



Connecticut interChange MMIS

Provider Manual

Chapter 7 - Nurse Practitioner / Midwife

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Nurse Practitioner and Nurse Midwifery Services
Regulation/Policy
Chapter 7

Medical Services Policy

7.1

This section of the Provider Manual contains the Medical Services policy sections that pertain to nurse practitioners and nurse midwives. A list of policy sections is given below.

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.

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7.1

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Requirements for Payment of Nurse-Midwifery Services

Sec. 17b-262-573 Scope

Sections 17b-262-573 through 17b-262-585 inclusive set forth the Department of Social Services requirements for payment of nurse- midwifery services performed by licensed nurse-midwives for clients who are determined eligible to receive such services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

Sec. 17b-262-574 Definitions

For the purposes of sections 17b-262-573 through 17b-262-585 the following definitions shall apply:

- (1) "**Acute**" means having rapid onset, severe symptoms, and a short course.
- (2) "**Client**" means a person eligible for goods or services under the department's Medical Assistance Program.
- (3) "**Commissioner**" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.
- (4) "**Consultation and Collaborative Management**" means those services rendered by the obstetrician-gynecologist who is part of the health care team whose opinion or advice is requested by the client's nurse-midwife in the evaluation or treatment of the client. The consultant obstetrician-gynecologist may prescribe a course of treatment provided by the nurse-midwife. It does not necessarily mean the client shall be seen by the obstetrician-gynecologist.
- (5) "**Department**" means the Department of Social Services or its agent.
- (6) "**Directed**" means a nurse-midwife shall always function within a health care system in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.
- (7) "**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.
- (8) "**Essentially Normal**" means a philosophic view of childbirth as a natural, normal process. Essentially normal means that if a client develops complications, the nurse-midwife either consults or collaborates with the physician in the management of care of the client or, depending on the severity of the complication, refers the client to the physician. This reflects again the team relationship with the physician, because normal is defined by the nurse-midwives and physicians in a particular practice setting.
- (9) "**Family Planning Services**" means any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

- (10) "**Health Care Team**" means the nurse-midwife shall function in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.
- (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) "**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.
- (14) "**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).
- (15) "**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).
- (16) "**Management of Care**" means the responsibilities and accountability the nurse-midwife shall assume and the mandatory relationship this shall require with a physician. This management is independent in the fact that a client who experiences an essentially normal maternity cycle or requires well-woman gynecological care may have her care provided entirely by the nurse-midwife.
- (17) "**Maternity Cycle**" means a period limited to:
- (A) pregnancy,
 - (B) labor,
 - (C) birth, and
 - (D) the immediate postpartum period, not to exceed six weeks from the child's date of birth.
- (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 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 also the Public Health Code.

(22) **"Nurse-midwife"** means a person who meets all of the conditions established in subsection (2) of section 20-86a of the Connecticut General Statutes.

(23) **"Nurse-midwifery Services"** are the services established in subsection (1) of section 20-86a and section 20-86b of the Connecticut General Statutes.

(24) **"Physician"** means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who practices as an obstetrician-gynecologist.

(25) **"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.

(26) **"Provider"** means a licensed nurse-midwife.

(27) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(28) **"Referral"** means the nurse-midwife requests a consultation and collaboration with the physician on a client which results in the physician providing the care for the client.

(29) **"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-262-575 Provider Participation

In order to enroll in the Medical Assistance Program and receive payment from the department, a nurse-midwife shall:

- (a) meet 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 the 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-262-576 Eligibility

Payment for nurse-midwifery services shall be available on behalf of all women and newborns, only throughout the maternity cycle, eligible for the Medical Assistance program subject to the conditions and limitations which apply to these services.

Sec. 17b-262-577 Services Covered and Limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed and certified nurse-midwife which conform to accepted methods of diagnosis and treatment, but shall not pay for any procedures or services 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 the following:

(1) services provided in the provider's office, client's home, hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or -operated institution, or home for the aged;

(2) family planning services as described in the Regulations of Connecticut State Agencies; and

(3) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) services concerned with the care and management of the care of essentially normal mothers and newborns, only throughout the maternity cycle, and well-woman gynecological care, including family planning services; and

(2) services covered shall be limited to these listed in the department's applicable fee schedule.

Sec. 17b-262-578 Services not Covered

The department shall not pay for the following:

(a) nurse-midwifery services to newborns occurring beyond the maternity cycle;

(b) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge;

(c) information or services provided to a client by a provider over the telephone;

(d) an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined; and

(e) cancelled office visits and appointments not kept.

Sec. 17b-262-579 Need for Service

The department shall pay for medically necessary and appropriate nurse-midwifery services for Medical Assistance Program eligible clients:

(a) requiring care during an essentially normal maternity cycle or requiring well-woman gynecological care;

(b) of child-bearing age who indicate a need for family planning services and are free from coercion or mental pressure and are free to choose the method of family planning to be used;

(c) provided by a licensed and certified nurse-midwife within the scope of the nurse-midwife's practice; and

(d) if the services are made part of the client's medical record.

Sec. 17b-262-580 Prior Authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

- (1) more than one visit per day per client; and
- (2) HealthTrack Special Services.

(A) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(B) 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 services required;
- (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.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, request for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a nurse-midwife shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) 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-262-581 Billing Procedures

(a) Claims from nurse-midwives 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) If a provider assumes the continuing care of a client or provides services to a client as a result of a referral by a nurse-midwife because the services cannot be provided by the nurse-midwife, an obstetrical-gynecological surgical procedure as an example, this procedure would be billed as a separate procedure, by any provider giving this service.

(c) When a Medical Assistance Program client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant provider shall enter the entire name as well as the state license number of the referring provider on the billing form.

(d) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(e) The following routine laboratory tests 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. Payment for these tests is included in the fee for a routine workup.

(f) Laboratory services performed in the nurse-midwife's office are payable to the nurse-midwife. Nurse-midwife's shall bill for these services as separate line items. When a nurse-midwife refers a client to a private laboratory for services, the laboratory shall bill directly. No laboratory charge shall then be paid to the nurse-midwife.

(g) Payment for laboratory services shall be limited to services provided by Medical Assistance providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

(h) 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 routine care for the same child.

Sec. 17b-262-582 Payment

Payment shall be made at the lowest of:

- (a) the provider's usual and customary charge to the general public;
- (b) the lowest Medicare rate;
- (c) the amount in the applicable fee schedule as published by the department;
- (d) the amount billed by the provider; or
- (e) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

Sec. 17b-262-583 Payment Rate

(a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Payment rates shall be the same for in-state and out-of-state providers.

(c) Nurse-midwifery rates for each procedure shall be set at 90% of the department's fee for physician procedure codes.

Sec. 17b-262-584 Payment Limitations

(a) The department shall pay for an initial visit by a nurse-midwife only once per client. Initial visits refer to the nurse-midwife'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 nurse-midwife-client relationship has been discontinued for three or more years and is then reinstated.

(b) The department shall pay for an initial visit once per inpatient hospitalization.

(c) Nurse-midwives who are fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive 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 nurse-midwife is employed. Nurse-midwives who are solely hospital, institution, 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.

(d) A nurse-midwife who maintains an office for private practice separate from the hospital, institution, group, or clinic, shall be able to bill 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.

(e) Fees for medical procedures shall include the fee for an emergency room visit. The department shall not pay a provider at a higher rate for any medical procedure which is performed in an emergency room.

(f) Payment for the total obstetric care procedure, shall include office visits for maternity care six months prior to delivery and six weeks after delivery.

(g) If antepartum care, vaginal delivery, or postpartum care are billed as separate procedures, total payment shall not exceed the fee for the total obstetric care procedure.

(h) If a client's medical problem necessitates the concurrent services and skills of two or more providers, each provider shall be entitled to the listed fee for the service.

(i) There shall be no payment for consultation and collaborative management services with an obstetrician-gynecologist when functioning as part of the health care team in the evaluation and treatment of a client.

(j) Although a nurse-midwife shall always function within a health care system in a team relationship with a physician which is directed and shall never be independent of physician back-up for consultation and collaborative management, or referral, directed does not necessarily imply the physical presence of the physician when care is being given by a certified and licensed nurse-midwife.

Sec. 17b-262-585 Documentation

(a) Nurse-midwives shall maintain a specific medical record for all services rendered to 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 nurse-midwife, 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 nurse-midwife's file subject to review by the 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 nurse-midwife for which the required documentation is not maintained or provided to the department upon request.

Requirements for Payment of Nurse Practitioner Services

Sec. 17b-262-607 Scope

Sections 17b-262-607 through 17b-262-618 inclusive set forth the Department of Social Services requirements for payment of nurse practitioner services provided by licensed advanced practice registered nurses 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).

Section 17b-262-608 Definitions

For the purposes of sections 17b-262-607 through 17b-262-618 the following definitions shall apply:

- (1) "**Acute**" means having rapid onset, severe symptoms, and a short course.
- (2) "**Allied Health Professional (AHP)**" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in providing health care and treatment and shall include, but shall not be limited to: licensed practical nurses, certified nurse assistants, and other qualified therapists.
- (3) "**By or Under the Supervision**" means the nurse practitioner 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 nurse practitioner to the allied health professional in person and within five minutes;
 - (B) availability of the nurse practitioner 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 nurse practitioner in the absence of the regular nurse practitioner.
- (4) "**Child**" means a person who is under twenty-one years of age.
- (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) "**Concurrent Review**" means the review of the medical necessity and appropriateness of admission upon or within a short period following an admission and the periodic review of services provided during the course of treatment.
- (8) "**Consultation**" means those services rendered by a nurse practitioner whose opinion or advice is requested by the client's nurse practitioner or agency in the evaluation or treatment of the client's illness.
- (9) "**CPT or Physician's Current Procedural Terminology**" means a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by licensed practitioners as published by the American Medical Association, as amended from time to time.
- (10) "**Criteria**" means the predetermined measurement variables on which judgment or comparison of necessity, appropriateness, or quality of health services shall be made.

- (11) "**Department**" means the Department of Social Services or its agent.
- (12) "**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.
- (13) "**Family Planning Services**" means any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.
- (14) "**Fees**" means the rates for services, treatments, and drugs administered by nurse practitioners which shall be established by the commissioner and contained in the department's fee schedules.
- (15) "**HealthTrack Services**" means the services described in subsection (r) of section 1905 of the Social Security Act.
- (16) "**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.
- (17) "**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).
- (18) "**Hospital**" means a facility licensed by the Department of Public Health as a general short-term hospital or a hospital for mental illness as defined in section 17a-495 of the Connecticut General Statutes, or a chronic disease hospital as defined in subdivision (2) of subsection (b) of section 19-13-D1 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.
- (19) "**Inpatient**" means a client who has been admitted to a general hospital for the purpose of receiving medically necessary and appropriate medical, dental, and other health related services and is present at midnight for the census count.
- (20) "**Institution**" means the definition contained in Title 42 of the CFR, Part 435, section 435.1009.
- (21) "**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.
- (22) "**Legend Device**" means the definition contained in section 20-571 of the Connecticut General Statutes.

- (23) **"Legend Drug"** means the definition contained in section 20-571 of the Connecticut General Statutes.
- (24) **"Licensed Practitioner"** means any Connecticut medical professional granted prescriptive powers within the scope of his or her professional practice as defined and limited by federal or state law.
- (25) **"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).
- (26) **"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).
- (27) **"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.
- (28) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.
- (29) **"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.
- (30) **"Medical Record"** means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.
- (31) **"Nurse Practitioner"** means an advanced practice registered nurse (APRN) who holds a current license as such issued by the Department of Public Health (DPH) under Chapter 378 of the Connecticut General Statutes, and who performs within the scope of practice for APRNs established pursuant to the Connecticut General Statutes and all relevant regulations.
- (32) **"Panel or Profile Tests"** means certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple tests performed on an individual, immediate, or "stat" reporting basis.
- (33) **"Physician"** means an individual licensed under Chapter 370 or 371 of the Connecticut General Statutes as a doctor of medicine or osteopathy.
- (34) **"Plan of Care"** means the definitions contained in Title 42 of the CFR, Part 441, sections 441.102, 441.103, 441.155, and 441.156.
- (35) **"Prescription"** means an order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order. The prescription needs to be renewed six months from the date of issuance. In long-term care facilities the signed order of a licensed practitioner shall be accepted in lieu of a written or oral prescription. The written prescription shall include:
- (A) the date of the prescription;
 - (B) the name and address of the client;
 - (C) the client's date of birth;

- (D) the diagnosis;
- (E) the item prescribed;
- (F) the quantity prescribed and strength, when applicable;
- (G) the timeframe for the product's use;
- (H) the number of refills, if any;
- (I) the name and address of the prescribing practitioner and his or her Drug Enforcement Act number when appropriate;
- (J) the dated signature of the licensed practitioner prescribing; and
- (K) directions for the use of the medication and any cautionary statements required.

(36) **"Prior Authorization"** means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

(37) **"Provider"** means a nurse practitioner who is enrolled in the Medical Assistance Program.

(38) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(39) **"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.

(40) **"Retrospective Review"** means the review conducted after services are provided to a client, to determine the medical necessity, appropriateness, and quality of the services provided.

(41) **"Routine Medical Visits"** means visits intended to check a client's general medical condition rather than visits which are medically necessary to treat a specific medical problem. For clients under twenty-one years of age, this can mean a HealthTrack interperiodic encounter or a periodic comprehensive health screening.

(42) **"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).

(43) **"Utilization Review"** means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures, and facilities. Utilization review evaluates the medical necessity and medical appropriateness of admissions, the services performed or to be performed, the length of stay, and the discharge practices. It is conducted on a concurrent, prospective, or retrospective basis.

Sec. 17b-262-609 Provider Participation

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

(a) General:

- (1) meet and maintain all applicable licensing, accreditation, and certification requirements;
- (2) meet and maintain all departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) Specific:

In order to qualify for payment under the Medical Assistance Program for laboratory procedures, a nurse practitioner shall be in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), as amended from time to time.

Sec. 17b-262-610 Eligibility

Payment for nurse practitioner 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-262-611 Services Covered and Limitations

- (a) Except for the limitations and exclusions listed below, the department shall pay for:
- (1) medically necessary and medically appropriate professional services of a nurse practitioner which conform to accepted methods of diagnosis and treatment;
 - (2) services provided in the practitioner's office, client's home, hospital, long-term care facility, or other medical care facility;
 - (3) family planning services as described in the Regulations of Connecticut State Agencies;
 - (4) unless defined elsewhere, CPT descriptive terms used by the department as standards;
 - (5) medical and surgical supplies used by the provider in the course of treatment of a client;
 - (6) injectable drugs which are payable by the department and administered by a provider; and
 - (7) HealthTrack Services and HealthTrack Special Services.
- (b) Limitations on covered services shall be as follows:
- (1) The department reserves the right to review the medical necessity and medical appropriateness of visits and to disallow payment for those visits it determines are not medically necessary or medically appropriate.
 - (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 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 payment from the department for services rendered to Medical Assistance Program clients.
 - (3) Nurse practitioners who maintain an office for private practice separate from the hospital, institution, group, or clinic, shall be able to bill 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.

- (4) The department shall pay nurse practitioners for drugs or devices which are administered or dispensed directly to a client under the following conditions:
 - (A) excluding oral medications, payment shall be made to a nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drugs or devices which are administered directly to the client; and
 - (B) for legend drugs or legend devices which shall be administered by a nurse practitioner, the department shall pay the nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drug or device which is administered.
- (5) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.
- (6) Admission or annual exams for long-term care facility residents shall meet the following criteria:
 - (A) the exam shall be performed in the facility;
 - (B) the admission examination shall be performed within forty-eight hours of admission to the facility and shall be limited to one per client, per provider, regardless of the number of admissions. However, if the nurse practitioner who attended the client in an acute or chronic care hospital is the same nurse practitioner who shall attend the client in the facility, a copy of a hospital discharge summary completed within five working days of admission and accompanying the client may serve in lieu of this requirement. An additional admission exam shall be performed only when a new medical record is opened for the client; and
 - (C) the annual comprehensive medical examination shall be limited to one per client per calendar year.
- (7) When billing allergy procedures the nurse practitioner shall bill for follow-up visits which include intracutaneous tests only if subsequent visits require testing. If follow-up visits do not include testing, regular office visit codes for established clients shall be used.
- (8) Payment for panel or profile tests shall be made according to the fees listed in the department's fee schedule for panel tests and not at the rate for each separate test included in the panel or profile.
- (9) Payment for any laboratory service shall be limited to services provided by Medical Assistance Program providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- (10) The fees listed in the department's fee schedule shall be payable only when these services are provided by or under the supervision of a nurse practitioner.
- (11) The department shall not pay a higher rate for any procedure which is performed in an emergency department.

(12) The department shall pay for an initial visit by a nurse practitioner in the office, home, or long-term care 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 exception to this is when the nurse practitioner-client relationship has been discontinued for three or more years and is then reinstated.

(13) The department shall pay for an initial visit once per inpatient hospitalization.

(14) The fee for a consultation shall apply only when the opinions and advice of a consultant nurse practitioner are requested by the client's nurse practitioner or agency in the evaluation or treatment of the client's illness. In a consultation the client's nurse practitioner carries out the plan of care. In a referral a second provider provides direct service to the client.

(15) When the consultant nurse practitioner assumes the continuing care of the client, any service subsequent to the initial consultation rendered by the consultant provider shall no longer be a consultation and shall be paid according to the fee listed for the procedure.

(16) A consultation initiated by a client or family, and not requested by a nurse practitioner, shall not be billed as an initial consultation, but shall be billed as a confirmatory consultation or as an office visit, whichever is appropriate.

(17) If a consultant nurse practitioner, subsequent to the consultation, assumes responsibility for management of a portion, or all of the client's medical condition, consultation codes shall not be billed. A specifically identifiable procedure, identified with a specific CPT code, performed on, or subsequent to the date of the initial consultation, shall be billed separately.

(18) When a newborn requires other than routine care following delivery, the nurse practitioner shall bill for the appropriate critical care. The department shall not pay both critical care and routine care for the same child.

Sec. 17b-262-612 Services Not Covered

The department shall not pay for the following:

- (a) any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; 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 examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge;
- (c) information or services provided to a client by a provider over the telephone;
- (d) 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 office visits and appointments not kept;
- (f) cosmetic surgery;
- (g) 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 of the Regulations of Connecticut State Agencies;

- (h) 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 laboratory charge for laboratory services performed by a laboratory outside of the nurse practitioner's office--the laboratory shall bill the department for services rendered when a nurse practitioner refers a client to a private laboratory;
- (j) 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.

Sec. 17b-262-613 Need For Service

The department shall pay for an initial office visit and continuing services which the department deems are medically necessary and medically appropriate, in relation to the diagnosis for which care is required, provided that:

- (a) the services are within the scope of the provider's practice, and
- (b) the services are made part of the client's medical record.

Sec. 17b-262-614 Prior Authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for the following services:

- (1) 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 to acute care hospitals pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies;
- (3) electrolysis epilation;
- (4) physical therapy services in excess of two treatments per calendar week per client per provider;
- (5) physical therapy services in excess of nine treatments per calendar year per client per provider, involving the following primary diagnoses:
 - (A) all mental disorders including diagnoses related to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;
 - (B) cases involving musculoskeletal system disorders covered by ICD, as amended from time to time; and
 - (C) cases involving symptoms related to nutrition, metabolism, and development covered by ICD, as amended from time to time;
- (6) reconstructive surgery, including breast reconstruction following mastectomy;
- (7) plastic surgery;
- (8) 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 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 required;
 - (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.
- (c) The initial authorization period shall be up to three months.
- (d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.
- (e) For services requiring prior authorization, a nurse practitioner shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.
- (f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.
- (g) 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-262-615 Billing Procedures

- (a) Claims from nurse practitioners 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 nurse practitioner's usual and customary charge for the services delivered.
- (c) When a Medical Assistance Program client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant provider shall enter the entire name as well as the state license number of the referring provider on the billing form.
- (d) Injectables shall be billed according to the number of units administered to the client by the nurse practitioner.
- (e) When billing for anesthesia services, providers shall include the name of the primary surgeon on the bill and enter the total number of minutes in units.
- (f) Providers shall bill for drugs or devices which are dispensed directly to the client as separate line items.

(g) All charges billed for supplies and materials provided by a provider, except glasses, shall be reviewed by the department.

Sec. 17b-262-616 Payment

(a) Payment rates shall be the same for in-state and out-of-state providers.

(b) 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 or substantially similar goods or services by the provider from any person or entity.

Sec. 17b-262-617 Payment Rate and Limitations

(a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Nurse practitioner rates for each procedure shall be set at 90% of the department's fees for physician procedure codes.

(c) The fees listed apply only when services are directly performed by the nurse practitioner or provided under the supervision of the nurse practitioner.

(d) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not at the rate for each separate test included in the panel or profile.

(e) Fees for surgical and medical procedures shall include the fee for an emergency room visit. The department shall not pay a provider at a higher rate for any surgical or medical procedure which is performed in an emergency room.

(f) The department shall pay nonhospital based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.

(g) If a client is referred to a provider for advice and treatment of a condition which the referring provider does not usually treat, the fee for a consultation shall not be paid.

(h) If a client's medical condition necessitates the concurrent services and skills of two or more providers, each nurse practitioner provider shall be entitled to the listed fee for the service.

(i) When a Medical Assistance Program applicant visits a provider for the purpose of determining eligibility, the department shall pay only for the test required to establish eligibility as requested by the department. No other procedures shall be paid.

(j) Newborn resuscitation may be billed in addition to billing for routine care of a newborn or billing for critical care.

(k) The admission and annual comprehensive medical examination, in a long-term care facility, shall be performed by or under the direct supervision of a provider.

(l) The admission examination, in a long-term care facility, shall be performed within forty-eight hours of admission to the long-term care facility and shall be limited to one per client, per provider, regardless of the number of admissions.

Sec. 17b-262-618 Documentation

(a) Nurse Practitioners shall maintain a specific record for all services rendered 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 nurse practitioner, 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 nurse practitioner'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 nurse practitioner for which the required documentation is not maintained or provided to the department upon request.