



Connecticut interChange MMIS

Provider Manual

Chapter 7 - Hospital Inpatient:

October 1, 2020

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

**Gainwell Technologies
55 Hartland Street
East Hartford, CT 06108**



IMPORTANT: Read instructions on back of last page (Certification Page) before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations

State of Connecticut REGULATION of

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Requirements Concerning Inpatient Hospital Services¹

Section 1. The Regulations of the Connecticut State Agencies are amended by adding sections 17b-262-900 to 17b-262-911, inclusive, as follows:

(NEW) Sec. 17b-262-900. Scope

Sections 17b-262-900 to 17b-262-911, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to general hospitals for providing inpatient hospital services to members who are determined eligible for Medicaid.

(NEW) Sec. 17b-262-901. Definitions

As used in sections 17b-262-900 to 17b-262-911, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Acute Care” means medical care needed for an illness, episode or injury that requires admission to a hospital for a short period of time;
- (2) “Admission” means the formal acceptance by a hospital of an individual who is to receive inpatient hospital services while lodged in an area of the hospital reserved for continuous nursing services. Admission does not include the relocation of an individual to another unit within the same hospital;
- (3) “Advanced practice registered nurse” or “APRN” means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes;
- (4) “APR-DRG grouper” or “All Patient Refined DRG grouper” means the grouper selected by the department to assign a DRG to a claim for an inpatient discharge;
- (5) “APC” or “Ambulatory Payment Classification” means the classification of clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources;

¹ **NOTE: Proposed Regulation / Operational Policy – Updated as of November 25, 2014** –This proposed regulation / operational policy is being posted to the Secretary of State and DSS websites. Pursuant to sections 17b-239 and 17b-10 of Connecticut General Statutes, as amended, effective January 1, 2015, DSS plans to implement these draft regulations as a binding operational policy / policies and procedures pending final adoption of the regulations.

- (6) “Billing provider” means the individual or entity enrolled in Medicaid that bills the department for services provided to a member;
- (7) “Border hospital” means an out-of-state hospital that routinely provides services to individuals residing in Connecticut and is deemed a border hospital provider by the department on a case-by-case basis;
- (8) “Chronic disease hospital” has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;
- (9) “Concurrent review” means review conducted during the time period when a provider is delivering inpatient hospital services to a member, which may focus on care coordination, discharge planning or continued stay review to evaluate the medical necessity and quality of services being rendered;
- (10) “Dentist” means an individual licensed pursuant to sections 20-106 to 20-110, inclusive, of the Connecticut General Statutes, as applicable to such individual;
- (11) “Department” means the Department of Social Services or its agent;
- (12) “Diagnosis Related Group” or “DRG” means the clinically similar grouping of inpatient hospital services that can be expected to consume similar amounts of hospital resources assigned by grouping software and includes the diagnosis related group, severity of illness assignment and risk of mortality subclass;
- (13) “Direct medical education costs” means costs calculated as the Medicaid inpatient percentage (which, in turn, is calculated using total Medicaid inpatient days excluding nursery days and behavioral health days for children under age nineteen divided by total inpatient days excluding nursery) of full-time equivalent residents multiplied by the Medicare allowed per resident amount;
- (14) “DRG base payment” means the hospital base payment rate multiplied by the DRG relative weight;
- (15) “DRG discharge payment” means a payment comprised of the DRG base payment plus any applicable outlier payment;
- (16) “DRG relative weight” means the factor that is assigned to each DRG that represents the national average resources required for a DRG classification paid under the DRG reimbursement methodology, relative to the national average resources required for all DRG discharges paid under the DRG reimbursement methodology for the same time period;
- (17) “Discharge” means any patient who was (A) discharged from the hospital after the date of admission or (B) admitted and released on the same day where such patient died, left the hospital against medical advice or where a one-day stay has been deemed appropriate subject to utilization review;
- (18) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the member’s

health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part;

- (19) “Early and Periodic Screening, Diagnostic, and Treatment special services” or “EPSDT special services” means the services provided in accordance with section 1905(r)(5) of the Social Security Act;
- (20) “Federal fiscal year” means the twelve month period established as the fiscal year for the United States government pursuant to 31 USC 1102, which, as of 2014, runs from October 1 to September 30, inclusive, each year;
- (21) “Free-standing birth center” means a “birth center” as defined in section 17b-262-957 of the Regulations of Connecticut State Agencies and that complies with section 17b-262-958 of the Regulations of Connecticut State Agencies;
- (22) “Hospital” or “general hospital” means a “general hospital” or a “children’s general hospital,” as applicable, each as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies or any other institution that provides inpatient hospital services and is separately licensed as a hospital by the Department of Public Health but does not include a specialty hospital;
- (23) “Hospital base payment rate” means a base rate determined by the department for a hospital that is used as part of calculating the DRG base payment and is calculated in accordance with section 17b-239 of the Connecticut General Statutes and may include adjustments based on factors identified by the department, including, but not limited to, capital payments and direct medical education costs;
- (24) “Hospital-specific” means pertaining to an individual hospital;
- (25) “Grouper” means the program that assigns a DRG to a claim for an inpatient discharge;
- (26) “Hysterectomy” has the same meaning as provided in 42 CFR 441.251;
- (27) “Informed consent” has the same meaning as provided in 42 CFR 441.257;
- (28) “Inpatient” means a patient who has been admitted to a hospital for the purpose of receiving medically necessary inpatient hospital services;
- (29) “Inpatient hospital services” means services provided by a hospital to an inpatient that comply with all applicable requirements, including 42 CFR 440.10 and sections 17b-262-900 to 17b-262-911, inclusive, of the Regulations of Connecticut State Agencies;
- (30) “Licensed practitioner” means a physician, physician assistant, APRN, dentist, nurse-midwife, podiatrist or any other type of practitioner licensed by the Department of Public Health and who the department permits to bill separately for services performed in an inpatient hospital setting;
- (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) “Medicaid State Plan” means the plan describing Medicaid eligibility, coverage, benefits and reimbursement that is established by the department and reviewed by the U.S. Centers for Medicare and Medicaid Services pursuant to 42 CFR 430, Subpart B;
- (33) “Medical necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (34) “Medical record” has the same meaning as provided in section 19-13-D3(d) of the Regulations of Connecticut State Agencies;
- (35) “Member” means an individual eligible for goods or services under Medicaid;
- (36) “Nurse-midwife” means an individual licensed pursuant to section 20-86c of the Connecticut General Statutes;
- (37) “Out-of-state hospital” means a hospital that is licensed, certified or accredited in its home state; has a business address outside of Connecticut; and is not a border hospital;
- (38) “Outlier payment” means the payment that is made when the outlier threshold is exceeded;
- (39) “Outlier threshold” means the level of estimated cost for a claim that when exceeded for an inpatient stay triggers an outlier payment in addition to the DRG base payment;
- (40) “Performing provider” means an individual enrolled in Medicaid who actually provides a service to a member;
- (41) “Physician” means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes;
- (42) “Physician assistant” means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes;
- (43) “Podiatrist” means an individual licensed pursuant to sections 20-54 or 20-57 of the Connecticut General Statutes;
- (44) “Prior authorization” means the department’s approval for a provider to render a service or deliver goods before the provider actually renders the service or delivers the goods, which is also known as prospective review;
- (45) “Provider” means a general hospital, border hospital or out-of-state hospital enrolled in Medicaid;
- (46) “Provider agreement” means the signed written contractual agreement between the department and the provider of medical services or goods;
- (47) “Provider preventable condition” has the same meaning as provided in 42 CFR 447.26, as amended from time to time;
- (48) “Psychiatric hospital” has the same meaning as provided in section 17b-262-500 of the Regulations of Connecticut State Agencies;

- (49) “Rate year” means the twelve month period beginning on October 1st of each year;
- (50) “Retrospective review” means review to determine the medical necessity and quality of inpatient hospital services after such services have been rendered;
- (51) “Specialty hospital” means a psychiatric hospital, chronic disease hospital or freestanding birth center that is not a general hospital;
- (52) “Sterilization” has the same meaning as provided in 42 CFR 441.251;
- (53) “Transfer” means that an individual is discharged from the hospital and is directly admitted to another hospital;
- (54) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary” shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and
- (55) “Utilization review” means the evaluation of the medical necessity, quality, and timeliness of the use of medical services, procedures and facilities. Utilization review may be conducted on a prospective, concurrent or retrospective basis and includes, but is not limited to, prior authorization, concurrent review and retrospective review.

(NEW) Sec. 17b-262-902. Provider Participation

- (a) To enroll in Medicaid and receive payment from the department, all hospitals seeking reimbursement for inpatient hospital services shall:
 - (1) Comply with sections 17b-262-522 to 17b-262-533, inclusive, and 17b-262-900 to 17b-262-911, inclusive, of the Regulations of Connecticut State Agencies;
 - (2) Be licensed by the Department of Public Health pursuant to section 19-13-D3 or 19-13-D4a of the Regulations of Connecticut State Agencies, as applicable, or any other applicable hospital licensure category that is not a specialty hospital, or for a hospital located outside Connecticut, be licensed as a hospital in the state where such hospital is located;
 - (3) Sign and maintain a valid provider agreement with the department; and
 - (4) Comply with all applicable federal requirements, including the conditions of participation pursuant to 42 CFR Part 482, as amended from time to time.
- (b) In addition to complying with subsection (a) of this section, each border hospital and each out-of-state hospital shall provide the department with a copy of a current and effective license or certification as a hospital issued by the appropriate official state governing body in the state where the hospital is located.

- (c) The department shall determine on a case-by-case basis if an out-of-state hospital qualifies for enrollment as a border hospital.
- (d) The department may require specified units of a hospital, such as the psychiatric and rehabilitation units of a hospital, to enroll as separate Medicaid providers in order to ensure accurate reimbursement, data collection, quality management and other related purposes.

(NEW) Sec. 17b-262-903. Eligibility

Payment for inpatient hospital services is available for members subject to sections 17b-262-900 to 17b-262-911, inclusive, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-904. Services Covered and Limitations

- (a) The department shall pay providers for:
 - (1) Only services that are medically necessary;
 - (2) An inpatient stay related to surgical services medically necessary to treat morbid obesity only when another medical illness is caused by, or is aggravated by, the obesity, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system;
 - (3) EPSDT special services; and
 - (4) In connection with a medically necessary organ transplant surgery, the following services provided to an organ donor: harvesting; diagnostic testing; medications; transportation services; and any service related to the actual procedure.
- (b) The department shall pay for sterilization only if the member is age twenty-one or older and gave informed consent pursuant to 42 CFR 441.250 to 42 CFR 441.259, inclusive, as amended from time to time.
- (c) The department shall pay for hysterectomies and related laboratory and hospital services that are medically necessary only if the provider has obtained:
 - (1) A consent form in accordance with 42 CFR 441.251 to 441.259, inclusive, as amended from time to time; or
 - (2) A physician's certification in accordance with 42 CFR 441.255(d), as amended from time to time.
- (d) Abortions.
 - (1) The department shall pay 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.

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

(NEW) Sec. 17b-262-905. Services Not Covered

- (a) The department shall not pay for the following:
 - (1) Services provided in a general hospital if the department determines the admission does not, or retrospectively did not, comply with the utilization review requirements as set forth in section 17b-262-907 of the Regulations of Connecticut State Agencies;
 - (2) Services to treat obesity other than those described in section 17b-262-904(a)(2) of the Regulations of Connecticut State Agencies;
 - (3) Infertility treatment or reversal of sterilization procedure;
 - (4) Sterilizations performed on mentally incompetent individuals or institutionalized individuals;
 - (5) A hysterectomy performed during a period of retroactive eligibility as described in 42 CFR 441.255(e);
 - (6) Any services that are unproven or experimental or any services that are solely for a social, research or cosmetic purpose;
 - (7) Services that are not medically necessary or that are not directly related to the member's diagnosis, symptoms or medical history;
 - (8) Provider preventable conditions; and
 - (9) Inpatient services that can be performed in an outpatient setting, such as fetal monitoring or false labor.
- (b) If the general hospital stay combines Medicaid covered and non-covered services, the department shall pay for covered services only.

(NEW) Sec. 17b-262-906. Out-of-State Hospitals

The department reimburses out-of-state hospitals for inpatient hospital services pursuant to 42 CFR 431.52 and section 17b-262-532 of the Regulations of Connecticut State Agencies using the reimbursement methodology set forth in sections 17b-262-908 or 17b-262-910, as applicable, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-907. Utilization Review

- (a) The department conducts utilization review for inpatient hospital services in order to:
 - (1) Determine if requested services are medically necessary;

- (2) Assure that the quality of service meets accepted and established standards;
 - (3) Monitor trends and patterns of utilization; and
 - (4) Facilitate discharge and transition planning, including, but not limited to, the coordination of post discharge care and services.
- (b) Prior authorization
- (1) Unless the department notifies providers in writing that a specified service does not require prior authorization and except for emergency admissions, as set forth in subsection (d) of this section, each provider shall receive prior authorization, in a form and manner specified by the department before rendering services for:
 - (A) All admissions;
 - (B) Relocations within the same hospital to or from a unit of the hospital if the hospital seeks to be reimbursed pursuant to the methodology described in subsection (b) of section 17b-262-910 of the Regulations of Connecticut State Agencies; and
 - (C) EPSDT special services.
 - (2) In order to receive payment from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met.
- (c) Retrospective Review for Member's Retroactive Eligibility. For a member who is not eligible on the date of admission to the hospital and subsequently becomes retroactively eligible to any date included as part of such admission, the provider shall request authorization not later than thirty calendar days after eligibility is granted.
- (d) Authorization Requirements for Emergency Admissions. Except as otherwise provided in this subsection, providers shall request authorization for emergency admissions not more than two business days after the date of admission.
- (1) Providers may request a limited number of retrospective reviews of emergency admissions more than two business days, but not more than thirty calendar days, after the date of admission. For each federal fiscal year, such requests may not exceed one percent of the hospital's total Medicaid discharges for the most recent federal fiscal year for which figures are available.
 - (2) Retrospective review pursuant to subdivision (1) of this subsection is permitted only for emergency admissions and only when all requirements for payment are met except for the failure to request authorization not more than two business days after the date of admission.

- (3) **Special Retrospective Reviews.** The hospital may request that the department waive the thirty calendar day time limit for retrospective review pursuant to subdivision (1) of this subsection only if the hospital:
 - (A) Proves to the satisfaction of the department that the failure to make the request within the thirty calendar day time limit was caused by reasons beyond the hospital's control, such as if the hospital neither knew nor had any reason to check a member's eligibility within the thirty calendar day time period or received erroneous information from the department's eligibility verification system. The total number of such exceptions for a hospital per federal fiscal year shall not exceed the greater of: (i) One discharge or (ii) 0.125% (0.00125) of such hospital's total Medicaid discharges for the most recent federal fiscal year for which figures are available; and
 - (B) Pays the department's standard fee for a retrospective review requested pursuant to this subdivision.
- (4) The department shall notify each hospital of the maximum number of retrospective reviews that are available during a federal fiscal year.
- (e) **General Retrospective Reviews.** The department may review a random or targeted sample of inpatient hospital services after such services are performed. Such review may focus on such factors as the medical necessity, quality and timeliness of the services provided and the patterns of utilization, including, but not limited to, readmissions. The department may adjust payments to the provider based on the outcome of such review.
- (f) The department may perform concurrent reviews as it deems appropriate. Such concurrent review may evaluate the medical necessity, timeliness and quality of services provided.

(NEW) Sec. 17b-262-908. Services Reimbursed Outside DRGs

- (a) The department reimburses for the following services separately from the DRG discharge payment:
 - (1) Professional services performed by licensed practitioners, as specified in subsection (b) of this section;
 - (2) Certain organ acquisition costs for transplants, as determined by the department;
 - (3) Direct medical education costs and similar costs;
 - (4) Supplemental payments, including disproportionate share hospital (DSH) payments and upper payment limit (UPL) payments; and
 - (5) Discharges excluded from the DRG reimbursement methodology pursuant to subsection (b) of section 17b-262-910 of the Regulations of Connecticut State Agencies.
- (b) **Licensed Practitioner Services.**

- (1) Professional services performed by a licensed practitioner shall be billed and reimbursed separately from the hospital's facility or technical services. The rates, regulations, procedures and policies applicable to the licensed practitioner's provider type apply to all services performed by the licensed practitioner in the inpatient hospital setting.
- (2) The department shall not pay licensed practitioners for services provided to a member during an inpatient stay if the stay was not medically necessary or if the hospital failed to comply with applicable utilization review requirements set forth in section 17b-262-907 of the Regulations of Connecticut State Agencies.
- (3) The hospital shall ensure that all licensed practitioners who perform professional services in any inpatient hospital setting of such hospital are enrolled in Medicaid in a manner specified by the department.
- (4) The hospital shall ensure that each licensed practitioner performing professional services in any inpatient hospital setting of such hospital does not charge any member in connection with such services, except for Medicaid cost-sharing approved by the department. The department may take such action as necessary to enforce this subdivision, including, but not limited to recouping some or all reimbursement from the hospital for facility charges related to professional charges for which a licensed practitioner bills directly to a member in violation of this subdivision, such as facility charges for services provided to the same member at the same hospital on the same date of service as the professional charges.

(NEW) Sec. 17b-262-909. Billing and Payment Procedures and Limitations

- (a) In a manner specified by the department, the provider shall submit claims on the department's uniform billing form or electronically transmit the claims and shall include all information required by the department to process the claim for payment.
- (b) The provider shall bill its usual and customary fee or as otherwise instructed in writing by the department.
- (c) Services Included in Reimbursement for Inpatient Hospital Services.
 - (1) Effective for dates of service from January 1, 2015 until the date that the department implements the APC methodology for outpatient hospital services pursuant to section 17b-239 of the Connecticut General Statutes, reimbursement for inpatient hospital services includes payment for:
 - (A) Emergency department services provided on the same date as an admission to the same hospital. The department shall not separately reimburse for such emergency department services.
 - (B) Observation services that result in an admission to the same hospital. The department shall not separately reimburse for such observation services.
 - (2) Effective for dates of service beginning on the date the department implements the APC methodology for outpatient hospital services pursuant to section 17b-239 of the

Connecticut General Statutes, except for categories of service specifically excluded in writing by the department, reimbursement for inpatient hospital services includes payment for all outpatient hospital services provided during the two days prior to the date of admission and all outpatient hospital services provided on the date of admission, which shall not be separately reimbursed by the department.

(NEW) Sec. 17b-262-910. Payment Rate and Limitations for Hospitals Reimbursed Using Diagnosis Related Groups (DRGs)

- (a) Applicability of DRG Reimbursement Methodology. Except as provided in subsection (b) of this section and section 17b-282-908 of the Regulations of Connecticut State Agencies, the department shall reimburse discharges from hospitals pursuant to the DRG reimbursement methodology described in this section.
- (b) The DRG reimbursement methodology described in this section applies to any discharge unless the hospital submits a prior authorization request specifically identifying the services as eligible to receive a per diem rate or other reimbursement methodology, such as psychiatric or rehabilitation services. If the department approves such prior authorization request, the discharge is reimbursed using the applicable per diem or other rate methodology established by the department.
- (c) Payment for general hospital services shall comply with applicable federal requirements, including 42 CFR 447, Subparts A to D, inclusive, as amended from time to time.
- (d) Effective for admissions on or after January 1, 2015, the department shall pay for inpatient hospital services on a fully prospective per discharge basis using DRG-based discharge payments, which shall be determined in accordance with the following methodology:
 - (1) The department assigns DRGs using the APR-DRG grouper.
 - (2) Each DRG discharge payment is comprised of the DRG base payment plus any outlier payment that may be made when the charges for the stay exceed the outlier threshold.
 - (3) Each DRG base payment is calculated by multiplying the hospital base payment rate by the DRG relative weight.
 - (4) DRG relative weights are taken from the same version of the APR-DRG grouper used to assign DRGs.
 - (5) The hospital base payment rate is calculated in accordance with section 17b-239 of the Connecticut General Statutes.
- (e) DRG Base Rate Adjustment for Hospital Mergers. When two or more hospitals merge to form a different legal entity, the department totals the data used to calculate the base rates of the original entities and uses such data as the basis for determining a rate for the new entity. The department uses the same methodology when one hospital purchases another hospital.
- (f) Updating Methodology. The department shall update the version of the grouper used not less than every three years, as determined by the department. The department shall recalculate the

hospital base payment rates and DRG relative weights not less than every four years, as determined by the department.

- (g) **Transfer Payment Methodology.** When a member is transferred from a hospital unit reimbursed using the DRG reimbursement methodology described in this section to another hospital, then:
 - (1) The hospital from which the member is transferred shall be reimbursed the lesser of the DRG base payment or the transfer DRG base payment, as determined by the department. The transfer DRG base payment equals the initial DRG base payment divided by the DRG average length of stay; the resulting amount is multiplied by the sum of one plus the actual length of stay, as determined by the department and not to exceed the DRG base payment.
 - (2) The hospital to which the member is transferred shall be reimbursed in accordance with the full applicable standard payment methodology, without any reduction due to the transfer.
- (h) Any applicable third party payments to a hospital on behalf of a member receiving inpatient hospital services shall offset allowed payments from the department to the hospital.
- (i) Except as otherwise provided in subsection (b) of this section or section 17b-262-908 of the Regulations of Connecticut State Agencies, the department shall pay out-of-state and border hospitals the statewide average DRG base payment for the discharge plus any applicable outlier payment.
- (j) For the period from January 1, 2015 to December 31, 2015, inclusive, all in-state rates and payments established pursuant to this section will be hospital-specific. On or after January 1, 2016, the department shall begin implementing statewide or peer-based hospital specific base rates and shall complete such implementation as soon as possible.

(NEW) Sec. 17b-262-911. Documentation and Record Retention

- (a) Providers shall maintain a specific record for all services received for each individual eligible for Medicaid payment, including, but not limited to: name; address; birth date; Medicaid identification number; pertinent diagnostic information; sterilization consent forms; documentation of services provided; the dates the services were provided; and, when required, a current treatment plan and treatment notes signed by the provider.
- (b) Providers shall preserve all required documentation in its original written or electronic form for a period of time not less than five years or the length of time required by statute or regulation, whichever is greater. Such documentation is subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is greater.
- (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 take any other appropriate quality assurance measures it deems necessary to assure compliance with applicable regulatory and statutory requirements.
- (e) Upon request, the provider shall make the original medical record or copies of the record available to the department during regular business hours.
- (f) Each hospital shall maintain financial and statistical records of the period covered by cost reports that the hospital has submitted to the department for a period of not less than ten years following the date of submittal of the cost report to the department. These records shall be accurate and shall contain sufficient detail to substantiate the cost data reported. Upon request, the provider shall make such records or copies thereof available to the department.

Section 2. Subsection (c) of section 17b-262-348 of the Regulations of Connecticut State Agencies is amended to read as follows:

- (c) The department [shall pay non-hospital-based] pays providers for [evaluation and management] physicians' services provided [to the provider's private practice clients in the emergency room] in a hospital only if the department excludes the professional component of services from applicable payments to the hospital and the provider ensures that no duplicate billing occurs.

Section 3. Subsections (g) to (i), inclusive, of section 17b-262-524 of the Regulations of Connecticut State Agencies are amended to read as follows:

- (g) [Notwithstanding any provisions of the Regulations of Connecticut State Agencies or any medical services policy, any] Any provider who is [(I)] compensated directly or indirectly by an institution or general hospital [or (2) located within an institution or general hospital, which includes being located in an institution or general hospital complex, campus or auxiliary or satellite location,] may bill the department for services rendered to [the provider's medical assistance program private practice] clients who receive services at the institution or general hospital [location if all of the following criteria are met:] only if: (1) the department excludes the professional component of services from applicable payments to the hospital, (2) the provider complies with all regulations, policies and procedures applicable to the provider's enrolled type and specialty and (3) the provider ensures that no duplicate billing occurs. Upon request, the provider shall demonstrate to the department that no duplicate billing has occurred or has any reasonable potential of occurring, including providing any information or documentation necessary for the department to confirm that no duplicate billing has occurred or has a potential of occurring.
 - [(1) The provider maintains a practice at a location other than the location which is within the institution or general hospital complex, campus or auxiliary or satellite location;
 - (2) the provider is enrolled as a medical assistance program provider at the location that is separate from the institution or general hospital location and actively bills, as determined by the department, the Medical Assistance Program for services rendered at that separate location;

- (3) the operations of the provider are entirely separate and independent from the institution or general hospital. The department considers the operations of a provider as entirely separate and independent if the following criteria are met:
 - (A) the provider does not utilize space that is directly or indirectly owned by the institution or general hospital unless the space is rented at fair market value;
 - (B) the provider and provider staff do not receive compensation in any form from the institution or general hospital for any reason for clinical services at the institution or general hospital;
 - (C) the provider and the institution or general hospital do not share administrative and support staff; and
 - (D) the provider and the institution or general hospital have no direct or indirect relationship relative to ownership or control;
- (4) any direct and indirect costs associated with the services performed by the provider or provider staff are not included in the annual cost report of the institution or general hospital; and
- (5) the provider has performed an evaluation and management service for the client at its separate location within the previous year.]
- [(h) Notwithstanding the criteria identified in subdivision (3) of subsection (g) of this section, the provider may bill if the provider can demonstrate to the satisfaction of the department that the arrangements between the provider and the institution or general hospital do not result in duplication of payments. Evidence of lack of duplication of payments may include, but is not limited to, a copy of the provider-facility contract.]
- [(i)] (h) [Notwithstanding the requirements of subsections (g) and (h) of this section, a] A medical foundation established pursuant to sections 33-182aa to 33-182ff, inclusive, of the Connecticut General Statutes, as amended by Public Act 14-168, may bill the department for goods or services provided to Medical Assistance Program clients only after obtaining the department's approval. In order to obtain such approval, and as requested by the department from time to time, the medical foundation shall demonstrate, to the department's satisfaction, that mechanisms are in place to ensure that there will be no duplicate billing to or payment by the department relating to the provision of such goods or services. Not later than three months after the medical foundation begins billing the department, and as requested by the department from time to time, the medical foundation shall demonstrate to the department that no such duplicate billing in fact occurs. Duplicate billing includes, but is not limited to, claims for costs associated with related party transactions among the medical foundation, the hospital and any other related party, as defined in subsection (o) of section 17b-262-531 of the Regulations of Connecticut State Agencies.

Section 4. Subsections (c) and (d) of section 17b-262-584 of the Regulations of Connecticut State Agencies are amended to read as follows:

- (c) [Nurse-midwives] Nurse-midwives who are fully or partially salaried by a [general hospital,] public or private institution, group practice[,], or clinic shall not receive separate payment from the department unless the nurse-midwife maintains an office for private practice at a separate location from the [hospital,] institution, group[,], or clinic in which the [nursemidwife] nurse-midwife is employed. [Nurse-midwives] Nurse-midwives who are solely [hospital,] institution, group[,], or clinic based, either on a full-time or part-time salary, are not entitled to separate payment from the department for services rendered to Medical Assistance Program clients. Nurse-midwives fully or partially salaried by a general hospital may receive separate payment from the department only if the department separately reimburses nurse-midwives for such services and the nurse-midwife ensures that no duplicate billing occurs.
- (d) A nurse-midwife who maintains an office for private practice separate from the [hospital,] institution, group[,], or clinic, [shall be able to] may bill separately for services provided at the private practice location or for services provided to the nurse-midwife's private clients in the [hospital,] institution, group[,], or clinic [only if the client is not a client of the hospital, institution, group, or clinic]. Nurse-midwives may bill separately for services provided to clients in a hospital only if the department separately reimburses nurse-midwives for such services and the nurse-midwife ensures that no duplicate billing occurs.

Section 5. Subdivisions (2) and (3) of subsection (b) of section 17b-262-611 of the Regulations of Connecticut State Agencies are amended to read as follows:

- (2) A nurse practitioner who is fully or partially salaried by a [general hospital,] public or private institution, group practice[,], or clinic shall not receive separate payment from the department unless the nurse practitioner maintains an office for private practice at a separate location from the [hospital,] institution, group, or clinic in which the nurse practitioner is employed. Nurse practitioners who are solely [hospital,] institution, group[,], or clinic based, either on a full- or part-time salary are not entitled to separate payment from the department for services rendered to Medical Assistance Program clients. A nurse practitioner fully or partially salaried by a general hospital may receive separate payment from the department only if the department separately reimburses nurse practitioners for such services and the nurse practitioner ensures that no duplicate billing occurs.
- (3) Nurse practitioners who maintain an office for private practice separate from the [hospital,] institution, group[,], or clinic, [shall be able to] may bill separately for services provided at the private practice location or for services provided to the nurse practitioner's private practice clients in the [hospital,] institution, group, or clinic. Nurse practitioners may bill separately for services provided to clients in a hospital only if the department separately reimburses nurse practitioners for such services and the nurse practitioner ensures that no duplicate billing occurs.

Section 6. Section 17b-262-612 of the Regulations of Connecticut State Agencies is amended to read as follows:

The department shall not pay for the following:

- (a) [any procedures or] Any services [of an] that are unproven[, educational, social, research,] or experimental[,] or any services that are solely for a social, research or cosmetic [nature] purpose; for any diagnostic, therapeutic[,] or treatment procedures in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms[,] or medical history;
- (b) [any] Any examinations, laboratory tests, biological products, immunizations[,] or other products which are furnished free of charge;
- (c) [information] Information or services provided to a client by a provider over the telephone;
- (d) [an] An office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;
- (e) [cancelled] Cancelled office visits and appointments not kept;
- (f) [cosmetic] Cosmetic surgery;
- (g) [services] Services provided in an acute care hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section [17-134d-80] 17b-262-907 of the Regulations of Connecticut State Agencies;
- (h) [services] Services provided by the admitting provider in an acute care hospital shall not be made or may be recouped if it is determined by the department's utilization review, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, [medical appropriateness,] appropriateness of setting[,] or quality of care;
- (i) [a] A laboratory charge for laboratory services performed by a laboratory outside of the nurse practitioner's office.~~[-the]~~ The laboratory shall bill the department for services rendered when a nurse practitioner refers a client to a private laboratory; and
- (j) [the] The following routine laboratory tests which shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy[,]; hemoglobin determination[,]; and urine glucose[; and].
- [(k)] transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone treatment and electrolysis.]

Section 7. Subsection (a) of section 17b-262-614 of the Regulations of Connecticut State Agencies is amended to read as follows:

- (a) Prior authorization, on forms and in a manner as specified by the department, is required for the following services:
 - (1) [more] More than one visit on the same day for the same client by the same provider. Authorization for additional visits need not be submitted in advance of the service, but

providers shall submit the authorization request prior to billing for the second or subsequent visits;

- (2) [admissions] Admissions to acute care hospitals pursuant to section [17-134d-80] 17b-262-907 of the Regulations of Connecticut State Agencies;
- (3) [electrolysis] Electrolysis epilation;
- (4) [physical] Physical therapy services in excess of two treatments per calendar week per client per provider;
- (5) [physical] Physical therapy services in excess of nine treatments per calendar year per client per provider, involving the following primary diagnoses:
 - (A) [all] All mental disorders including diagnoses related to [mental retardation] developmental disabilities [and specific delays in development] covered by the International Classification of Diseases [(ICD), as amended from time to time];
 - (B) [cases] Cases involving musculoskeletal system disorders covered by [ICD, as amended from time to time] the International Classification of Diseases; and
 - (C) [cases] Cases involving symptoms related to nutrition, metabolism[, and development covered by [ICD, as amended from time to time] the International Classification of Diseases;
- (6) [reconstructive] Reconstructive surgery, including breast reconstruction following mastectomy;
- (7) [plastic] Plastic surgery;
- (8) [transplant] Transplant procedures; and
- (9) HealthTrack Special Services.
 - (A) HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis; and
 - (B) [the] The request for HealthTrack Special Services shall include:
 - (i) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within [his or her] the physician or licensed practitioner's respective scope of practice as defined under state law, justifying the need for the item or service required;
 - (ii) [a] A description of the outcomes of any alternative measures tried; and
 - (iii) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Section 8. Subsection (f) of section 17b-262-617 of the Regulations of Connecticut State Agencies is amended to read as follows:

- (f) The department [shall pay nonhospital based] pays providers for [evaluation and management] services provided [to the provider's private practice clients in the emergency room] in a hospital only if the department excludes the professional component of services from applicable payments to the hospital and the provider ensures that no duplicate billing occurs.

Section 9. Section 17-134d-63 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) Definitions

[For the purposes of this regulation, the following definitions apply] As used in this section:

- [(1) "Allowed Cost" means the Medicaid costs reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.]
- [(2)] (1) "Border [Hospital] hospital" means an out-of-state general hospital which has a common medical delivery area with the [State] state of Connecticut and is deemed a border hospital by the [Department] department on a hospital by hospital basis[.];
- [(3)] (2) "Connecticut [In-state Hospital] in-state hospital" means a general hospital located within the boundaries of the [State] state of Connecticut and licensed by the [Connecticut State] Department of Public Health [Services.];
- [(4)] (3) "Department" means the [State of Connecticut] Department of [Income Maintenance.] Social Services or its agent;
- [(5) "Department's Manual" means the Department's Connecticut Medical Assistance Provider Manual which contains the Medical Services Policy as amended from time to time.]
- [(6)] (4) "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 patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part[.];
- [(7)] (5) "General [Hospital] 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.]
- [(8) "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.]

[(9)] (6) “Medical [Necessity]” 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.] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(10)] (7) [“Out-of-State Hospital”] “Out-of-state hospital” means a general hospital located outside of the [State] state of Connecticut and is not [deemed by the Department to be] a border hospital[.];

[(11)] (8) “Outpatient” means 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[.];

[(12)] (9) “Prior [Authorization] authorization” means approval for a service from the [Department] 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] department. The [Department] department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request[.];

[(13)] (10) “Provider [Agreement] agreement” means the signed written contractual agreement between the [Department] 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[.];

[(14)] (11) “Rate [Year] year” means the twelve (12) month period beginning on October 1st of each year[.]; and

[(15)] (12) “Total [Customary Charges] customary charges” means the revenue generated by the aggregate of the total customary charges reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

(b) Rate Setting

- (1) For [inpatient and] outpatient services, [rendered on and after the effective date of this regulation, the Department] 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] rates established pursuant to sections 17b-239 and 17b-239d of the

Connecticut General Statutes. The standard methodology to be employed shall either be the fixed percentage calculated in accordance with [subsections (b) (1) (A) and (B) of this regulation] subparagraph (A) of this subdivision or a fixed fee, as determined by the department. [However, for inpatient services, the hospital may elect to have its fixed percentage determined in accordance with subsection (b) (1) (C) of this regulation.]

[(A) For inpatient services the standard fixed percentage shall be calculated by the Department based on the ratio between the allowed cost and total customary charges for Title XIX recipients for all Connecticut in-state general hospitals.]

[(B)] (A) For outpatient services, the standard fixed percentage shall be calculated by the [Department] department based on the ratio between the aggregates of the amount paid by the [Department] department and the amount billed to the [Department] department for all Connecticut [instate] in-state hospital outpatient services. The amount billed represents the hospital's usual and customary charges for outpatient services and the [Department's] department's payment represents the amount paid up to the amount allowed in accordance with the [Department's] 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] 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) However, for inpatient services as defined in this regulation, each out-of-state and border hospital may have its fixed percentage optionally determined based on its total allowable cost under Medicare principles of reimbursement pursuant to Title 42 of the Code of Federal Regulations, Part 413, and as may be hereafter amended. The hospital must submit its most recently available Medicare cost report within the time period specified in subsection (b) (2) (A) below. The Department shall determine from the filed Medicare cost report the ratio of total allowable inpatient cost to gross inpatient revenue. The resulting ratio shall be the hospital's fixed percentage not to exceed 100%. If an out-of-state or border hospital chooses to file for a fixed percentage under this subsection it must maintain all the supporting documentation to justify the amounts claimed. The Department, in its discretion, may audit said hospital and make any adjustment required in favor of the provider or the state resulting from the audit.]

[(D)] (B) The [Department] department shall pay out-of-state and border hospitals utilizing the methodology as set forth in [subsection (b) (1) (A), or (B), or (C) of this regulation] subparagraph (A) of this subdivision or a fixed fee, as determined by the department, unless a different methodology is required by federal law, in which case, the required federal methodology shall be employed.

- (2) Upon the effective date of this regulation and annually thereafter, meaning at the beginning of the rate year, as defined in this regulation, the [Department] department shall notify each out-of-state and border hospital enrolled in the Connecticut Medicaid Program as to the standard fixed [percentages] percentage for that rate year.

[(A) Each year each out-of-state and border hospital shall have ten (10) days from the date of receipt of said notification to submit a request in writing to the Department, if it wishes to have its inpatient fixed percentage calculated using the optional methodology set forth in accordance with subsection (b) (1) (C).

(B) Failure of the hospital to notify the Department of said election within ten (10) days or failure of the hospital to provide the necessary information described in subsection (b) (1) (C) within said time shall result in the Department making payment to the hospital for inpatient services for the applicable rate year using the standard methodology in accordance with subsection (b) (1) (A) of this regulation.]

- [(C)] (3) Upon the effective date of this regulation, the fixed percentages set in accordance with [subsections (b) (1) (A) or (B) or (C) of this regulation] subparagraph (A) of subdivision (1) of this subsection shall expire at the end of the rate year in which this regulation is made effective.

[(D) A hospital which enrolls in the Connecticut Medicaid Program during any rate year may elect to have its inpatient fixed percentage determined in accordance with subsection (b) (1) (C) of this regulation. Such initial fixed percentage shall expire at the end of the rate year in which said fixed percentage is approved by the Department. Thereafter, if the hospital wishes to elect the optional methodology it must comply with the provisions of subsection (b) (1) (C).

(E) If a hospital elects to have its inpatient fixed percentage set in accordance with subsection (b) (1) (C), it may not request a change in said methodology during the rate year in which the fixed percentages are approved by the Department.]

(c) Provider Participation

In order to receive payment from the Connecticut Medicaid Program:

- (1) 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.
- (2) [The out]Out-of-state and[/or] border hospitals must enter into a provider agreement with the [Department] department.
- (3) The [Department] department shall determine when an out-of-state hospital qualifies for enrollment as a border hospital.

(d) Prior Authorization

- (1) Border Hospitals. Prior authorization[, as defined in this regulation, for inpatient and outpatient services, shall be] is required for [such] outpatient hospital services in accordance with [the Department's Manual, Sections 150.1 and 150.2 pertaining to Connecticut in-state hospitals] section 150.2 of the department's Medical Services Policy and other applicable requirements.
- (2) Out-of-state Hospitals
 - (A) Prior authorization for [inpatient and] outpatient services [shall be] is required for all non-emergency cases as described in subsection (e) of this [regulation] section.
 - (B) The following services shall not require prior authorization:
 - (i) Care in an emergency [situation as defined in this regulation];
 - (ii) Newborns and/or deliveries; or
 - (iii) Outpatient services for a child for whom the [State]state of Connecticut makes adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.
- (e) Need for Service
 - (1) Out-of-state hospitals and border hospitals who treat Connecticut [Title XIX recipients] Medicaid members 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 Medicaid [Title XIX program as set forth in the Department's Manual].
 - (2) [The Connecticut Title XIX program] Pursuant to 42 CFR 431.52, as amended from time to time, Medicaid reimburses for medically necessary [and Appropriate] services provided in out-of-state hospitals, other than border hospitals as defined in subsection (a) of this [regulation] section, under the following conditions:
 - (A) For emergency cases, as defined in subsection (a) of this [regulation] section, and necessitating the use of the most accessible general hospital available that is equipped to furnish the services; or
 - (B) For non-emergency cases, when prior authorization is granted by the [Department] department, for the following reasons:
 - (i) Medical services are needed because the [recipient's] member's health would be endangered if they were required to travel to Connecticut; or
 - (ii) 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] state.

Section 10. Section 17b-262-338 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 17b-262-338. Definitions

[For the purposes of] As used in 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] Department of Social Services 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 or the commissioner’s designee;

- (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) such that [a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect] the absence of immediate medical attention could reasonably be expected 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] 17b-262-901 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] individuals with intellectual disabilities” or “ICF/[MR]IID” means a residential facility for persons with [mental retardation] intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an [intermediate care facility for the mentally retarded] ICF/IID 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 subsection (c) or subsection (e) of 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] an individual 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] who is: (A) Licensed pursuant to section 20-12b of the Connecticut General Statutes and (B) acting within the physician assistant’s scope of practice under state law;
- (46) “Physicians’ services” means services that are billed by the billing provider and are provided by:
 - (A) [By an] An individual physician who is also the billing provider;
 - (B) [by a] A physician who is employed by or affiliated with the billing provider; or
 - (C) [by an] 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] 17b-262-901 of the Regulations of Connecticut State Agencies.

Section 11. Section 17b-262-342 of the Regulations of Connecticut State Agencies is amended to read as follows:

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] (1) [immunizations,] Immunizations, biological products and other products available to providers free of charge;
- [3] (2) [examinations] Examinations and laboratory tests for preventable diseases that are furnished free of charge;
- [4] (3) [information] Information or services provided to a client by a provider electronically or over the telephone;
- [5] (4) [cosmetic] Cosmetic surgery;
- [6] (5) [an] An office visit for the sole purpose of the client obtaining a prescription where the provider previously determined the need for the prescription;
- [7] (6) [cancelled] Cancelled services and appointments not kept;
- [8] (7) [services] 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] 17b-262-907 of the Regulations of Connecticut State Agencies;
- [9] (8) [infertility] Infertility treatment;
- [10] (9) [sterilizations] Sterilizations performed on mentally incompetent individuals or institutionalized individuals;
- [11] (10) [more] More than one visit per day to the same provider by a client;
- [12] (11) [services] Services to treat obesity other than those described in section 17b-262-341(9) of the Regulations of Connecticut State Agencies; and

[13] (12) [any procedures or] Any services [of an] that are unproven[, educational, social, research,] or experimental or any services that are solely for a social, research or cosmetic [nature] purpose; 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.

Section 12. Subsection (b) of section 17b-262-344 of the Regulations of Connecticut State Agencies is amended to read as follows:

- (b) Prior authorization is required for all hospital admissions pursuant to section [17-134d-80] 17b-262-907 of the Regulations of Connecticut State Agencies.

Section 13. Subsection (q) of section 17b-262-348 of the Regulations of Connecticut State Agencies is amended to read as follows:

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

If the department determines either prospectively or retrospectively pursuant to section [17-134d-80] 17b-262-907 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.

Section 14. Subsection (a) of section 17b-262-456 of the Regulations of Connecticut State Agencies is amended to read as follows:

- (a) The department shall pay for:
- (1) [psychiatric] Psychiatric evaluation;
 - (2) [psychotherapy] Psychotherapy, including: individual, group, family, hypnosis[,] and electroshock;
 - (3) [psychiatric] Psychiatric consultation;
 - (4) [drugs] Drugs, as limited in subsection (b) of section 17b-262-456;
 - (5) [all] 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] 17b-262-907 of the Regulations of Connecticut State Agencies; and
 - (5) HealthTrack Services and HealthTrack Special Services.

Section 15. Section 17b-262-620 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 17b-262-620. Definitions

As used in [section] sections 17b-262-619 to [section] 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Acute” means symptoms that are severe and have a rapid onset and short course;
- (2) “Admission” means the formal acceptance by a hospital of a client who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services;
- (3) “Border provider” means an out-of-state provider who routinely serves clients and is deemed a border provider by the department on a [provider by provider] case-by-case basis;
- (4) “Chronic disease hospital” [means “chronic disease hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies] has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;
- (5) “Client” means a person eligible for goods or services under [the department's] Medicaid [program];
- (6) “Commissioner” means the Commissioner of Social Services or [his or her designee] the commissioner’s designee;
- (7) “Consultation” means those services rendered by a podiatrist or other practitioner whose opinion or advice is requested by the client's podiatrist or other appropriate source in the evaluation or treatment of the client's illness;
- (8) “Customized item” means an item or material adapted through modification to meet the specific needs of a particular client;
- (9) “Department” means the Department of Social Services or its agent;
- (10) “Early and Periodic Screening, Diagnostic and Treatment services,” [or] “EPSDT services” or “HealthTrack Services” means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;
- (11) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;
- (12) “Freestanding clinic” [means “freestanding clinic” as defined] has the same meaning as provided in section 171B of the department's Medical Services Policy for clinic services;
- (13) “General hospital” [means “general hospital” as defined] has the same meaning as provided in section [17-134d-80] 17b-262-901 of the Regulations of Connecticut State Agencies;

- (14) “Home” means the client’s place of residence, including, but not limited to, a boarding home, community living arrangement or residential care home. “Home” does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for [the mentally retarded (ICFs/MR)] individuals with intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;
- (15) “Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities” or [“ICF/MR”] “ICF/IID” means a residential facility for persons with [mental retardation] intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;
- (16) “Legend device” [means “legend device” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;
- (17) “Legend drug” [means “legend drug” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;
- (18) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;
- [(19) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;]
- [(20)] (19) “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] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- [(21)] (20) “Medical record” [means “medical record” as defined] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;
- [(22)] (21) “Nursing facility” [means “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;
- [(23)] (22) “Out-of-state provider” means a provider that is located outside Connecticut and is not a border provider;
- [(24)] (23) “Physician” means [a person] an individual licensed pursuant to [chapter 370] section 20-13 of the Connecticut General Statutes;
- [(25)] (24) “Podiatric [Services] services” means services provided by a podiatrist within the scope of practice as defined by state law, including chapter 375 of the Connecticut General Statutes;

- [(26)] (25) “Podiatrist” means a doctor of podiatric medicine licensed pursuant to section 20-54 of the Connecticut General Statutes;
- [(27)] (26) “Prior authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;
- [(28)] (27) “Provider” means a podiatrist or a podiatrist group enrolled in Medicaid;
- [(29)] (28) “Quality of care” means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;
- [(30)] (29) “Routine foot care” means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryposis or onychiauxis; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;
- [(31)] (30) “Simple foot hygiene” means self-care, including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;
- [(32)] (31) “Systemic condition” means the presence of a metabolic, neurologic[,] or peripheral vascular disease, including, but not limited to: diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neuropathies involving the feet, which would justify coverage of routine foot care;
- [(33)] (32) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary” shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and
- [(34)] (33) “Utilization review” [means the evaluation of the necessity and appropriateness of medical services and procedures as defined] has the same meaning as provided in section [17-134d-80] 17b-262-901 of the Regulations of Connecticut State Agencies.

Section 16. Section 17b-262-624 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 17b-262-624. Services not covered

The department shall not pay a podiatrist for:

- (1) [for information] Information or services provided to a client by a podiatrist over the telephone;
- (2) [for any] Any product available to podiatrists free of charge;

- (3) [for more] More than one visit per day per client to the same podiatrist;
- (4) [for cosmetic] Cosmetic surgery;
- (5) [for simplified] Simplified tests requiring minimal time or equipment and employing materials nominal in cost, including, but not limited to, urine testing for glucose, albumin and blood;
- (6) [for simple] Simple foot hygiene;
- (7) [for repairs] Repairs to devices judged by the department to be necessitated by willful or malicious abuse on the part of the client;
- (8) [for repairs] Repairs to devices under guarantee or warranty. The podiatrist shall first seek payment from the manufacturer;
- (9) [for an] An office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;
- (10) [for cancelled] Cancelled services and appointments not kept;
- (11) [for services] Services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section [17-134d-80] 17b-262-907 of the Regulations of Connecticut State Agencies; or
- (12) [for any procedures or] Any services [of an] that are unproven[, educational, social, research,] or experimental or any services that are solely for a social, research or cosmetic [nature] purpose; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

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

Sec. 17b-262-628. Payment

(l) Admission to a general hospital

Payment for services provided by the admitting podiatrist in a general hospital shall not be made available if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity[, medical appropriateness], appropriateness of setting or quality of care. Specific requirements are described in section [17-134d-80] 17b-262-907 of the Regulations of Connecticut State Agencies.

Section 18. Subparagraphs g to j, inclusive, of subsection J of section 150.2 of the department's Medical Services Policy are amended to read as follows:

- [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.] g. The [Department] department does not reimburse interns or residents for their services; these services are included in the hospital rate.

Section 19. Sections 17-134d-20, 17-134d-36, 17-134d-40, 17-134d-43, 17-134d-80, 17-312-101 to 17-312-107, inclusive, and sections 17-312-201 to 17-312-203, inclusive, of the Regulations of Connecticut State Agencies are repealed. Section 150.1 of the department's Medical Services Policy is repealed.

Statement of Purpose

Pursuant to CGS Section 4-170(b)(3), "Each proposed regulation shall have a statement of its purpose following the final section of the regulation." Enter the statement here.

The purposes of the regulation are to: (1) update and recodify the department's inpatient hospital medical services policy in regulation form; (2) update and consolidate all of the department's inpatient hospital regulations into one regulation; and (3) implement the inpatient hospital reimbursement reforms set forth in section 17b-239 of the Connecticut General Statutes.

(A) The problems, issues or circumstances that the regulation proposes to address: In 2013, the Connecticut General Assembly amended section 17b-239 of the Connecticut General Statutes to require the department to reimburse acute care and children's hospitals for inpatient hospital services using the Diagnosis Related Group (DRG) methodology. This payment reform modernizes the department's inpatient hospital reimbursement methodology and is similar to the inpatient hospital reimbursement methodology used by the Medicare program. The DRG reimbursement methodology pays hospitals solely for the facility and technical components of hospital services, which means that physicians and certain other licensed practitioners must be reimbursed separately from the hospital for providing their professional services. The regulation implements the DRG reimbursement methodology both by establishing rules for hospital reimbursement and DRG rate-setting as well as enabling the department to reimburse physicians and certain other licensed practitioners separately for their services from the hospital. In order to improve clarity and to simplify the regulations, this regulation also updates and consolidates all inpatient hospital regulations and repeals regulations that are obsolete or are being consolidated into this regulation.

(B) The main provisions of the regulation: (1) Establish a new consolidated inpatient hospital regulation that updates provisions from the department's inpatient hospital medical services policy regarding coverage, billing, provider enrollment, documentation and related requirements; (2) implement the DRG hospital payment reform project by setting forth specific rules for reimbursement and rate-setting both for discharges reimbursed under DRGs and non-DRG discharges; (3) update and consolidate various other inpatient hospital regulations regarding hospital reimbursement and rate-setting, utilization review, border and out-of-state hospitals and certain organ acquisition costs; (4) amend various other regulations as necessary to enable the department to reimburse physicians and certain other licensed practitioners separately from the hospital, as required by the DRG reimbursement methodology; (5) update citations in other regulations to regulations that have been renumbered or repealed; (6) make various technical and other updates and revisions; and (7) repeal regulations that are obsolete or have been consolidated into the new inpatient hospital regulation.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation recodifies and updates the existing inpatient hospital medical services policy in regulation form. The regulation updates and consolidates all inpatient hospital regulations into one regulation. This regulation also amends existing regulations as necessary to enable the department to implement the hospital payment reform project as well as updating cross-references to regulations that are being repealed or renumbered in this regulation. Finally, this regulation repeals older inpatient hospital regulations that are obsolete, redundant or have been consolidated into this new regulation.