - (e) Requests for continued treatment beyond the initial authorized period shall be submitted prior to the onset of services for which authorization is requested. The form shall include the progress made to date and the future gains expected through additional treatment.
  - (f) Outpatient services beyond the initial authorized period shall be extended up to six months.
  - (g) One extension of hospital inpatient services for the same episode of illness shall be allowed up to an additional twenty one days unless the client requires hospitalization for a concurrent medical problem.
  - (h) Clients who require hospitalization for a concurrent medical problem shall receive hospital inpatient psychiatric services until hospital inpatient treatment for the concurrent medical problem is no longer necessary.
  - (i) The authorization request form shall include the name of the physician, person, or agency making the referral.
  - (j) In emergency or urgent situations involving services which require prior authorization, the provider of the service may request verbal approval by the department during normal working hours, or no later than the next business day if the emergency or urgent situation occurs outside of the department's normal working hours, when such authorization may be given. However, approval in such a manner shall be limited to psychiatric services that are immediately necessary and vital to the health and safety of the client.
  - (k) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

**Sec. 17b-262-459. Billing procedures**

- (a) Claims from psychiatrists shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.
- (b) The amount billed to the department shall represent the psychiatrist's usual and customary charge for the services delivered.
- (c) When a Medical Assistance Program client is referred to a psychiatrist for consultation, the consultant psychiatrist shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant psychiatrist shall enter the entire name as well as the state license number of the referring physician on the billing form.
- (d) Psychiatric consultations in the hospital, home, or long-term care facility shall be billed as a comprehensive consultation.
- (e) All charges billed for supplies and materials provided by a psychiatrist, except glasses, shall be reviewed by the department.

**Sec. 17b-262-460. Payment**

- (a) Payment shall be made at the lowest of:
  - (1) the provider's usual and customary charge to the general public;
  - (2) the lowest Medicare rate;
  - (3) the amount in the applicable fee schedule as published by the department;
  - (4) the amount billed by the provider; or
  - (5) the lowest price charged or accepted for the same of substantially similar goods or services by the provider from any person or entity.
- (b) A psychiatrist who is fully or partially salaried by a general hospital, public or private institution, physicians' group, or clinic shall not receive payment from the department unless the psychiatrist maintains an office for private practice at a location separate from the hospital, institution, physicians' group, or clinic in which the psychiatrist is employed. Psychiatrists who are solely hospital, institution, physicians' group, or clinic-based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.
- (c) A psychiatrist who maintains an office for private practice separate from the hospital, institution, physicians' group, or clinic shall be able to bill for services provided at the private practice location or for services provided to the psychiatrist's private practice clients in the hospital, institution, physicians' group, or clinic only if the client is not a patient of the hospital, institution, physicians' group, or clinic.

**Sec. 17b-262-461. Payment rate**

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

**Sec. 17b-262-462. Payment limitations**

- (a) Psychiatrists' services shall be performed at the psychiatrist's private or group practice location, hospital, long-term care facility, clinic, or the client's home.
- (b) The psychiatrist who employs allied health professionals shall personally conduct the evaluation and, accordingly, develop the treatment plan in all cases.
- (c) In situations where the psychiatrist employs allied health professionals on a salary or fee-for-service basis, the psychiatrist shall be paid at the psychiatrists' rate only under the following conditions:
  - (1) for clients personally being treated by the psychiatrist; and
  - (2) when the psychiatrist personally interviews the client as part of the psychiatrist's supervisory responsibilities, but only at that rate which corresponds to the time or service he or she actually provides to the client.
- (d) Services provided by allied health professionals shall be billed at the rate for allied health professionals established by the department and not at the scheduled rate for psychiatrists.
- (e) Fees for psychiatric evaluations include an allowance for the preparation of a full written report.
- (f) When a psychiatrist renders consultation services and thereafter assumes the continuing care of the client, any subsequent services rendered by the psychiatrist or the psychiatrist's staff shall no longer be considered as a consultation and shall be billed at the rate applicable for the ongoing service.
- (g) The fee for any procedure, as stipulated in the fee schedule for psychiatric services published by the department, represents the maximum amount payable per day regardless of the time it takes to complete the procedure.
- (h) Payment for hospital inpatient services shall be limited to admissions to acute care hospitals.
- (i) Payment for services provided by the admitting psychiatrist in an acute care hospital shall not be made, or shall be recouped, if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting, or quality of care.
- (j) The department shall pay psychiatrists for drugs which are administered or dispensed directly to a client under the following conditions:



- (1) excluding oral medications, payment shall be made to a psychiatrist for the estimated acquisition cost as determined by the department for drugs which are administered directly to the client; and
- (2) for legend drugs which must be administered by a psychiatrist, the department shall reimburse the psychiatrist for the estimated acquisition cost as determined by the department for the amount of the drug which is administered.

**Sec. 17b-262-463. Documentation**

- (a) Psychiatrists shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the psychiatrist, documentation of services provided, and the dates the services were provided.
- (b) All required documentation shall be maintained for at least five years in the psychiatrist's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.
- (c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the psychiatrist for which the required documentation is not maintained or provided to the department upon request.