

OFFICE OF HEALTH CARE ACCESS UNOFFICIAL REGULATIONS  
[FORMERLY COMMISSION ON HOSPITALS AND HEALTH CARE]  
FY 1992 Hospital Budget Review Regulations  
Effective December 27, 1991

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\*NOTE: This compilation of the regulations concerning the FY 1992 and Subsequent Years Hospital Budget Review regulations is unofficial and for the convenience of the public only. While every effort was made to obtain complete accuracy herein, the reader is advised to consult the Regulations of Connecticut State Agencies or the formal regulation filings for the official codification of these regulations.  
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**Sec. 19a-167g-50. Reserved**

**Sec. 19a-167g-51. General Purpose**

A hospital shall be exempt from the detailed budget review process, for the fiscal year commencing October 1, 1991 and annually thereafter, if its projected net revenue per equivalent discharge, its projected net expenses per equivalent discharge and its projected gross revenue per equivalent discharge do not exceed the applicable cap, except that any hospital not subject to a detailed budget review for fiscal year 1990 shall be subject to a detailed budget review for fiscal year 1991. Each hospital, beginning in fiscal year 1991, shall be required to meet the gross and net revenue and expense caps pursuant to section 19a-167g-57 once in every three years, and each hospital shall be subject to a detailed budget review at least once in every three years. A hospital shall be entitled to request partial budget review if it is able to attribute the need for generating revenue and expenses greater than such caps to one and only one of four defined factors: (1) malpractice costs, (2) changes in case mix, (3) changes in payor mix, or (4) costs associated with approved certificate of need projects.

Nothing in sections 19a-167g-51 through 19a-167g-94, should be interpreted as preventing the commission from reviewing any financial requirement in carrying out its mandate under Connecticut laws.

**(Effective July 1, 1991.)**

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**Sec. 19a-167g-52. Consistency**

Unless otherwise specified in these regulations, all financial and statistical data submitted to the commission in compliance with regulations sections 19a-167g-51 through 19a-167g-99 must be prepared in accordance with the following principles:

- (a) Consistency: Consistency refers to continued uniformity during a period and from one period to another in methods of accounting, mainly, but not only, in valuation bases and methods of accrual and statistical units of measure such as diagnosis related group relative weights. Any change in accounting procedure which results in a lack of consistency and which is material in nature, must be brought to the attention of the commission by way of a cover letter which will accompany the hospital's revenue cap or budget submission and shall include both a description and analysis of the impact such accounting procedure change has on the data submitted.
- (b) Depreciation policies: Straight line depreciation must be used in the reporting of depreciation relating to all assets. The estimated useful life of a depreciable asset is its normal operating or service life. Useful lives of hospital assets shall be based on the most recent American Hospital Association useful life guidelines.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-53. Reserved**

**Sec. 19a-167g-54. Pricemaster**

- (a) New or adjusted charges: It is understood that hospitals may start to provide new drugs, supplies, tests and procedures that were not provided in the base year and that are not on the latest authorized pricemaster of the hospital. Hospitals shall be permitted to establish charges for such new drugs, supplies, tests and procedures provided that such new charges shall not result in the approved revenue caps of the hospital being exceeded. In addition, hospitals shall be permitted to make certain non-substantive changes in their pricemaster. Changes shall be considered to be non-substantive if the cumulative impact of the changes over the course of the year is less than 0.5% of the gross revenue that served as the basis for the current year revenue cap. The hospital shall provide notice to the commission of its intent to implement such new charges or non-substantive changes, and shall project the impact of

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such new charges or other changes on the gross and net revenue caps of the hospital, listing each specific change in charge or new charge with the related volume and impact on gross revenue and the effective date of the change. These data shall be filed in a format and medium specified by the commission. The commission may review this data and order that the pricemaster of the hospital be reduced in order to ensure that the gross and net revenues are within the caps established by the commission.

- (b) The Payor Advisory Board may request that the commission review changes in a hospital's pricemaster upon submitting evidence that suggests that new or adjusted charges are having a significant impact on the gross or net revenues of a hospital.
- (c)
  - (1) In the event that a hospital has displayed a significant understatement of the impact of pricemaster changes then the commission shall require that the hospital provide at least fifteen days advance notice to the commission of its intent to implement any new or modified charges, and shall project the impact of such new charges on the gross and net revenues of the hospital, listing each specific change in charge or new charge with the related volume and impact on gross revenue. This data shall be filed in a format and medium specified by the commission. After a review of this data the commission may order that the pricemaster of the hospital be reduced in order to ensure that the gross and net revenues are within the caps established by the commission.
  - (2) A hospital shall be determined to have displayed a significant understatement if it has implemented changes to its pricemaster and it is found by the commission that such changes have resulted in increased revenue in excess of one percent of the approved gross revenue.
  - (3) The commission may require quarterly filings of volume and revenue data to enable it to monitor the impact of changes in the pricemaster of hospitals which have displayed significant understatement.
- (d) Any hospital proposing a change in billing practice due to rebundling, shall provide at least 30 days advance notice in writing to the commission of its intent to implement such expansion and shall project the impact of the expansion on the gross and net revenue of the hospital. The commission shall review the reasonableness

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of these projections and may require an adjustment to the pricemaster and revenue caps of the hospital. For purposes of this subsection, rebundling is the transfer of a service (previously rendered by the hospital and unbundled to an affiliate) from an affiliate, back to the hospital.

- (e) Charges to patients: Hospitals shall charge patients based on charges identified in the latest pricemaster approved by the commission, with changes as specified in (a), (c) and (d) above and section 19a-167g-81a.
- (f) The maximum allowable percentage price increase to be applied to the hospital's latest authorized pricemaster resulting from approval of a hospital's budget or revenue caps shall be the result of authorized budget year gross revenue per budget year equivalent discharge divided by the authorized base year gross revenue per equivalent discharge as converted to a percentage. The hospital shall be required to file a pricemaster which reflects an increase in each individual charge no greater than this amount. This pricemaster shall serve as the basis to which future years budget adjustments are made.

The price increase which the hospital will be allowed to implement shall reflect adjustment for any prior years enforcement or compliance determined pursuant to section 19a-167g-82 as applicable to the budget year and shall be determined as the product of 1 (one), plus the above percentage increase, times the result of 1 (one) minus, the total overcharge for the applicable year divided by the budget year authorized revenues.

- (g) Increase in the pricemaster: It is likely that the gross revenue per adjusted discharge will increase at a higher percentage rate than the increase in the pricemaster of the hospital due to increased utilization of services. At present the commission has no experience to allow it to quantify this effect. The Payor Advisory Board shall study the extent to which the change in gross revenue per adjusted discharge exceeds the increase enacted in the pricemaster and make appropriate recommendations to the commission for any changes in its regulations.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-55. Definitions**

- (a) The definitions provided by section 19a-145, of the general statutes and section 19a-160-48 of the regulations of Connecticut state agencies, shall govern

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the interpretation and application of sections 19a-167g-51 to 19a-167g-94, inclusive.

- (b) The following definitions shall apply to the deliberations of this commission concerning all matters arising under public act 89-371, as applicable:
- (1) **Adjusted discharges:** Inpatient discharges adjusted to reflect all patient service volumes, including outpatient volumes, also called equivalent discharges.
  - (2) **Affiliate:** A person, entity or organization controlling, controlled by, or under common control with another person, entity or organization, i.e., parent company, holding company, related entities, etc. Factors to be considered include: common ownership of fifty or more percent; shared boards of directors; purpose, i.e., one entity operating for the benefit of others. Control exists where an individual or organization has the power, directly or indirectly, to significantly direct the actions or policy of an organization or entity. A person, entity or organization may be an affiliate for purposes of a particular project.
  - (3) **Alternative delivery system:** A health care center as defined in section 33-179a of the general statutes or an eligible organization as defined by Medicare in 42 U.S.C. section 1395 mm(b).
  - (4) **Authorized budget:** The fiscal plan including a rate order and pricemaster approved by the commission on hospitals and health care.
  - (5) **Bad debts:** The uncollectible accounts receivable of the hospital relating to patients from whom reimbursement was expected. Bad debts are distinguished from free care, i.e. care for which the hospital does not expect to receive full reimbursement. Bad debts, net of recoveries, shall be deductions from revenue if, after reasonable collection efforts, it is determined that the accounts are uncollectible.
  - (6) **Base year:** The fiscal year prior to the fiscal year for which a budget or revenue caps are being determined. It is also referred to as the current year or the base period.
  - (7) **Building and building equipment:** Roofs, walls, and attachments to buildings such as wiring, electrical

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fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. Building equipment is equipment affixed to buildings, not subject to transfer or movement and is used for general purposes rather than specific departmental functions.

- (8) Board-designated funds: Unrestricted funds available for specific purposes or projects.
- (9) Budget year: The fiscal period beginning October 1 following the base year.
- (10) BY: Budget year.
- (11) Case mix: The average of inpatient cases, as differentiated by DRG, treated by a specific hospital during a given fiscal year. The "case mix index" for a hospital for a given year shall be the arithmetic mean of the Medicare DRG case weights assigned to each inpatient discharge.
- (12) Capital expenditures: Expenditures for items which at the time of acquisition have an estimated useful life of at least three years and a purchase price of at least \$500. Such items shall include, but not be limited to, the following:
  - (A) Land, buildings, fixed equipment, major movable equipment and any attendant improvements thereto.
  - (B) The total cost of all studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion or replacement of the plant or equipment in question when such total cost, in aggregate, exceeds \$100,000.
  - (C) Leased assets. Purchase price for leased assets shall be the fair market value at the time of lease.
  - (D) Maintenance expenditures capitalized in accordance with generally accepted accounting principles.
  - (E) Donated Assets. Donations of property and equipment which under generally accepted accounting principles are capitalized at fair market value at the date of contribution. In addition, capital expenditures shall include expenditures of at least \$1,200 for groups of related items with an expected life of more than

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three years which are capitalized under generally accepted accounting principles.

- (13) CHAMPUS: The Federal Civilian Health and Medical Program of the uniformed services, 10 U.S.C. 1071 et seq.
- (14) CHAMPUS shortfall: The difference between the projected net revenue of a hospital apportioned to CHAMPUS and the amount projected to be received by the hospital from CHAMPUS based on the payments from the most recently completed fiscal year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, and contractual allowances to total charges for all patients.
- (15) Cluster: A group of cost centers.
- (16) Commission: The Commission on Hospitals and Health Care.
- (17) Contractual allowances: Negotiated discounts provided to nongovernmental payors for either prompt payment and/or administrative services as described more fully in subsections (d) and (e) of section 19a-166 of the general statutes.
- (18) Cost center: An expense classification which identifies the salary, non-salary and depreciation expenses of a specific department or function. In addition, cost centers may be established to identify specific categories of expense such as interest, malpractice, leases, building and building equipment depreciation.
- (19) Current year: The year prior to the budget year. Also referred to as the base year or the base period.
- (20) CY: Current year.
- (21) Diagnosis Related Group Revenue: The amount the hospital was permitted by the commission to charge nongovernmental non-exempt inpatients, exclusive of outliers, in the fiscal year 1989.
- (22) Discharge: Any patient who was discharged on a date subsequent to the date admitted to the hospital for treatment as an inpatient; except that it shall also mean such patient admitted and discharged on the same day where such patient:
  - (A) Died; or



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(B) Left against medical advice.

For purposes of this definition, a patient transferred between an exempt unit, as defined in (27) below, and any nonexempt inpatient unit prior to October 1, 1989, shall be considered discharged and readmitted.

- (23) D R G: Diagnosis Related Group
- (24) D.R.I.: Data Resources' Inc. or the firm preparing projections under contract with the Federal Health Care Financing Administration if Data Resources, Inc., ceases to be the firm preparing such projections.
- (25) Endowment funds: Funds in which a donor has stipulated, as a condition of his gift, that the principal amount of the fund is to be maintained inviolate and in perpetuity, and that only income from investments of the fund may be expended. (See also term endowments.)
- (26) Exempt inpatient: A psychiatric inpatient or a rehabilitation inpatient treated in a unit meeting the criteria set forth in 42 CFR 405.471(c)(4).
- (27) Exempt Psychiatric Unit or Exempt Rehabilitation Unit: Respectively, an inpatient psychiatric unit or an inpatient rehabilitation unit of a hospital which has been determined by Medicare as meeting the criteria set forth in 42 CFR 405.471(c)(4).
- (28) Expense recoveries: Adjustments made to expenses, based on the income received due to rebates, refunds, and gifts or grants which are specifically intended by the donor or grantor to finance particular expenses incurred or to be incurred by the hospital.
- (29) Factor prices: An indicator of relative differences in hospital salary costs by geographic area in Connecticut, which are due to variations in the general cost of living.
- (30) Financial requirements: The total monetary elements, e. g., expenses, contractual allowances, bad debt and free care, required by a hospital to implement its authorized operating budget and revenue caps.
- (31) Fiscal year: The hospital fiscal year, commencing October 1, and ending September 30.

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- (32) Fixed expenses: Expenses whose magnitude does not vary with volumes.
- (33) Free care: The difference between the amount of expected reimbursement from charity patients, as defined by a hospital board approved free care policy approved by the commission, for hospital services rendered, and the amount of the hospital's published charges for such services. Courtesy discounts, contractual allowances, and charges for health care services provided to employees are not included under the definition of free care.
- (34) Funded depreciation reserves: Patient revenues related to depreciation expense and specifically set aside for the replacement of capital assets.
- (35) Funding of depreciation: The assignment of all or a portion of patient revenue related to depreciation expense to a fund to be held in reserve for the purpose of providing funds for future replacement of depreciable assets.
- (36) Equivalent discharges: Inpatient discharges adjusted to reflect all patient service volumes, including outpatient volumes, also called adjusted discharges.
- (37) Government discharges: Discharges for which the principle payor is Medicare, Medicaid or CHAMPUS. A discharge will be classified as a government discharge if Medicare, Medicaid or CHAMPUS is responsible for a majority of the cost of service rendered to the patient.
- (38) Gross inpatient revenue: The total patient charges for inpatient patient care services.
- (39) Gross outpatient revenue: The total patient charges for outpatient patient care services.
- (40) Gross revenue: The total patient charges for all patient care services.
- (41) Hospital: A hospital included within the definition of health care facilities or institutions under section 19a-145 of the general statutes and licensed as a short-term general hospital by the Department of Health Services, except John Dempsey Hospital of the University of Connecticut Health Center.
- (42) Inflation factor: The estimated rate of increase or decrease in a hospital's expenses due to anticipated

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economic conditions in the budget year, also called Regional Hospital Inflation.

- (43) Inpatient non-exempt: Inpatients who are not patients in an exempt psychiatric unit or exempt rehabilitation unit and who are not outliers.
- (44) Leased asset: See capital expenditure.
- (45) Major movable equipment: Equipment which usually has a relatively fixed location in the building but is capable of being moved and generally has a function related to a specific cost center.
- (46) Medical assistance: Programs provided pursuant to chapters 302 and 308 of the general statutes.
- (47) Medicare Cost Report: Form 2552, the provider reimbursement report, and all supplemental schedules and attachments required to be filed annually pursuant to 42 CFR section 405.406(b).
- (48) Medicare principles of reimbursement: Title 42 of the code of federal regulations (CFR) subchapter B, part 405, subpart D, and, unless cited as of a specific date shall incorporate any amendments.
- (49) Medical assistance shortfall: The difference between the projected net revenue of a hospital apportioned to medical assistance and the amount projected to be received by the hospital for these services from the Department of Income Maintenance based on the most recently filed medical assistance cost report divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, and contractual allowances to charges for all patients.
- (50) Medicare shortfall:
  - (A) For fiscal years 1990, 1991 and 1992 the difference between the projected net revenue of a hospital apportioned to Medicare and the amount projected to be received by the hospital from the federal government for Medicare patients (based on the most recently filed Medicare cost report) divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, and contractual allowances to charges for all patients.

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- (B) Beginning in fiscal year 1993, the difference between the projected net revenue of a hospital apportioned to Medicare excluding fifty per cent (50%) of the projected net revenue associated with disallowed admissions and days and services determined by Medicare to be medically unnecessary, excluding claims pending under appeal, and the amount projected to be received by the hospital from the federal government for Medicare patients (based on the most recently filed Medicare cost report) divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, and contractual allowances to charges for all patients. Medicare charges shall exclude fifty per cent (50%) of the charges associated with disallowed admissions and days and services determined by Medicare to be medically unnecessary, excluding claims pending under appeal, for all situations in which Medicare charges are used in sections 19a-167g-51 through 19a-167g-99.
- (51) Non-operating revenue: Unrestricted revenue not directly derived from patient care, related patient services, or the sale of related goods and services. Non-operating revenue is further classified as revenue derived from either philanthropic or non-philanthropic sources.
- (52) Net expense: Gross expenses less expense recoveries which are reported as credits to expense.
- (53) Net patient revenue: Gross revenues less: governmental allowances, uncompensated care, contractual allowances. Discounts granted to alternative delivery systems are not included as deductions from gross revenue in determining net revenue nor will such discounts be considered in determining compliance for hospitals.
- (54) New or additional debt: Increased financial requirements which result from new or additional borrowing.
- (55) Non-recurring items: Compliance and enforcement adjustments and any costs identified by the commission in the base year rate order as non-recurring. Any adjustment for non-recurring compliance and enforcement adjustments shall be at the dollar value stated in the rate order.

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- (56) Operating expense: The expenses necessary to maintain the functions of the hospital net of any expense recoveries.
- (57) Other operating revenues: Revenue from non-patient goods and services. Such revenue is normal to the operation of a hospital but should be accounted for separately from patient revenues. Revenue from gifts, grants or subsidies specified by the donor for research, educational or other programs, and therefore, revenues restricted by the donor or grantor for operating purposes, are considered other operating revenue.
- (58) Outlier revenue: The total of
- (A) day outlier revenue, the sum of the per diem charges for the days a patient stays in a hospital in excess of three times the average length of stay for the diagnosis related group and
  - (B) charge outlier revenue, the sum of the itemized charges which exceed by more than two and one-half times the fixed charges per case and
  - (C) short stay outlier revenue, the sum of the itemized charges for inpatient cases involving hospital stays of two calendar days or less.
- (59) Outliers: A category of cases which includes
- (A) day outliers, which shall include all cases with a length of hospital stay which exceeds three times the average length of stay as determined by the commission;
  - (B) charge outliers, which shall be cases not included within the definition of day outliers in which the itemized charges exceed by more than two and one-half times the fixed charge per case as determined by the commission; or
  - (C) short stays, which shall be inpatient cases involving hospital stays of two calendar days or less.
- (60) Payor classifications: Medicare, medical assistance, CHAMPUS, commercial insurance, Blue Cross/Blue Shield, no charge, uninsured, workers compensation, alternative delivery systems, other sources.
- (61) Payor mix: The proportionate share of itemized charges attributable to patients assignable to a

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payor classification to total itemized charges for all patients.

- (62) Plant replacement and expansion funds: Funds donated for renewal or replacement of plant.
- (63) Presumptively reasonable budget: The operating budget of a hospital subject to detailed review which meets the criteria set forth in these regulations.
- (64) Projected actual: A prediction of the total operating expenses, revenues, volumes and related data for the base period, all of which are based on six (6) months actual experience and six (6) months projected experience.
- (65) Proxies: Surrogates of actual hospital expense categories which represent forces in the general economy that are likely to impact on changes in hospital expense categories. These economic surrogates, which are provided by D.R.I., are applied to the respective cost components of the hospital for projections of annual cost increases attributable to regional hospital inflation.
- (66) Repayment of debt: Retirement of principal indebtedness.
- (67) Related corporation: A corporation is related to a hospital where the corporation is an affiliate or where the hospital has an ownership interest of ten per cent or more in the corporation or where the corporation has an ownership interest in the hospital of ten per cent or more.
- (68) Restricted funds: Funds restricted by donors for specific purposes. The term refers to specific purpose and endowment funds.
- (69) Revenue cap: The authorized budget year gross revenue per equivalent discharge and the authorized net revenue per equivalent discharge.
- (70) Self pay patient: An aggrieved person as described in section 19a-165q-26a of the regulations of Connecticut state agencies.
- (71) Specific purpose funds: Funds restricted externally by a donor, or otherwise, for a specific purpose or project. Board-designated funds do not constitute specific purpose funds.

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- (72) Screens: Financial measurements or statistical ratios developed by the commission to determine presumptively reasonable financial requirements.
- (73) Term endowments: Donated funds which by the terms of the gift become available either for any purpose designated by the governing board or for a specific purpose designated by the donor upon the happening of an event or upon the passage of a stated period of time.
- (74) Third party payors: A governmental agency or private entity that is liable to pay all or a part of the cost of hospitalization or ambulatory service because of statute or a contractual agreement.
- (75) Uncompensated care: Bad debts and free care.
- (76) Unrestricted funds: Funds which bear no external restrictions as to use or purpose; i.e., funds which can be used for any purpose as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion, or for endowment.
- (77) Variable expenses: Expenses whose magnitude varies with volume.
- (78) Volume: The number of equivalent discharges rendered by the hospital.
- (79) Working capital: Current assets (excluding funds committed for the retirement of long term debt) minus current liabilities (excluding the current portion of long term debt). All amounts due to or from other funds, affiliates or related organizations, may be considered as current assets or current liabilities. The current portion of long term debt is excluded from this definition because it is treated separately in reviewing financial requirements.

**(Effective Dec. 27, 1991.)**

**Sec. 19a-167g-56. Scope, Filing Requirements**

- (a) Scope. The procedures set forth in Sections 19a-167g-51 through 19a-167g-99 for exemption from review, partial budget review and detailed budget review pursuant to public act 89-371 shall govern only non-governmental, short-term acute care hospitals and World War II Veterans' Memorial Hospital.

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- (b) Date of filing. Each hospital shall file an original and five copies of the forms, including schedules required to qualify for exemption, partial budget review or detailed budget review, as the case may be, for the fiscal year commencing October 1, 1990 and thereafter. In addition, the commission may require that such information be accompanied by a submission in machine readable form. The format for such submission shall be provided by the commission. All such information shall be submitted to the commission on or before the date specified in sections 3(e) and 4(a) of public act 89-371.
- (c) Special components of budget filing for all hospitals. In addition to the specific requirements subsequently identified in sections 19a-167g-57 to 19a-167g-94 of these regulations for exemption, partial budget review and detailed budget review which are deemed necessary for a complete application, all hospitals shall submit other relevant information deemed necessary by the commission.  
**(Effective April 20, 1990.)**

**Sec. 19a-167g-57. Exemption**

- (a) For the fiscal year commencing October 1, 1991 and thereafter, a hospital shall be exempt from detailed budget review as set forth in subsection (d) of section 19a-167b of the general statutes, if:
- (1) Gross revenue per equivalent discharge for the budget year commencing October 1 is budgeted to increase to no more than the gross revenue per equivalent discharge calculated in (1) below, and
  - (2) The increase in net revenue per equivalent discharge for the budget year commencing October 1, computed pursuant to (c) below is no more than inflation as determined in section 19a-167g-61 plus 2% , and
  - (3) The increase in net expense per equivalent discharge for the budget year commencing October 1, computed pursuant to (m) below is no more than inflation as determined in section 19a-167g-61 plus 2%.

A hospital must meet the gross revenue cap specified in (1), the net revenue cap specified in (2) and the expense cap specified in (3) to qualify for exemption from detailed budget review.

- (b) Volume adjustments shall be calculated by using a fifty percent variable cost adjustment factor, as follows:



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- (1) The difference between budget year projected equivalent discharges computed pursuant to subsection (f) and the number of equivalent discharges which served as the basis for the current year authorization will be derived.
  - (2) (A) This difference shall be multiplied by the authorized base year net revenue per equivalent discharge adjusted for unbundling and non-recurring items to determine total net revenue subject to the volume adjustment.  
  
(B) This difference shall be multiplied by the base year maximum net expense per equivalent discharge to determine total net expenses subject to the volume adjustment. The base year maximum net expense is the expense amount which served as the basis for the base year authorization.
  - (3) Fifty percent of the total net revenue subject to the volume adjustment shall be the variable cost adjustment factor to net revenue and fifty percent of the total net expense subject to volume adjustment shall be the variable cost adjustment factor to net expenses. If budget year equivalent discharges have increased over base year equivalent discharges, the variable cost adjustment factor is positive, whereas if equivalent discharges have decreased, the variable cost adjustment factor is negative.
- (c) To determine if a hospital qualifies for exemption on the basis of its net revenue increase:
- (1) Budgeted net revenue shall be divided by the number of budgeted equivalent discharges calculated in (f) below to determine budgeted net revenue per equivalent discharge.
  - (2) Base year net revenue adjusted for unbundling and non-recurring items shall have added to it the variable cost adjustment factor computed in (b) (3) above to determine the adjusted base year net revenue.
  - (3) The result of (c) (2) above shall be multiplied by the inflation rate determined in sec. 19a-167g-61 plus 2%.
  - (4) The product of (c) (3) above shall be divided by the budgeted equivalent discharges calculated in (f) below to determine maximum net revenue per equivalent

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discharge to qualify for exemption from detailed budget review.

- (5) The hospital's net revenue per equivalent discharge shall qualify for exemption if the result of (c) (1) is equal to or less than the result of (c) (4).
- (d) For purposes of the exemption from detailed budget review, gross revenue per equivalent discharge in the base year shall be the approved gross revenue established by the commission for the base year less any non-recurring expenses and compliance adjustments applicable to fiscal year 1990 and thereafter, fiscal year 1989 enforcement adjustments pursuant to section 19a-167g-82 or fiscal year 1988 enforcement adjustments applied to the fiscal year 1990 authorization.
- (e) For purposes of the exemption from detailed budget review, net revenue per equivalent discharge in the base year shall be the approved net revenue established by the commission for the base year adjusted for unbundling and non-recurring items.
- (f) Computing budget year volume.

The volume projection for the budget year shall be based on equivalent discharges, computed according to section (g) below. The volume projection shall be computed for each hospital in the manner described in (1) through (3) below.

- (1) Computing the rate of change of volume.

The rate of change in volume for the third year prior to the budget year shall be computed by dividing the number of equivalent discharges in the third year prior to the budget year by the number of equivalent discharges in the fourth year prior to the budget year, and then subtracting one (1) from this quotient.

The rate of change in volume for the second year prior to the budget year shall be computed by dividing the number of equivalent discharges in the second year prior to the budget year by the number of equivalent discharges in the third year prior to the budget year, and then subtracting one (1) from this quotient.

The rate of change in volume for the first year prior to the budget year (the base year) shall be computed by dividing the number of equivalent discharges, which served as the basis for the

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commission's authorization in the first year prior to the budget year, by the number of equivalent discharges in the second year prior to the budget year, and then subtracting one (1) from this quotient.

- (2) Computing the weighted average rate of change.

The weighted average rate of change of volume shall be the quotient of the rate of change in volume for the first year prior to the budget year (the base year) multiplied by two (2), plus the rate of change in volume for the second year prior to the budget year multiplied by one (1), plus the rate of change for the third year prior to the budget year multiplied by one (1), and the sum of these products divided by four (4).

- (3) Computing the budget year volume.

The budget year volume is the product of the volume in the first year prior to the budget year (the base year) times the sum of one (1) plus the weighted average rate of change of volume.

- (4) In addition, for the purposes of the budget filing a hospital undergoing detailed budget review may propose an alternative methodology for forecasting budget year volume. For the purposes of establishing the presumptively reasonable budget, the budget year volume shall be the greater of the result of (3) above, or the volume calculated by the alternative methodology. After the hearing, the commission shall approve, modify or deny the use of the proposed methodology based upon the evidence presented.

- (g) Equivalent discharges for the base year, the budget year and prior years shall be computed in the following manner: The hospital's annual gross revenue from outpatients shall be divided by its annual number of outpatient visits to determine its average revenue per outpatient visit; the hospital's annual gross revenue from inpatients shall be divided by its annual number of inpatient discharges to determine average revenue per inpatient discharge; average revenue per outpatient visit shall be divided by average revenue per inpatient discharge and the resulting quotient multiplied by the annual number of outpatient visits; equivalent discharges shall be the sum of inpatient discharges and the product of such multiplication.

- (h) Hospitals seeking or required to qualify for exemption from the detailed budget review process shall submit on

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the appropriate forms and schedules no later than May 1, 1991 and May 1 annually thereafter or by a later date specified by the commission:

- (1) Unit cost screen data identified in section 19a-167g-60(a) and (b) to permit the commission to perform the presumptively reasonable tests identified in said sections;
- (2) An agreed upon procedures report as described in section 19a-167g-60(a); and the following information which shall be submitted to the commission no later than June 1, 1991 and on June 1 annually thereafter, or on a later date if so authorized by the commission:
- (3) Discharge data as required pursuant to section 19a-167g-94 of these regulations.
- (4) A schedule which identifies the approved gross and net revenues for the base year based on the volumes used by the commission in establishing the authorizations for the base year;
- (5) A schedule which identifies the various financial requirements and statistics applicable to the budget year and the calculation of the gross and net revenue caps;
- (6) A source and applications of funds statement;
- (7) All required data to permit determination of any enforcement/compliance adjustments applicable to the fiscal year commencing October 1, 1988 and corresponding subsequent years, as set forth in section 19a-165q-43 of the Regulations of Connecticut State Agencies and section 19a-167g-82 of these regulations;
- (8) A schedule of detailed charges for the fiscal year beginning October 1, 1990 and subsequent years which increases each detailed charge included in the pricemaster filed by the hospital with the commission for the preceding fiscal year by an amount no greater than that necessary to generate the gross revenue per adjusted discharge increase calculated in (a) above minus any enforcement/compliance adjustment applicable to the fiscal year commencing October 1, 1988 and corresponding subsequent years, and including adjustments for variations in the number of equivalent discharges between the budget year and the base year as well as any other nonrecurring

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adjustments included in the authorized rates for the fiscal year commencing October 1, 1989 and corresponding subsequent years. The form and manner of the pricemaster submission is set forth in section 19a-167g-90.

- (9) A certification from the chief executive officer of the hospital attesting to the exclusion of the value of all unbundled services from the base year actual experience and projections of the hospital.
- (10) Other relevant data as the commission deems appropriate and required by the application forms and schedules.
  - (i) Within thirty business days of receipt of all information identified in subsection (h), the commission shall issue its decision for hospitals which qualify for exemption. The decision shall specify the hospital's gross and net revenue caps for the budget year, the approved equivalent discharges which served as the basis for the revenue authorization and all other information necessary to determine the hospital's future compliance with the authorization as more specifically set forth in section 19a-167g-82.
  - (j) Hospitals whose authorized revenue caps for the fiscal year commencing October 1, 1989, have been set pursuant to the provisions of section 19a-167g-04 of the transition year regulations, shall be subject to detailed budget review for the fiscal year commencing October 1, 1990.
  - (k) Schedule for reviews and exemptions for the fiscal year 1993 and thereafter:
    - (1) Any hospital which did not qualify for an exemption pursuant to the provisions of this section for either of the two previous years, shall be required to submit a budget which passes the net and gross revenue and expense screens specified in (a) above and so entitles the hospital to an exemption from budget review.
    - (2) Any hospital which was not subject to a detailed budget review pursuant to the provisions of this section in either of the two previous years, shall be required to submit a budget and be subject to a detailed budget review for the fiscal year.
- (1) Calculation of gross revenue from net revenue.

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The cap on the gross revenue of the hospital for the purpose of the exemption test under (a)(1) above shall be calculated from the net revenue from (a)(2) above as follows:

- (1) To the total amount of net revenue resulting from the calculation described in (a)(2) above shall be added the following items:
  - (A) The non-governmental contractual allowances calculated pursuant to section 19a-167g-68(c).
  - (B) The Medical Assistance shortfall calculated pursuant to the methodology described in section 19a-167g-67(a). Adjustments for changes in case mix and changes in payor mix may only be made in partial budget review pursuant to section 19a-167g-58 and in detailed budget review.
  - (C) 0.9 times the CHAMPUS shortfall calculated pursuant to the methodology described in section 19a-167g-67(a). Adjustments for changes in case mix and changes in payor mix may only be made in partial budget review pursuant to section 19a-167g-58 and in detailed budget review.
  - (D) 0.9 times the Medicare shortfall calculated pursuant to section 19a-167g-67(a). Adjustments for changes in case mix and changes in payor mix may only be made in partial budget review pursuant to section 19a-167g-58 and in detailed budget review.
  - (E) The reasonable uncompensated care or uncompensated care calculated pursuant to the methodology described in section 19a-167g-66, divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, and contractual allowances to total gross revenue.
- (2) This total gross revenue shall be divided by the number of budget year equivalent discharges. The result of this calculation is the gross revenue cap.
- (m) To determine if a hospital qualifies for exemption on the basis of its net expense increase:
  - (1) Budgeted net expense shall be divided by the number of budgeted equivalent discharges to determine budgeted net expense per equivalent discharge.

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- (2) Base year maximum net expenses adjusted for unbundling and non-recurring items shall have added to it the variable cost adjustment factor computed in (b) (3) above to determine the adjusted base year net expense. The base year maximum net expense is the expense amount which served as the basis for the base year authorization.
  - (3) The result of (m) (2) above shall be multiplied by the inflation rate determined in 19a-167g-61 plus 2%.
  - (4) The product of (m) (3) above shall be divided by the budgeted equivalent discharges to determine maximum net expense per equivalent discharge to qualify for exemption from detailed budget review.
  - (5) The hospital's net expense per equivalent discharge shall qualify for exemption if the result of (m) (1) is equal to or less than the result of (m) (4).
- (Effective July 1, 1991.)**

**Sec. 19a-167g-58. Partial Budget Review**

- (a) A hospital may request that its gross revenue cap and/or its net revenue cap be increased above the limits calculated in section 19a-167g-57 for one and only one of the following:
  - (1) malpractice costs which affect both the gross revenue cap and the net revenue cap,
  - (2) changes in case mix which affect both the gross revenue cap and the net revenue cap,
  - (3) changes in payor mix which only affect the gross revenue cap,
  - (4) costs associated with certificate of need projects which affect both the gross revenue cap and the net revenue cap.

For purposes of partial budget review, costs associated with certificate of need projects means additional financial requirements previously authorized by the commission pursuant to the provisions of sections 19a-154 and 19a-155, C.G.S.

- (b) Hospitals seeking partial budget review shall file all the information set forth in subsection (h) of section 19a-167g-57 for exempt hospitals, excluding the schedule of detailed charges identified in subdivision (h) (8), a

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justification for the requested single item adjustment in light of the criteria set forth in C.G.S., section 19a-153 and the following information applicable to the single item for which the hospital seeks additional consideration:

- (1) Malpractice costs - Hospitals are required to submit quotations from at least three unrelated insurers which identify premiums for malpractice insurance applicable to the budget year. In addition, invoices and cancelled checks which quantify the premium payments made in the base year should be submitted. If any adjustment is allowed for malpractice costs, the related adjustment to the hospital's gross and net revenue caps shall be determined in accordance with the provisions of subsection (c) of this section.
- (2) Case mix - Hospitals shall submit data which justify and quantify the adjustment based on incidence and prevalence rates of various admissions and outpatient procedures, applied to the service area population adjusted for market share. All assumptions made by the hospital are to be identified and justified. For the purpose of changes in case mix, volume as measured by case mix changes, shall be adjusted for by using a fifty percent variable cost adjustment factor. In addition, the resultant adjustment to the hospital's gross and net revenue caps shall be determined in accordance with the provisions of subsection (c) of this section.
- (3) Payor mix - The data identified in (2), above, for case mix changes shall be filed by hospitals to justify payor mix changes; however, these data must apply incidence and prevalence rates to the service area population by payor category. All assumptions made to quantify service area population adjusted for market share by payor category are to be identified and justified. In determining the appropriate amount of adjustment attributable to payor mix, reimbursement rates shall be recognized as one hundred percent variable, where applicable, whereas expenses shall be fifty percent variable.
- (4) Certificate of Need Projects - The information required shall consist of the prior decision of the commission wherein a certificate of need was granted and related information included in the record. If additional expense is authorized by the commission, the related adjustment to the hospital's gross and



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net revenue caps shall be determined in accordance with the provisions of subsection (c) of this section.

In addition, hospitals seeking adjustments for malpractice costs, case mix changes or payor mix changes, shall file information pertinent to the request which is required of hospitals under detailed budget review, e.g., the information set forth in section 19a-167g-67 shall be required of hospitals seeking payor mix adjustments. All the information required under this subsection shall be filed by the hospital on or before the date specified in section 4(a) of public act 89-371 or a later date if so authorized by the commission.

- (c) To determine the adjustment to a hospital's gross revenue cap for any additional expenses granted for malpractice insurance costs, changes in case mix, or previously authorized certificates of need, the amount of any additional expenses added to the hospital's net revenue cap shall be multiplied by the hospital's ratio of gross revenue calculated pursuant to section 19a-167g-57(1) to net revenue. The resultant amount shall be the adjustment to the hospital's gross revenue cap. In the event that the hospital requests reconsideration of the commission's authorization pursuant to the provisions of subsection (d) of this section, the hospital may present evidence to justify its request.
- (d) Within thirty business days of the filing date of a complete budget application as specified in subsection (b) above, the commission shall issue its decision for hospitals which seek to qualify for the partial budget review process. The decision shall specify: the hospital's gross and net revenue caps for the budget year; the approved equivalent discharges which served as the basis for the revenue authorization; the adjustment, if any, to the gross and net revenue caps resultant from the single item requested under partial budget review; the percent increase in the hospital's price master for the year beginning October 1, 1990, or subsequent year, authorized by the commission; and all other information necessary to determine the hospital's future compliance with the authorization as more specifically set forth in section 19a-167g-82. Within three business days of the commission's decision, the commission shall notify the hospital of its decision by certified mail and shall notify the public by publication in a newspaper having a substantial circulation in the area served by the hospital. Within ten business days of the date of the commission's notice, the hospital may request that the commission reconsider its decision to modify or deny its

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request for a single item adjustment through a second-level review pursuant to section 19a-167g-73(b). All such requests shall be in writing. If the commission grants a second-level review the commission shall schedule a public hearing in accordance with the provisions of subsection 19a-167g-73(b) and shall issue its decision within ten business days of the conclusion of the hearing. If no request for second-level review is received, the hospital shall file its pricemaster consistent with the commission's authorization and in the form and manner identified in section 19a-167g-90 and subdivision 19a-167g-57(h)(8) by September 30, 1990, or subsequent year, or a date certain prescribed by the commission, whichever is later.

- (e) Hospitals requesting partial budget review shall be subject to the requirements set forth in subsections (a) through (g) of section 19a-167g-57.
- (f) Hospitals whose authorized revenue caps for the fiscal year commencing October 1, 1989, have been set pursuant to the provisions of this section, shall be subject to detailed budget review for the fiscal year commencing October 1, 1990.

**(Effective July 1, 1991.)**

**Sec. 19a-167g-59. General Approach - Detailed Budget Review**

- (a) Sections 19a-167g-60 through 19a-167g-70 set forth the various tests which will be conducted in the course of detailed budget review to determine if a particular financial requirement may be deemed reasonable. Tests of expenses include a base year assessment as well as tests of expense increases attributable to volume, inflation, non-volume, depreciation and interest proposed for the budget year. In addition, tests of other financial requirements such as uncompensated care and governmental shortfalls are set forth.
- (b) The hospital has the burden of justifying its entire budget request. The presumptively reasonableness tests are guidelines which the commission will consider with all the evidence included in the record. Notwithstanding this provision, the commission shall not issue revenue caps which are less than inflation, determined pursuant to section 19a-167g-61, and adjustments for volume and non-recurring items.
- (c) The various tests identified in subsection (a) result in the presumptively reasonable budget. The presumptively reasonable gross revenue and net revenue shall each be

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divided by the budget year equivalent discharges to determine the hospital's presumptively reasonable revenue caps. The commission shall notify the hospital of the presumptively reasonable revenue caps and shall schedule a hearing pursuant to the provisions of subsection (a) of section 19a-167g-73 of these regulations. At such hearing, the hospital may present evidence and testimony to justify the entire amount of its budget year financial requirements and to demonstrate that the presumptively reasonable budget is insufficient. In so doing the hospital shall present evidence and testimony in relation to the various presumptively reasonable tests set forth in these regulations. The commission shall receive testimony and other evidence from the hospital, parties, intervenors and other participants. The commission shall render a decision based on the evidence presented and may find that financial requirements deemed presumptively reasonable pursuant to the provisions of sections 19a-167g-60 through 19a-167g-70 are not, in fact, justified or that any amounts in excess of the presumptively reasonable budget are not justified. Any such financial requirements shall be excluded from the commission's authorization. Within ten business days of receipt of the commission's decision, the hospital shall submit a schedule of detailed charges consistent with the requirements of section 19a-167g -90 and subdivision 19a-167g-57(h) (8) of these regulations. The detailed charges shall increase in relation to the authorized annualized detailed charges on file with the commission for the prior fiscal year up to the percentage prescribed by the commission. The commission may not order a rate increase in the revenue per adjusted discharge which is less than the hospital's inflation factor, adjusted for volume and non-recurring items.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-60. Presumptively Reasonable Test of Budget Base**

- (a) Budget Base: Hospitals subject to detailed budget review shall be required to identify base year net direct expenses by department or cost center, as the case may be. Depreciation expense attributable to buildings and building equipment, interest, malpractice insurance premiums, and physicians' compensation shall be separately identified. Employee benefit costs shall be allocated to all departments or cost centers other than employee benefits based on each center's percentage of non-physician and physician employee compensation (excluding physician fees) to total employee compensation for all departments/cost centers to derive total

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departmental or cost center expenses. Physician compensation will be excluded to determine non-physician costs for each department or cost center. The non-physician costs will then be adjusted by the hospital's factor price index. The most current Medicare area wage index published in the Federal Register by the Health Care Financing Administration shall be used to determine factor price.

- (1) Non-physician cost adjusted for factor prices will be divided by case mix adjusted discharges to determine expense per unit.
- (2) The data identified in (a) above, for the first six months of the base year and reported on columns and lines specified by the commission on Schedule C-1 (or comparable schedules for years subsequent to 1990) shall be subject to agreed upon procedures and guidelines by the hospital's independent public accountants as specified in subsections (a)(3) and (4). An independent public accountant's report on the agreed upon procedures, compiled in accordance with the standards of the American Institute of Certified Public Accountants, shall be filed with the commission.
- (3) The independent public accountant shall perform the following functions and specific agreed upon procedures:
  - (A) Compare cost center expenses to the amounts reported in the hospital's general ledger or other accounting records;
  - (B) Review the allocation of fringe benefit expenses, if such an allocation is again required by the commission;
  - (C) Reconcile amounts per audited financial statements and/or unaudited interim financial statements which are presented to the hospital's management and board to amounts reported on applicable schedules;
  - (D) Review the interim closing process, compared to the year-end closing process, with specific emphasis on the differences between the two processes and the potential application of year-end closing entries (hospital year-end closing entries and/or audit entries) to interim financial information.

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(4) The following guidelines are to be employed by the independent public accountants when completing and reporting on the agreed upon procedures:

(A) The commission, at its option, may specify for particular columns and line items on the designated schedules, line items deemed de minimus and therefore requiring no agreed upon procedures by the independent accountants;

(B) The independent public accountant need not report differences between amounts included on the specified columns and lines of the designated schedules and amounts identified as a result of the procedures specified above if such differences are less than the greater of \$20,000 or 3% of the particular line item;

(C) The independent public accountant should include in the body of the agreed upon procedures report other comments deemed relevant to the particular situation, e.g., the consistency of the preparation of the schedules due to changes in the hospital's accounting systems or policies, chart of accounts, or organization.

(b) Projection of the Second Six Months of Base Year.

(1) The second half of the base year expenses shall be projected. The six month projected expenses for each department or cost center shall be determined by the hospital using the formula-driven projection methodology specified in subsection (b)(2). This projection methodology shall be the methodology used to calculate a detailed review hospital's projected actual expenses.

(2) The formula-driven projection methodology used to calculate the expenses for the second six months of the base year is as follows:

The ratio of the expenses in the second six months of the year preceding the base year to the expenses in the first six months of the year times the expenses in the first six months of the base year.

(c) Case mix adjusted discharges for the first six months of the base year shall be calculated by multiplying the total number of discharges, including psychiatric service and rehabilitation service discharges, in each diagnosis related group in the base year by the case weight assigned to the discharge for the base period. The

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resultant products for each diagnosis related group shall then be aggregated to determine total inpatient case mix adjusted discharges. Equivalent case mix adjusted discharges shall be derived following the same methodology set forth in subsection (g) of section 19a-167g-57 for equivalent discharges except case mix adjusted discharges shall be substituted for discharges.

- (d) The commission shall calculate a presumptively reasonable expense budget base which will utilize screens described in subsection (e), below, to identify hospitals reporting base year expenses which appear either greater than or less than expenses of similar hospitals. Hospitals reporting expenses greater than those of similar hospitals will be required to provide justification for these additional expenses. To ensure that hospitals with lesser expenses are not competitively disadvantaged in their ability to recruit personnel and acquire other resources, any such hospital may qualify for authorization of additional non-volume expenses pursuant to section 19a-167g-63 of these regulations.
- (e) The screens shall apply to the actual first six months non-physician costs adjusted for factor prices and excluding depreciation expense on buildings and building equipment, interest expense, and malpractice insurance premiums. The screens will be applied on two levels. First level screens shall apply to three clusters of departments, i.e., the routine services cluster, the special services cluster and the general services cluster. Second level screens will be applied on a departmental or cost center basis.

- (1) Routine Service - First Level Screen shall be determined by dividing the total non-physician cost, adjusted for factor price for the service areas listed below, by total inpatient case mix adjusted discharges. Service areas included are:

Adult medical and surgical routine services  
(including intensive and coronary care);  
Psychiatric inpatient routine services;  
Rehabilitation inpatient routine services;  
Maternity routine services;  
Newborn, well and sick (including newborn intensive care units).

(Case mix adjusted discharges for each of the above service areas will be used for second level screens.)

- (2) Special Service - First Level Screen shall be determined by dividing the total non-physician cost,

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adjusted for factor price, by total equivalent case mix adjusted discharges. Departments included are:

Operating and recovery room;  
Delivery room (deliveries rather than total equivalent case mix adjusted discharges shall be used as the unit at the second level);  
Diagnostic radiology (includes CT scanning and MRI);  
Radioisotopes/Nuclear Medicine Laboratory;  
Physical Medicine;  
Respiratory therapy;  
Intravenous therapy;  
Pharmacy and medical supplies (includes routine service departments, delivery, operating and recovery rooms, and routine special service drug and medical supply costs);  
Emergency Room (emergency room visits rather than total equivalent case mix adjusted discharges will be used as the unit at the second level).

(Total equivalent case mix adjusted discharges shall be used for second level screens unless an alternative unit is listed above.)

- (3) General Service - First Level Screen shall be determined by dividing the total non-physician cost, adjusted for factor price, by total equivalent case mix adjusted discharges.  
Departments include:

General Administration;  
General accounting and other administrative service departments;  
Dietary and pay cafeteria;  
Housekeeping;  
Laundry and linen;  
Operation of plant and repairs and maintenance;  
Medical Records; Social services.

(Total equivalent case mix adjusted discharges shall be used for second level screens unless an alternative unit is listed above.)

- (4) The median cost for first and second level screens will be derived for each of the following groups of hospitals:

Group A  
Yale-New Haven  
Hartford  
St. Francis  
St. Raphael

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Bridgeport

Group B

Norwalk  
Waterbury  
New Britain  
St. Vincent's  
Mt. Sinai  
St. Mary's  
Danbury  
Middlesex  
Stamford  
Lawrence & Memorial

Group C

Greenwich  
Manchester  
Griffin  
Meriden-Wallingford  
Bristol  
Park City  
St. Joseph  
Backus  
Day Kimball  
Charlotte Hungerford  
Windham

Group D

Milford  
Rockville  
Sharon  
World War II  
Johnson  
New Milford  
Bradley  
Winsted

For purposes of calculating unit costs, Newington Children's Hospital will be excluded from the groups in order to eliminate the effects of its high unit costs on screens applied to other hospitals. Newington's cost will be evaluated in light of costs from other comparable children's hospitals or, if such information is not available, by adjusting the hospital's costs to exclude expenses unique to a children's hospital and then comparing such adjusted costs to the median costs of Group C hospitals.

- (5) Where a hospital's unit costs for a given cluster fall below or equal 105 percent of the median unit cost of the hospitals in its group, the commission will conclude that said costs are presumptively reasonable.



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- (6) Where a hospital's unit costs for a given cluster exceed 105 percent of the median unit cost of hospitals in its group, second level screens will be applied to each cost center within that cluster. Excess expense in each cost center is the amount of expense in excess of 105 percent of the median cost for the cost center derived based on all hospitals in the group. This amount will be readjusted by the hospital's factor price index to reflect the amount of adjustment which can not be presumed reasonable. This amount shall be adjusted to reflect a twelve month base period by multiplying the excess six month base year expense per unit adjusted for factor price times the projected actual comparable number of units for the base year. The projected actual number of units for the base year shall be calculated by multiplying the actual number of units for the first six months of the base year times the total number of comparable units for the year prior to the base year divided by the number of comparable units for the first six months of the year prior to the base year.

The hospital will have the opportunity to present evidence to demonstrate that any such excess expense is justified and should be included in the authorized budget.

- (f) All hospitals including hospitals which may be exempt from detailed budget review pursuant to section 19a-167g-57 of these regulations as well as hospitals seeking partial budget review pursuant to section 19a-167g-58, shall file the unit cost screen information set forth in subsection (a) of this section on or before May 1 of the base year or on a later date specified by the commission.
- (g) The presumptively reasonable budget base shall be the lower of the amounts calculated in (1) or (2) below:
- (1) The sum of the first six months actual expense for the base year plus the projected actual second six month expense amount calculated in (b) above less the twelve month excess expense calculated as the unit cost screen adjustment in (e). This expense base is the projected actual expense base.
  - (2) The expense amount which served as the basis for the base year authorization also referred to as the "maximum net expense" is recalculated by replacing the fixed expense amounts with the comparable projected actual expenses for these categories calculated in (b) and by adjusting the remaining base

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year variable expense amounts which served as the basis for the base year authorization, for volume as described in section 19a-167g-62 of these regulations. The volume adjustment shall reflect the change in equivalent discharges from that which served as the basis for the base year authorization to the amount projected for the base year in section (h).

- (h) The projected actual equivalent discharges for the base year are calculated by multiplying the actual equivalent discharges for the first six months of the base year times the relationship of the total actual equivalent discharges for the year prior to the base year to the actual equivalent discharges for the first six months of the year prior to the base year.

**(Effective July 1, 1991.)**

**Sec. 19a-167g-61. Inflation Factor**

- (a) The commission views inflation as a broad economic force whose magnitude is beyond the control of the hospital industry. Accordingly, in determining regional hospital inflation, it is necessary for the commission to recognize the impact of external factors.
- (b) A predictive model will be used to forecast inflation rates in various cost categories. The hospital inflation factor will consist of a composite index to predict the impact of inflation on the cost of hospital services based on consistent proxies of actual hospital expense categories which are external to the hospital industry but, to the extent practicable, comparable to the regional hospital industry. This index will be based on relevant inflation and deflation factors in applicable sectors of the non-hospital economy and will be used to prepare a statistical screen for the comparison of changes in hospital costs.

For purposes of projecting the impact of inflation on the cost of hospitals, the commission shall use independent forecasts published or produced by Data Resources, Inc. and published in or consistent in timing with the First Quarter publication of Health Care Costs for the applicable year.

- (c) The commission shall use the following cost components and proxies:

Cost Component

Proxy

Salaries and Wages

The simple average of the

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|                           |   |
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|                           | annual percent change of:   |
|                           | - Average Hourly Earnings, Production Workers, General Medical and Surgical Hospitals, Northeast.   |
|                           | - Employment Cost Index   |
|                           | - Wages and Salaries, All Private Industry Workers, Northeast.  |
| Fringe Benefits           | Supplements to Wages and Salaries per Employee (Nonwage Rate), New England.   |
| Professional Fees         | Eighty percent of the proxy value for the Salaries and Wages cost component plus 20 percent of the proxy value for the Fringe Benefits cost component.  |
| Food                      | Consumer Price Index - Food at Home, New England.   |
| Drugs and Pharmaceuticals | Producer Price Index - Pharmaceutical Preparations, Ethical, U.S.   |
| General and Medical       | Equal weighting of the average annual Supplies percent change in the following components of the Producer Price Index, U.S.:<br><br>- Chemical and Allied Products<br>- Special Machinery and Equipment<br>- Rubber and Plastic Products - Textile Products and Apparel |
| Purchased Services        | Consumer Price Index - Services less Medical Care, New England.   |
| Electricity               | Producer Price Index - Commercial Electric Power, New England.  |
| Natural Gas               | Price of Natural Gas to the Commercial Sector, New England.   |
| Fuel Oil                  | Implicit Price Deflator - Consumption of Fuel Oil and Coal, U.S.  |

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- (d) For the fiscal year 1991 and subsequent fiscal years, budget year inflation forecasts shall be issued by the commission and forwarded to the hospitals on or before April 15 of each year using the cost components delineated in subsection (c).
- (e) The components, or expense categories of the index, will then be weighted in terms of the proportionate contribution of each component to the total hospital current year projected actual budget to derive that hospital's presumptively reasonable inflation factor.
- (f) The budgeted percentage increase in a hospital's total costs owing to inflation will be considered presumptively reasonable to the extent that it does not exceed its inflation factor. Costs not directly related to changes in the economy, such as previously approved new programs or services, depreciation, interest, and leased equipment shall be considered separately.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-62. Changes Due to Volume (Budget Year vs. Base Year)**

Changes in expense due to changes in volumes will be calculated as follows:

- (1) The difference between budget year projected equivalent discharges and the base year projected actual equivalent discharges will be derived.
- (2) The presumptively reasonable budget base shall be divided by the number of projected actual equivalent discharges for the base year to calculate the presumptively reasonable cost per equivalent discharge for the base year.
- (3) The difference calculated in (1) shall be multiplied by the result of (2) and this amount shall be multiplied by the inflation factor determined in sec. 19a-167g-61.
- (4) The volume adjustment shall be 50% of the amount calculated in (3). If volume has increased from the base year to the budget year then this amount shall be an addition to the presumptively reasonable budget base, and if volume has decreased this amount shall be a reduction to the presumptively reasonable budget base.

**(Effective July 1, 1991.)**

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**Sec. 19a-167g-63. Non-volume**

- (a) Where a hospital has budgeted for expense increases that are not volume related, the commission will evaluate such net expense increases in light of the hospital's unit cost performance, first in the cost cluster first level screen and then in the second level cost center screens in which additional expenses are proposed. A hospital's unit costs will then be compared to costs of the same cluster and cost centers in other hospitals. For purposes of this section, hospitals will be grouped in the same manner as set forth in subsection (e) of section 19a-167g-60 and non-physician compensation will be adjusted for factor price.
- (b) For hospitals whose cost cluster first level screen performance is in excess of 95 percent of the median, in the absence of evidence to the contrary, the hospital should finance additional expenses not already covered by the volume adjustments through productivity improvements. Therefore, unit costs of hospitals in excess of 95 percent of the first level cluster screen median will not be considered presumptively reasonable. For hospitals with cost centers below 95 percent of the first level cluster screen median, additional costs will be considered presumptively reasonable in cost centers within that cluster whose costs are less than 95 percent of the median of the cost center provided the additional proposed cost does not exceed fifty percent of the difference between the hospital's cost in that cost center and 95 percent of the median of the cost center. The actual six months non-physician costs of the hospitals shall be used in determining the relationship to the median and the median itself. The relationship will then be adjusted to reflect the entire twelve months of the base year. For example, if the hospital is below 95 percent of the cluster median for general services and the hospital is at 70 percent of the median in the dietary cost center, and the cost difference in the dietary cost center between 70 percent of the median and 95 percent of the median is \$20,000, the commission will consider an increase in costs in that cost center up to \$10,000 presumptively reasonable. The \$10,000 will then be adjusted to reflect a twelve month base period.
- (c) Should a hospital not pass the cost center screen, it will be required to justify all its non-volume requests in the cost center. A hospital shall be required to justify why increases up to the amount by which it failed the cost center screen cannot be financed through improvements in internal efficiencies.

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- (d) Hospitals proposing non-volume increases for case mix, certificates of need, and/or malpractice costs shall also submit pertinent information identified in section 19a-167g-58 of these regulations.  
**(Effective April 20, 1990.)**

**Sec. 19a-167g-64. Funding of Depreciation**

- (a) Proposed funding of depreciation will be analyzed in relation to existing funds available such as plant expansion and replacement funds, as well as the hospital's reserve for depreciation.
- (b) For reporting purposes, the hospital is required to establish two separate and distinct funds, one relating to funded major movable equipment depreciation and one relating to building and building equipment funded depreciation. In the event that the hospital has already established separate funds for major movable equipment funded depreciation and building and building equipment funded depreciation, the separation of total funded depreciation will be reported on this basis. In the absence of such established separate funds, the establishment of these funds shall be made based upon the percentage relationship of accumulated depreciation attributable to major movable equipment and building and building equipment to the total of such accumulated depreciation as reported by the hospital for the most recently completed fiscal year unless otherwise allowed by the commission. As part of all budget data submissions to the commission pursuant to public act 89-371, the hospital is also required to report changes in the balances of these funds as well as the source and application of all monies donated or designated for capital purposes and all monies generated through patient revenues which relate to depreciation expense in the hospital's budget.
- (c) Changes in depreciation from base year levels to budget levels will be deemed presumptively reasonable only if such changes are directly associated with certificates of need approved by the commission and the hospital's capital expenditures program for the budget year is consistent with the following:
- (1) The capital expenditures program does not exceed the hospital's budget year aggregate major movable equipment depreciation plus ten (10) percent, and

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- (2) Patient revenues are not required to finance the acquisition of the proposed capital assets, i.e., situations where funding requirements exceed the sources identified, and
  - (3) No new service otherwise reviewable under section 19a-154, C.G.S. will be offered as a result of the acquisition of the proposed capital assets, and
  - (4) No additional function or service otherwise reviewable under section 19a-154, C.G.S., which will increase the operating costs of the hospital, will be offered as a result of the acquisition of the proposed capital assets, and
  - (5) The commission is satisfied that the hospital's budget request is consistent with provisions of section 19a-153, C.G.S.
- (d) For the purpose of reviewing the capital expenditures of the hospital, information which includes, but is not limited to the following will be required:
- (1) A Letter of Intent must be filed for each item whose capital cost is in excess of the \$400,000 and/or \$1,000,000 threshold as applicable per section 19a-155 C.G.S., 60 days in advance of the budget filing, and
  - (2) Separate identification of each item whose capital cost is in excess of the \$400,000 and/or \$1,000,000 threshold as applicable per section 19a-155, C.G.S., and
  - (3) Distinction between replacement equipment and new equipment, and
  - (4) Documentation that addresses the required criteria under section 19a-153, C.G.S., with respect to the capital expenditures program in its entirety and for each specific proposal that exceeds the applicable thresholds of \$400,000 and \$1,000,000 set forth in section 19a-155, C.G.S.
- (e) The commission shall consider the relationship of applications of funds to sources of funds. Applications of funds shall include but are not limited to authorized capital expenditures, transfers to board designated funds and retirement of debt principal, i.e., the current portion of long term debt. Source of funds shall include but are not limited to depreciation, transfers from board designated funds and commitment to long-term debt. The

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hospital shall submit the fund balances of all affiliated organizations as of September 30, 1989 and annually thereafter, distinguishing between restricted and unrestricted funds. In general, applications of funds will be presumed reasonable if the criteria identified in subsection (c) are satisfied and no patient revenues other than revenues generated through depreciation expense are required as sources of funds to finance capital expenditure related applications of funds.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-65. Interest, Operating Leases**

(a) Increases and decreases in interest expense from base year levels to budgeted levels will be deemed presumptively reasonable only if such changes are directly associated with any of the following:

- (1) Approved certificates of need;
- (2) Capital expenditure programs reviewed under section 19a-167g-64 of these regulations;
- (3) Increases and decreases in interest rates paid on current year borrowing levels.

(b) Changes in operating lease expense from current year levels to budgeted levels will be deemed presumptively reasonable only if such changes are either:

- (1) Directly associated with the amount of an approved certificate of need, or
- (2) Not in excess of current year operating lease expense (not including multi-year fixed payment leases) multiplied by the hospital's budget year inflation factor.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-66. Uncompensated Care Consisting of Bad Debts and Free Care.**

(a) Review of hospital policies. The commission may review the hospital's policies relating to uncompensated care. Such review may include, but shall not be limited to, a consideration of the following:

- (1) The number of medical assistance cases of the hospital; and



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- (2) The level of bad debt; and
  - (3) The level of free care; and
  - (4) The socioeconomic characteristics of the hospital service area such as the percent of the population receiving assistances under chapter 302 or 308 of the general statutes, the unemployment rate, and the number of uninsured, etc.
- (b) Filing requirements:
- (1) Each hospital shall insure that the commission has on file, a copy of its policies relating to free care and bad debts, which have been adopted by the hospital and are currently in effect.
  - (2) Each hospital shall file with the commission any amendments to its policies relating to free care and bad debts submitted pursuant to (1), above, within 30 days of the adoption of any such amendments.
- (c) Annual review.
- (1) Each hospital shall annually file, on forms to be provided by the commission, information regarding the amount of free care given as well as the total amount of bad debts written off during the previous year.
  - (2) The commission may annually review each hospital's level of uncompensated care, which includes free care and bad debts, to assure that an appropriate level of care is provided to the indigent and the uninsured and that appropriate collection efforts have taken place.
  - (3) The amounts used in the computation of reasonable free care pursuant to subsection (d) of this section associated with the provision of free care shall be limited to free care determined by the commission to be appropriate pursuant to (2), above.
- (d) For hospitals subject to detailed budget review, the presumptively reasonable test for free care and bad debts in the budget year shall be computed for each hospital as described below.
- (1) For the second and third year prior to the budget year, the amount of actual revenue deductions attributable to free care shall be divided by the actual non-government gross patient service revenue for the applicable year. For the year immediately

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preceding the budget year, the projected amount of revenue deductions attributable to free care shall be divided by the projected amount of non-government gross patient service revenue for the year. The projected amounts will be based on the actual amounts for the first six months of the applicable year and the projected amounts for the last six months of the applicable year. The hospital will file specific information to support the projections. The percentage obtained for the third year prior to the budget year will be multiplied times a factor of one (1), the percentage obtained for the second year prior to the budget year will be multiplied times a factor of one and one-half (1 1/2) and the percentage obtained for the year immediately preceding the budget year will be multiplied times a factor of two (2). The same process shall be followed to calculate bad debts.

- (2) The revenue amounts used to compute the numerators and the denominators in (1), above, shall include only those revenues related to patient care.
- (3) The sum of the products computed pursuant to (1), above, is obtained and divided by four and one-half (4 1/2). The resulting amounts for free care and bad debts shall be aggregated and shall be called the "adjusted average uncompensated care amount".
- (4) The commission will consider that a hospital's projections for free care and bad debts in the budget year are reasonable where a hospital's projections for free care and bad debts in the budget year do not exceed one hundred percent (100%) of the adjusted average uncompensated care amount computed in (3), above. The commission will consider that a hospital's projections for free care and bad debts in the budget year are not reasonable where a hospital's projections for free care and bad debts in the budget year exceed one hundred percent of the adjusted average uncompensated care amount computed in (3), above.
- (5) The hospital shall identify all available sources of funds other than patient revenue distinguishing between restricted funds specifically intended by the donor to finance free care and bad debts and unrestricted funds available to finance free care and bad debts. The presumptively reasonable uncompensated care shall be the reasonable amount of uncompensated care derived in (4), above, less all nonpatient sources of funding.

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- (6) Hospitals whose budget year projected uncompensated care amounts are not presumed reasonable shall have the opportunity to present evidence to demonstrate that such projections of uncompensated care are justified and/or that funds other than patient revenues specifically intended by the donor for this purpose as well as other available funds should not be applied to reduce the amount of patient revenues required to finance uncompensated care.
- (7) Each of the computations or reports specified in (1) through (5), above, shall be performed or reported by the hospital, as specified above, on forms to be provided by the commission, and shall be subject to verification.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-67. Medicare, Medical Assistance and CHAMPUS Shortfalls**

- (a) The amount of Medicare, medical assistance and CHAMPUS shortfalls presumed reasonable by the commission for the budget year shall be derived as follows:
- (1) Authorized budget year net revenue for all patient care services shall be calculated pursuant to sections 19a-167g-57, 19a-167g-58 or 19a-167g-59 as appropriate.
- (2) The amount of authorized budget year net patient revenue, (1) above, shall then be apportioned to payor classifications based on the percent of total itemized charges which served as the basis for the base year authorization as adjusted below, applicable to patients in that payor classification to gross revenues, i.e., total itemized charges for all patients. The payor classifications to which apportionments of net revenue shall be made are: Medicare; medical assistance; CHAMPUS; commercial insurance; Blue Cross/Blue Shield; no charge; uninsured (self pay); workers compensation; alternative delivery systems; other sources. In this calculation the charges applicable to Medicare patients shall beginning in fiscal year 1993, exclude fifty per cent (50%) of the charges associated with admissions that were denied by Medicare as inappropriate or days or services denied as not medically necessary, excluding claims pending under appeal. The calculation of the total charges applicable to Medicare excluding fifty per cent (50%)

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of the charges associated with admissions that were denied by Medicare as inappropriate or days or services denied as not medically necessary shall be done as follows:

- (A) The total charges applicable to Medicare in the base year shall be calculated pursuant to (B) and (C) below. The fifty per cent (50%) adjustment described in section 19a-167g-55(b) (50) (B) shall be applied where applicable.
  - (B) The total charges applicable to Medicare in the year prior to the base year excluding charges associated with admissions that were denied by Medicare as inappropriate or days or services denied as not medically necessary shall be divided by the total charges applicable to Medicare in the year prior to the base year including charges associated with admissions that were denied by Medicare as inappropriate or days or services denied as not medically necessary.
  - (C) The result of (B) shall be multiplied by the total Medicare charges which served as the basis for the base year authorization to obtain the estimated base year charges applicable to Medicare excluding charges associated with admissions that were denied by Medicare as inappropriate or services denied as not medically necessary.
- (3) The actual amount of payments to be received by the hospital from each of these payors for services rendered to patients treated at the hospital during the budget year shall be calculated as the base year authorized government payments, plus the projected increase in payments adjusted for changes in the equivalent discharges which served as the basis for the authorized budget for the base year to the budget year equivalent discharges calculated in section 19a-167g-57(f) for Medicare, CHAMPUS and medical assistance. The projected payments shall be calculated by multiplying the payment components which served as the basis for the base year authorization by the increase in payment rates or factors. The increase in payment rates shall be for Medicare and CHAMPUS the PPS update factors, as well as any other factors affecting hospital payment rates, as published in the Federal Register for the appropriate fiscal years, and for medical assistance the update factor for Medicare exempt hospitals or units, as published in the Federal Register for the appropriate fiscal year.

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- (4) The shortfall for Medicare, medical assistance and CHAMPUS for the budget year shall be the difference between the net revenue apportioned to each of these payors (item 2) less the amount of payments projected to be received by the hospital from each of these payors (item 3) divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, and nongovernmental contractual allowances. For purposes of exemption and for establishing the presumptively reasonable gross revenue level for hospitals undergoing detailed budget review, this proportion shall be based on the payor proportions which served as the basis in establishing the current year approved budget.
  - (5) The total amount of shortfall for the budget year as derived in (4), above, is then divided by the number of total equivalent discharges for the budget year. The resultant shortfall per equivalent discharge is the amount presumed reasonable for the budget year under detailed review and the amount used to calculate gross revenue from net revenue for exempt and partial review hospitals.
- (b) All hospitals shall provide the data identified in subsection (a). In addition, the following shall be submitted by the hospital:
- (1) The Medicare Cost Report for the fiscal year two years prior to the budget year and the audited Medicare Cost Report for the most recently available fiscal year.
  - (2) Other audit reports received by the hospital applicable to the period beginning two years prior to the budget year to date, not previously filed with the commission.

These reports as well as other pertinent information will be used to determine the amount of any adjustment necessary to reflect expenses incurred by the hospital for goods and/or services unrelated to patient care.  
**(Effective July 1, 1991.)**

**Sec. 19a-167g-68. Contractual Allowances**

- (a) Contractual allowances reported and projected pursuant to the projection methodology identified in subsections (b) and (c) of this section shall reflect discounts to non-governmental payers consistent with the discount

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agreements filed with the commission pursuant to section 19a-166 of the Connecticut General Statutes and section 19a-166-2(b) of the Regulations of Connecticut State Agencies. The discount percentages used shall be the amount in effect for the applicable reporting period and actual and projected charges and payments shall be provided for each payor receiving a discount.

(b) The average percentage of contractual allowances to total gross revenue for the budget year shall be calculated as follows:

(1) For each non-governmental payor receiving a discount pursuant to a discount agreement filed with the Commission, the percentage amount of the discount shall be multiplied by the proportion of charges projected for that payor for the budget year.

(2) The products resulting from (1) above shall be added, and the result divided by 100 to obtain the average percentage of contractual allowances to gross revenue for the budget year.

(c) The dollar amount of the non-governmental contractual allowances shall be calculated by multiplying the percentage calculated in (b)(2) above by the net revenue resulting from the calculation described in Sec. 19a-167g-57, 19a-167g-58 or 19a-167g-59 as appropriate. The resultant product shall then be divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, uncompensated care, non-governmental contractual allowances, workers compensation allowance, other allowance and self insurance allowance to determine the total amount of contractual allowances for the budget year. This proportion shall be based on the payor proportions which served as the basis in establishing the current year approved budget.

**(Effective July 1, 1991.)**

**Sec. 19a-167g-69. Reserved**

**Sec. 19a-167g-70. Reporting Requirements for Detailed Budget Review Hospitals**

(a) Hospitals subject to detailed budget review shall submit the information identified in sections 19a-167g-56 and 19a-167g-58, and sections 19a-167g-60 through 19a-167g-70 of these regulations. In addition, the hospital shall provide evidence to demonstrate the relationship of the

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proposed budget to each of the criteria identified in section 19a-153, C.G.S.

- (b) Budget year volume forecasts shall be determined in accordance with the methodology set forth in subsections (g) and (f) of section 19a-167g-57.  
**(Effective April 20, 1990.)**

**Sec. 19a-167g-71. Reserved**

**Sec. 19a-167g-72. Review Schedule**

The commission will attempt to comply with the following review schedule for the fiscal year 1991 and subsequent year reviews:

- (a) The commission shall issue the forms and instructions for exemption, partial budget review and detailed budget review by May 1, or four weeks after regulations applicable to the budget year are adopted, whichever is later.
- (b) Submission of information by hospital, suspension of review.
- (1) On or before the date established by sections 19a-167b(e) and 19a-167c(a) of the general statutes and by section 19a-167g-57(h) or by a date specified by the commission, any hospital required to obtain a budget authorization under sections 19a-167 to 19a-167k, inclusive, of the general statutes, for fiscal year 1991 or any subsequent year, whether through a full detailed review, a partial review or a review to establish revenue caps for those hospitals exempt from detailed review, shall submit all information required by sections 19a-167g-51 through 19a-167g-94, inclusive, in the form and manner prescribed by the commission.
- (2) If the commission for any reason is unable to proceed with this review schedule and issue a rate order before October 1, all rate orders or budget orders in effect the preceding September 30, shall continue in effect during the following rate or budget period until the commission issues a rate or budget order for the hospital for the new fiscal year or rate period or portion thereof. Whether or not the commission has issued a new rate or budget order for a hospital by September 30, the hospital shall bill patients discharged on or after October 1 exclusively

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on the basis of the individual detailed charges in conformance with the authorized pricemaster on file with the commission at that time.

(c) Completeness review.

- (1) On or before ten (10) business days after the date of the formal submission by the hospital of the required information, the commission shall notify the hospital of any missing or incomplete information. If the hospital makes more than one submission of information during the initial or any subsequent ten (10) day completeness review period, the completeness review period shall be extended to ten (10) business days from the last submission.
- (2) For purposes of calculating time periods under this regulation, the provisions of section 19a-160-53 shall apply and a budget submission shall not be formally before the commission until a complete submission has been received by the commission. If a hospital fails to submit all the information required under these regulations when due and in the form and manner prescribed, then in addition to any other remedy or penalty available to the commission under any statute or regulation, the process and schedule prescribed under this section may be suspended at the commission's discretion, until a complete submission is received by the commission. When a complete submission is received, the commission shall then commence its review in accordance with this section's schedule adjusted for the delay.
- (3) The failure of the commission to send a notification to a hospital that its submission is incomplete or missing within the ten (10) business day completeness period shall be deemed acceptance by the commission of the submission as complete.
- (4) The acceptance of a submission as complete by the commission is in no way a determination that a submission is accurate. The commission may at any time determine based on information it obtains that a submission is inaccurate.
- (5) Within ten (10) business days, unless otherwise required by the commission, hospitals must file information deemed missing or incomplete in any completeness letter. A hospital which files a timely response to an incompleteness letter shall still be subject to the civil penalty provisions of section 28



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of public act 89-371 for not initially filing a complete submission but such timely response to an incompleteness may be considered by the commission to be a mitigating factor.

(d) Exemption from detailed budget review determination.

- (1) On July 1 if a hospital has filed a complete submission on or before June 1, or on or before thirty (30) business days after the filing of a complete request for exemption from detailed budget review, the commission shall issue a decision as to whether or not a hospital has qualified for exemption from detailed budget review.
- (2) If a hospital is found not to qualify for exemption from detailed budget review, the hospital shall submit all the information required under section 19a-167g-51 through 19a-167g-94 for a detailed review ten (10) business days from the date of the commission decision, provided that if a hospital is required by section 3(f) of public act 89-371 to achieve the exempt revenue caps, the commission shall issue its authorization without detailed review.
- (3) Any request for reconsideration of the commission's determination under this subsection must be filed within fifteen calendar days of the commission's decision and must specify the error which requires reconsideration. If the commission decides to reconsider its decision based on a claimed error, it shall proceed in a reasonable time to conduct such additional proceedings as may be necessary to render a decision modifying, affirming or reversing its decision.

(e) Partial review determination:

- (1) On or before thirty (30) business days after the filing of a complete submission for partial budget review the commission shall issue a decision as to whether or not all or any portion of the hospital's request for a single item adjustment has been granted and whether the hospital is otherwise found to qualify for exemption from detailed budget review.
- (2) If a partial review hospital is found not to qualify for exemption from detailed budget review for a reason other than the requested single-item adjustment, the hospital shall submit all the information required under sections 19a-167g-51 through 19a-167g-94 for a detailed review ten (10)

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business days from the date of the commission decision.

- (f) The hearings for hospitals subject to detailed budget review shall be scheduled within 30 days from a complete filing. The commission shall issue its decision on such a hearing within ten (10) business days of completion of the hearing.
- (g) The commission and the parties may by mutual agreement modify the timeframes for hearings included in this section.
- (h) If the forms and instructions are issued on May 1 and complete information is filed on June 1, then the schedule described above would be as follows:

|                                    |                       |
|------------------------------------|-----------------------|
| Issue forms and instructions       | May 1                 |
| Submission of budgets by hospitals | June 1 If             |
| budgets are complete, then,        |                       |
| Partial review authorizations:     | June 1*               |
| * plus 30 business days.           |                       |
| Exempt authorizations              | July 1                |
| Detailed review hearings:          | August 1-September 15 |
| Decisions on detailed reviews:     | September 15          |

**(Effective July 1, 1991.)**

**Sec. 19a-167g-73. Hearings**

- (a) Detailed budget hearing procedures.
  - (1) Upon a determination that a hospital has submitted all the information required for a detailed budget review, in the form and manner prescribed by the commission, the commission shall schedule a public hearing on the proposed budget. Such hearing shall be scheduled as described in section 19a-167g-72 and may be continued as necessary until all issues have been addressed. Hospitals shall be immediately notified, i.e., within twenty-four (24) hours or one business day, by facsimile machine, or telephone and certified mail, of the scheduling of the hearing. Within three (3) business days of the scheduling of a hearing, notice of the initial session shall be given any person requesting party status by certified mail and the public by notice to a newspaper having a substantial circulation in the area served by the hospital. Such notice shall contain the date, time, and place of the hearing. In addition, such notice shall specify the date by which the hospital and

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other participants in the proceeding are to prefile testimony.

- (2) The commission shall make the written findings required under section 19a-153 of the general statutes within the time frame as described in section 19a-167g-72. The commission shall approve, modify or deny the hospital's request for additional revenue in writing.
  - (3) Within three (3) business days of the commission's final decision, the commission shall notify the hospital of its decision by certified mail and the public by notice to a newspaper having a substantial circulation in the area served by the hospital.
- (b) Second level review for partial review hospitals: Upon receipt of a request for review of the commission's decision regarding a single item adjustment from a partial review hospital, the commission may schedule a public hearing to consider whether to grant the review. If the commission grants a request for second-level review the commission shall schedule a public hearing. Such hearing shall be scheduled within thirty (30) days of the date upon which the commission receives the request for second-level review, and may be continued as necessary until all issues relating to the single item adjustment have been addressed. Within three (3) business days of the scheduling of a hearing, notice of the initial session shall be given the hospital and any person requesting party status by certified mail and the public by notice to a newspaper having a substantial circulation in the area served by the hospital. Such notice shall contain the date, time, and place of the hearing. A review under the second level review procedure is not intended as a reconsideration as used in the Uniform Administrative Procedure Act.
- (c) Designation of parties, intervenors, and interested persons. Participation at hearings shall be as follows:
- (1) Interested persons may participate in detailed budget hearings or partial budget review hearings and submit relevant information to the commission. An interested person means any member of the public or representative group who may be affected by any increase in a hospital's budget or who has relevant information to present to the commission. An interested person may participate as a party, intervenor or an informal participant pursuant to section 19a-160-32.

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- (2) All requests for party status or intervenor status shall be in writing. An original and five copies shall be filed at the commission's office at least five (5) business days prior to the scheduled beginning of the public hearing. Any person seeking party or intervenor status shall also mail such request to all parties at that same time. The request for intervenor status must state facts that demonstrate that the petitioner's participation is in the interests of justice and will not impair the orderly conduct of the proceedings. In all other respects, such written request for intervenor status and written requests for party status shall conform to the requirements of sections 19a-160-29 through 19a-160-31 of the commission's regulations.
- (3) Testimony submitted by any participant at the hearing shall be under oath if oral and adopted under oath if written.
- (4) Persons not named as parties or intervenors may, in the discretion of the presiding officer, be given an opportunity to present oral or written statements pursuant to section 19a-160-32.

**(Effective April 20, 1990.)**

**Secs. 19a-167g-74 -- 19a-167g-80 Reserved.**

**Sec. 19a-167g-81. Interim Adjustments**

- (a) Each hospital subject to the provisions of sections 19a-167 to 19a-167k, inclusive, of the general statutes, shall be required to comply with the revenue caps authorized by the commission. All interim adjustments authorized pursuant to sections 19a-167 to 19a-167k, inclusive, of the general statutes, shall be made pursuant to the provisions of this section. If in the course of the budget year, unforeseeable and material changes occur, the hospital should request adjustment of its previously authorized revenue caps pursuant to the provisions of this section. If no interim adjustment is requested during the fiscal year in question for an unforeseeable and material event as described in subsection (b)(2), the hospital will be presumed to have waived any such adjustment for purposes of section 19a-167g-82. If an unbundling in the performance or billing of a service occurs, the hospital shall request adjustment of its previously authorized revenue caps pursuant to this section.

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(b) As used in this section, unforeseeable and material is defined to include:

(1) Adjustments, other than for inflation, to the hospital's authorization as a result of the commission's approval or modification of an application submitted pursuant to Connecticut General Statutes sections 19a-154 or 19a-155.

(2) Increases or decreases which represent more than one percent (1%) of the hospital's total authorized net revenues other than for inflation, attributable to:

(A) Acts of God;

(B) Compliance with any federal, state or local laws, statutes, ordinances, regulations passed or enforced after submission of the hospital's budget. In particular, upon publication of the Federal Register containing the final budget year update factors and adjustments for both PPS and PPS-exempt hospitals and units for the budget year, the commission shall recalculate the hospital's gross revenue cap using these final published factors. As part of this recalculation, the commission shall determine whether the hospital's total net revenue using the final published factors results in an increase or decrease in the hospital's total net revenue of 1% or more relative to the authorized net revenue. If the final Medicare rates using these factors result in an increase in the hospital's total net revenue of 1% or more, relative to the authorized net revenue, the hospital's gross revenue cap and attendant pricemaster percentage increase shall be subject to an interim adjustment pursuant to this section of the regulations. If the final Medicare rates using these factors result in a decrease in the hospital's total net revenue of 1% or more, relative to the authorized gross revenue, upon receiving a request by the hospital, the hospital's gross revenue cap and attendant pricemaster increase shall also be subject to an interim adjustment.

(C) Disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources and not known at the time of the budget authorization;

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- (D) The correcting of deficiency citations issued for failure to comply with mandated government requirements related to hospital licensure and participation in programs pursuant to 42 U.S.C. section 395, et seq. and unknown to the hospital at the time of its budget authorization.
- (3) Any other increase or decrease in the financial requirements which served as the basis for the hospital's authorized revenue caps determined by the commission to be unforeseeable and material except for changes in volume as defined in section 19a-167g-62 of these regulations.
- (c) Any request for such budget adjustment due to unforeseen and material changes shall include:
- (1) The intended date of implementation;
  - (2) An explanation of the alterations in the revenue caps that the hospital proposes or is required to place in effect during the current fiscal year, including supporting detail set forth in relation to the cost or revenue center affected;
  - (3) An explanation of the increases or decreases in rates and charges that the hospital proposes or is required to make effective upon adoption of the proposed revised revenue caps for the current fiscal year;
  - (4) All pertinent statistical or other data that the applicant or the commission deems necessary to support the request.
- The applicant shall provide information concerning each of the above and information identified in section 19a-153, C.G.S.
- (d) Such requests to adjust approved authorizations must be filed with the commission no later than seventy-five (75) days prior to the intended date of the implementation of the proposed or required revisions. For good cause shown the commission may waive the 75 day advance filing requirement.
- (e) All requests pursuant to this section shall be evaluated for reasonableness by applying these regulations and the criteria set forth in section 19a-153, C.G.S.
- (f) Upon receipt of a complete request for an interim adjustment, or upon a determination by the commission that an adjustment may be necessary, the commission shall

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give notice of the proposed adjustment by placing a notice of the proposed adjustment on the agenda of a regularly scheduled commission meeting and by also notifying interested persons who have requested such notice in writing for that fiscal year. The commission shall also announce receipt of said request at that commission meeting.

- (1) A hearing on a proposed interim adjustment shall be held within forty-five (45) days of the commission's receipt of a complete proposal for an interim adjustment. Hearings held by the commission pursuant to this provision shall be conducted in accordance with the commission's Rules of Practice. Participation by interested persons shall be consistent with the standards provided by sections 19a-160-29 through 19a-160-33 of the commission's regulations.
- (2) The commission may waive the hearing provision of this subsection if it
  - (A) Places a notice of its intent to waive on the agenda of a regularly scheduled commission meeting, and
  - (B) Receives no written objection to the waiver by the close of business five (5) business days after the date of the meeting.
- (3) The commission shall render its decision based on the evidence and testimony presented, if any, and may consider any proposed final decision submitted by a hearing officer, presiding officer or designated commissioner. The commission shall issue its decision within ten (10) business days of completion of the hearing. The commission may for cause modify the timeframes established in this subsection.
- (4) No later than fifteen (15) days after receipt of the final decision, the hospital must submit to the commission a revised pricemaster in the form and manner prescribed in sections 19a-167g-90 and 19a-167g-57(h) (8) of these regulations.

**(Effective July 1, 1991.)**

**Sec. 19a-167g-81a. Unbundling**

- (a) As used in this section, an unbundling in the performance or billing of a service or the termination of a service is defined to include the value of any service:

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- (1) performed by a hospital in the base year but performed by an affiliate of a hospital, during any portion of the budget year, or
  - (2) billed by the hospital in the base year and billed by another health care provider for any portion of the budget year, or
  - (3) discontinued by the hospital during any portion of the budget year.
- (b) If during the budget year, an unbundling in the performance or billing or termination of a service occurs, the hospital shall report such change to the commission immediately and request adjustment of its previously authorized revenue caps and pricemaster. For purposes of this subsection, immediately shall mean that a hospital shall advise the commission as soon as the information is known but in no event later than the close of the business day following the date of the unbundling.
- (c) The commission may require a hospital to submit, within 15 days of the commission's notice of such requirement, such additional information as will allow the commission to determine the amount of the adjustment to be made to the revenue caps and to the pricemaster.
- (d) If the commission has reason to believe that an unreported unbundling has occurred, the commission may require a hospital to submit within 30 days such information as the commission deems necessary to determine whether a service was performed by an affiliate or billed by another provider.
- (e) Any adjustment ordered by the commission as a result of the unbundling shall be retroactive to the date of the unbundling.
- (f) A hospital which fails to report an unbundling in the performance or billing of a service as defined in subsection (a)(1) or (2), or fails to file any other information requested by the commission under subsections (b), (c) or (d) shall be subject to a civil penalty in accordance with section 6 of public act 89-371.

An unbundling as defined in subsection (a) may also require prior approval under C.G.S., 19a-154.  
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**Sec. 19a-167g-82. Compliance**

The following section shall be used to calculate compliance with budget and/or rate orders authorized for fiscal year 1990 and subsequent fiscal years, and the provisions of this section shall supersede the provisions of section 19a-167g-32 of the fiscal 1990 budget review regulations.

- (a) Compliance with the commission's authorized gross revenue and net revenue caps per equivalent discharge for exempt hospitals, partial review hospitals and detailed review hospitals, may be monitored for the budget year pursuant to the provisions of these regulations or pursuant to C.G.S., section 19a-149.

A final compliance determination for the budget year will be made based on the audited financial statements and cost reports of the hospital filed pursuant to section 19a-167g-91 of these regulations. This final compliance determination shall assess whether the hospital exceeded its authorized revenue caps.

- (b) Final compliance adjustments for exempt, partial review, and detailed budget review hospitals will be based on audited data required to be filed with the commission on or before February 28 of the fiscal year subsequent to the year for which compliance is being calculated, pursuant to section 19a-167g-91. The amounts of the compliance adjustments shall be calculated as follows:

- (1) The approved gross revenue per equivalent discharge shall be compared with the actual gross revenue per equivalent discharge. The amount of any overcharge shall be calculated as the amount that the actual gross revenue per equivalent discharge exceeds for non-governmental payors the approved gross revenue per equivalent discharge for non-governmental payors times the number of equivalent discharges for non-governmental payors in the year for which compliance is being calculated.
- (2) The approved net revenue per equivalent discharge shall be compared with the actual net revenue per equivalent discharge. The amount of any overcharge shall be calculated as the amount that the actual net revenue per equivalent discharge exceeds the approved net revenue per equivalent discharge times the number of equivalent discharges in the year for which compliance is being calculated.

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- (3) The result of (2) above shall be converted to gross revenue by multiplying by the approved ratio of gross revenue to net revenue for the year for which compliance is being calculated.
- (4) The compliance adjustment to gross revenue shall be the greater of the amount calculated in (1) above divided by the proportion of non-governmental charges projected for the budget year, and the amount calculated in (3) above. This amount shall be subtracted from the authorized gross revenue for the subsequent year.
- (5) The compliance adjustment to net revenue shall be the result of (4) above divided by the ratio of gross revenue to net revenue for the budget year. This amount shall be subtracted from the authorized net revenue for the budget year.

The amount of the gross revenue compliance adjustment calculated in (4) above, shall automatically result in both a reduction in its authorized gross revenue cap for the fiscal year two years subsequent to the year for which compliance is being calculated, and an attendant reduction in the pricemaster percentage increase associated with the budget authorization. The amount of the net revenue compliance adjustment calculated in (5) above, shall automatically result in a reduction in its authorized net revenue cap, for the fiscal year two years subsequent to the year for which compliance is being calculated. The amount by which a hospital exceeded its gross and/or net revenue authorization for the fiscal year commencing October 1, 1989, shall be applied in its entirety as a reduction of the fiscal year 1992 authorization. No adjustments shall be made to the fiscal year 1991 or subsequent year authorization or to the base for the fiscal year 1991 or subsequent year review for amounts by which a hospital was at or below the authorized revenue caps.

- (c) For the FY 1991 budget year, the commission shall adjust the gross revenue cap, the net revenue cap and the related pricemaster percentage increase to reflect the impact of FY 1989 enforcement as determined pursuant to section 19a-165q-43 except that, the impact of FY 1989 enforcement shall be limited to the FY 1989 total dollar amount of overcharges only. The adjustment shall not include or reflect undercharges. For inpatient service areas overcharges are based on non-governmental data only; the overcharge will be applied to the budget year to assure that non-governmental charges are reduced by

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the amount of the non-government overcharge which occurred in FY 1989.

- (d) The payor advisory board shall study and make recommendations to the commission with respect to changes in the regulations to provide greater incentives to hospitals to become more efficient. This shall include but not limited to changes in compliance provisions to ensure that hospitals are not penalized for improved collection policies.  
**(Effective July 1, 1991.)**

**Secs. 19a-167g-83 -- 19a-167g-89. Reserved.**

**Sec. 19a-167g-90. Filing of Pricemaster Data.**

- (a) By June 1 prior to fiscal year 1991 and each year thereafter, each hospital exempt from detailed budget review will file a copy of its proposed budget year pricemaster with the commission.
- (b) Budget year pricemasters must contain:
- (1) each individual base year charge, unannualized, approved by and on file with the commission; and
  - (2) each individual proposed budget year charge.
- (c) Proposed budget year charges must be derived from individual base year charges as prescribed in subdivision 19a-167g-57(h)(8) of these regulations.
- (d) These pricemasters must be filed on floppy disk in a machine-readable format acceptable to the commission as specified in (e), below.
- (e) For data submitted on floppy disk, floppy disks must be either 5.25 inch, double-sided, double-density floppy disks or 3.5 inch double-sided, double-density, double-track, 135-tracks-per-inch floppy disks. They must be formatted using IBM DOS version 3.0 or higher, or a DOS version which is compatible with IBM DOS version 3.0 or higher, on a high or low density disk drive. Disks should be clearly marked with the hospital name, the contents of the disk, and the type of drive on which it was formatted. The data contained on these disks must be written in standard ASCII code. Data should be arrayed in a M x N matrix, with M columns and N rows. Individual columns should contain distinct data elements for all priced items. Individual rows (or "records") should

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contain the values of the data elements for individual items. The standard length of all records should be eighty (80) characters or bytes.

- (f) If a hospital cannot submit its pricemasters in the format described in (e), above, for a budget year then the hospital must file a proposed format for its pricemaster submission before June 1 prior to the budget year. This proposed format must contain enough detailed technical information so that the commission may determine whether it has the resources to read the data submitted in a cost-effective and timely manner. The proposed format must contain at least the following information:

- (1) the type of medium on which the data is to be submitted;
- (2) the formatting specifications of the medium;
- (3) the type of code(s) used to encode the data on the medium;
- (4) the way in which the data is arrayed on the medium;  
and
- (5) the size of the data array.

The commission will notify the hospital within five (5) business days as to whether the hospital's proposed format for the submission of the pricemaster data is acceptable. If the proposed format is not acceptable, the hospital is responsible for the submission of the pricemaster data on the required medium and in the required format.

- (g) To facilitate submission of the pricemasters, a hospital shall not be prohibited from filing all the data in its pricemasters; however, the following data elements must be filed:

- (1) an item code number which uniquely identifies each item on the pricemaster;
- (2) an item description which uniquely describes each item on the pricemaster;
- (3) two item prices for each line item which equal:
  - (A) the base year charge, which is the charge appearing on the pricemaster filed with the commission for the base fiscal year

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- (B) the proposed budget year charge, which is derived from the base year charge specified in (1), above, according to the method prescribed in subdivision (8), subsection (h), section 19a-167g-57 of these regulations.
- (h) Accompanying the data submission, hospitals must also submit a full written description of the data submitted. This description must include, at minimum, the name and description of the data elements submitted, a schedule detailing how individual proposed budget year charges were derived from their corresponding base year charges, the total number of priced items submitted, a description of those items which are new or have changed from the base year to the budget year; the location of individual data elements on an item record; the dates, actual or proposed, during which the pricemasters will be in effect; and a hard copy of the pricemaster.
- (i) Implementation of increases in individual detailed charges identified in a hospital's pricemaster shall not be authorized in situations where a hospital has not complied with the provisions of this section.

**(Effective April 20, 1990.)**

**Sec. 19a-167g-91. Annual Reporting To The Commission.**

- (a) Applicability: Each hospital and any other health care facility or institution which is subject to the provisions of section 19a-156 or sections 19a-167 to 19a-167g, inclusive, of the general statutes, shall report with respect to its operations in the prior fiscal year by February 28th of each year in such form as the commission may require.
- (b) Content of annual report: The annual report shall consist of:
- (1) Financial statements and all related schedules and footnotes which have been audited and certified to by an independent auditor or auditing firm for the most recently completed fiscal year for the hospital and each of its affiliates, including consolidated financial statements;
  - (2) The Medicare Cost Report for the most recently completed fiscal year as filed and any final audited Medicare Cost Reports for prior years which have not been previously submitted to the commission;

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- (3) The most recent internal chart of organization for the facility, duly dated;
- (4) The most recent legal chart of corporate structure for the facility, duly dated;
- (5) The complete audited Connecticut Hospital Association (CHA) Cost Report for the most recently completed fiscal year including all allocations of indirect expenses, or a comparable report acceptable to the commission;
- (6) A listing of capital expenditures as defined in section 19a-167g-52 of the commission's regulations for the most recently completed fiscal year distinguishing between capital expenditures requiring authorization pursuant to section 19a-154 or section 19a-155 of the general statutes, and all other capital expenditures;
- (7) For the hospital and each affiliate, including the hospital's parent or holding company and related entities:
  - (A) Articles of Incorporation and Charter, if applicable, in effect as of the filing date,
  - (B) Bylaws in effect as of the filing date,
  - (C) List of current officers and directors;
- (8) A report which identifies by purpose, specific restrictions on ending fund balances of the hospital and each affiliate as of the close of the most recently completed fiscal year, distinguishing between donor restrictions and board restrictions, as well as the amount of fund balance which is unrestricted;
- (9) A report which describes all transactions between the hospital and affiliates during the most recently completed fiscal year including, but not limited to, the amount of any transfers of funds, transfers of assets, and sales/purchases of services or commodities between affiliates;
- (10) A report which describes all expenditures incurred by affiliates for the benefit of the hospital, e.g., subsidized housing for staff, during the most recently completed fiscal year, and the amount of any such expenditures;

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- (11) A report which indentifies all commitments or endorsements entered into by the hospital for the benefit of affiliates;
- (12) Number of discharges and related number of patient days by town of origin, based on zip codes, and diagnostic category for the most recently completed fiscal year accounting for 100 percent of total discharges and related patient days;
- (13) Average length of stay and length of stay range by diagnostic category, age grouping and expected payor source;
- (14) Total number of discharges to home, to home health agency, another hospital, a skilled nursing facility, an intermediate care facility and all others;
- (15) Inpatient surgical procedures by diagnosis, principal surgical procedure and age grouping with related number of cases and patient days;
- (16) Number of total licensed beds and distribution of such beds by service, e.g., adult medical and surgical, maternity, pediatrics, newborn, psychiatric inpatient, rehabilitation, etc.;
- (17) Average number of staffed beds by service;
- (18) Average percent occupancy by service based on licensed bed distribution, (16) above, and staffed beds, (17) above; (An explanation of the derivation of patient days by service should be included, e.g., aggregation of midnight census counts for the fiscal year.)
- (19) Outpatient surgical procedures including ambulatory surgery by principal surgical procedure and age grouping with related number of cases; for purposes of this section ambulatory surgery is defined as surgical admissions discharged prior to the midnight census on the day of admission after having undergone a surgical procedure requiring the use of a fully equipped operating room, i.e. one equipped to administer general anesthesia, whether or not the patient is admitted to a discrete ambulatory/same day surgery unit;
- (20) All information concerning compliance required pursuant to section 19a-167g-82 of these regulations;

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- (21) Case mix and revenue support schedules in a format acceptable to the commission; (Case mix shall be reported by identifying the number of discharges in each diagnostic category. A hospital's case mix index shall be derived by dividing the aggregate total case mix adjusted discharges by the actual number of discharges for the fiscal year. The aggregate total case mix adjusted discharges shall be derived by multiplying the number of discharges in each diagnostic category by the Medicare weights in effect for the applicable fiscal year and aggregating the resultant products of each diagnostic category. Revenue support schedules shall include identification of gross charges by payor classification for each diagnostic category and shall indicate and quantify the factors comprising each category such as payor classification, service area and, through FY 1989, outlier payments.)
- (22) Information concerning uncompensated care and policies related to uncompensated care; (Each hospital shall annually file, on forms to be provided by the commission, information regarding the amount of free care given as well as the total charges for bad debts written off during the previous year.)
- (23) A report identifying all donations and funds which are or have been restricted for the care of indigent patients at the end of the previously completed fiscal year. (The report shall include, but is not limited to, information which identifies the principal balance and all earned income for the previous year, as well as, projected interest income expected to be earned during the current fiscal year.)
- (24) A report identifying the average salaries in each department of administrative personnel, supervisory personnel, and direct service personnel by job classification.

For purposes of this section, administrative personnel shall include all persons from the chief executive officer to department heads; supervisory personnel includes any one who supervises and doesn't provide direct care or service to patients; direct service personnel includes anyone who provides direct care or service to patients. Any personnel who come under more than one category shall have their costs prorated according to the portion of time spent in each category.



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For purposes of this report, departments shall include but not be limited to the following:

- (A) Routine Service Departments:
  - (1) Adult Medical and surgical routine services;
  - (2) Intensive care units;
  - (3) Coronary care units;
  - (4) Newborn intensive care units;
  - (5) Other intensive care units;
  - (6) Psychaitric inpatient routine services;
  - (7) Rehabilitation inpatient routine services;
  - (8) Maternity routine services;
  - (9) Newborn, well and sick.
  
- (B) Special Service Departments:
  - (1) Operating and recovery room;
  - (2) Delivery and labor room;
  - (3) Diagnostic radiology (includes CT scanning);
  - (4) MRI scanning;
  - (5) PET scanning;
  - (6) Radioisotopes/nuclear medicine laboratory;
  - (7) Physical medicine;
  - (8) Respiratory therapy;
  - (9) Intravenous therapy;
  - (10) Pharmacy;
  - (11) Medical supplies;
  - (12) Emergency Room.
  
- (C) General Service Departments:
  - (1) General administration;

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- (2) General accounting and other administrative service departments;
  - (3) Dietary and pay cafeteria;
  - (4) Housekeeping;
  - (5) Laundry and linen;
  - (6) Operation of plant and repairs and maintenance;
  - (7) Medical records;
  - (8) Social services.
- (D) Other hospital cost centers; list individually.
- (25) Salaries and fringe benefits for the ten highest paid positions in the hospital. Fringe benefits shall include all the value of all forms of compensation whether actual or deferred, made to or on behalf of any employee whether full or part-time. Fringe benefits shall include but not be limited to:
- (A) The cost to the hospital of all health, life, disability or other insurance or benefit plans;
  - (B) The cost of any employer payments or liability to employee retirement plans or programs;
  - (C) The cost or value of any bonus or incentive or longevity plans which are not included under normal salary reporting guidelines;
  - (D) The cost or value of any housing, whether in the form of a house, apartment, condominium, dormitory or room of any type, whether full-time or only available for part-time use, if subsidized in full or in part by the hospital and not located directly within a hospital building offering direct patient care.
  - (E) The fair market value of any office space, furnishings, telephone service, support service staff, support service equipment, billing or collection services or similar benefit provided to any person for use when seeing non-hospital or private patients or clients. This value shall be prorated based on the total number of hospital and non-hospital patient billing units or

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provider man-hours involved. For purposes of this subparagraph, if both hospital and non-hospital clients are served from the same location, hospital patients are defined as patients who are billed directly by the hospital for the service provided and for whom the hospital retains the full payment received as part of its gross operating revenue.

- (F) The fair market value of the cost or subsidy of the use of any automobile, transportation tickets or passes, free or reduced parking, travel expenses, hotel accommodations, etc.
  - (G) Any items of value available to employees and not specifically listed above.
- (26) A report containing:
- (A) The name of each joint venture, partnership and corporation related to the hospital;
  - (B) The name and address of the chief executive officer of each entity listed under this subdivision;
  - (C) The name and address of the Connecticut agent for service of each entity listed under this subdivision; and
  - (D) A brief description of what the entity is, does or is proposed to do and how it interacts with or is related to the hospital.
- (27) A report containing the salaries and the fair market value of any fringe benefits as described in (25), above, paid to hospital employees by each such joint venture, partnership and related corporation, either directly or indirectly, and by the hospital to the employees of such related entities. Indirect payments include but are not limited to payments made to related entities. For purposes of this section, a hospital employee is anyone who provides a service which incurs an expense for the hospital.
- (28) A report containing a breakdown of total hospital and department budgets by administrative, supervisory and direct service categories, by total salary and fringe benefit dollars and by full-time equivalent staff. For purposes of this report, type of category

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and department are defined as in (24) and fringe benefit is defined as in (25), above.

(c) Any facility wishing a partial waiver for information required to be filed by an affiliate must request such a waiver from the commission at least thirty (30) days prior to the date of the required submission. Such a request must include the following items:

- (1) A chart of organization showing all affiliates and lines of control and of interrelationships;
- (2) The name, address, title and telephone number of the President or Chief Executive Officer of each affiliate;
- (3) A list of each affiliate for which a waiver of further informational filings, and specifically what filing and when it is due, is sought;
- (4) A statement signed under penalty of false statement by the Chief Executive Officer of the Connecticut health care facility for each facility listed in (3) which states that the affiliate for which the waiver is sought:
  - (A) Does not direct or control the Connecticut facility seeking the waiver; and
  - (B) Does not do business with or share facilities, finances, personnel or services with the Connecticut health care facility; and
  - (C) Is not located in Connecticut and does not do business in Connecticut; or
  - (D) An explanation of why the affiliate should be given a waiver of some or all of the filing requirements even though (A), (B), or (C) above do not apply. Such an explanation shall include details of the extent to which (A), (B) and/or (C) do apply.

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**Sec. 19a-167g-92. Reserved**

**Sec. 19a-167g-93 Pool/Demonstration Project -  
Disproportionate Share Hospitals**

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The following section shall be used to develop an uncompensated care pool\demonstration project for fiscal year 1991 and subsequent fiscal years and the provisions of this section shall supersede the provisions of section 19a-167g-43 of the fiscal 1990 budget review regulations.

(a) General:

The commission may establish a pilot (demonstration) program involving the three short-term acute care hospitals located in Hartford with an objective to redistribute uncompensated care (bad debts and free care) and undercompensated care (shortfalls) costs among all participating hospitals to equalize charges. Absent a pooling arrangement, patients treated at hospitals with a greater share of CHAMPUS, Medicare, medical assistance, and uninsured patients disproportionately assume a greater share of the uncompensated and undercompensated care cost of a particular service area than patients treated at other area hospitals.

(b) Requests.

(1) A hospital which wishes to request that the commission establish an uncompensated and undercompensated care pool shall do so by filing, in writing at the commission's office, such request. The hospital shall demonstrate that its current share of uncompensated and undercompensated care patients, negatively impacts on current operations as a result of disparities in the rates charged by the hospital and that the disparity is directly attributed to the effects of the disproportionate number of patients eligible for CHAMPUS, Medicare, medical assistance and uninsured patients. The request shall identify all hospitals that may be included in the uncompensated and undercompensated pool demonstration. In addition all requirements under subsection (c) of this section shall apply.

(2) If a request is filed in accordance with the provisions of subdivision (1), above, the commission may hold a hearing within ten (10) business days after receipt of all information required under subsection (c) of these regulations, and said hearing will include all hospitals identified as participating hospitals.

(c) Information required by all participating hospitals shall include, but not be limited to the following:

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- (1) The amount of CHAMPUS, Medicare, medical assistance and uninsured patients' shortfall, as defined in the commission's regulations,
  - (2) Case mix adjusted discharges, by payor,
  - (3) Actual and projected discharge data, by payor class,
  - (4) Gross and net revenue by payor class,
  - (5) Rate per equivalent discharge by payor class, and
  - (6) Actual and projected number of full-time equivalent employees and salary expenses, by department.
- (d) Hearing.
- If a hearing is to be held, notice of the date, place and time of the hearing shall be sent to the participating hospitals and to the public by publication in a newspaper having a substantial circulation in the area served by the hospitals. Such notice will be given within three (3) business days of the scheduling of the hearing. In addition the notice shall specify the date by which information required under subsection (c) of this regulation shall be prefiled with the commission.
- (e) The commission shall allow area hospitals, participating in an uncompensated and undercompensated pool to add a specific surcharge to the detailed charge for room and board per patient day of the hospitals who will participate in funding the pool. This surcharge may have a separate identification in the detailed charge price master. The surcharge will be accounted for by calculating the actual private patient days times the surcharge. This amount shall be submitted monthly to the hospital identified as having a disproportionate share of the area's CHAMPUS, Medicare, medical assistance and uninsured patients.
- (1) The hospital receiving the pool funds shall provide a segregated, interest bearing account, to which deposits can be made and from which only commission authorized withdrawals can be made. No commingling of these funds with any other funds of any hospital shall be allowed. Copies of the activity from the financial entity controlling such account will be provided to the commission monthly, within 15 days of the end of the previous month. In addition, the following information shall be provided:
    - (A) information related to discussions with other area hospitals or entities regarding a more

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efficient and cost effective delivery of health care services to the area population and,

- (B) information related to discussions with federal, state and local governmental agencies, regarding efforts to improve payments received for services rendered to patients who are beneficiaries of programs administered by those agencies, and
  - (C) information on any planning and actual implementation of hospital expense reductions segregated between system wide (reduction of expenses to health care system) and hospital (reduction of hospital expenses which will be incurred by another health care entity), and
  - (D) projected target dates, to implement cost effective changes, as a result of the planning and discussions, as previously outlined.
- (2) The hospitals contributing to the pool funds shall provide to the commission monthly, by the 15th of the following month, the number of nongovernmental patient days for which room and board has been charged by the hospitals, times the surcharge, as may be identified in the detailed charge price master, to calculate the fund contribution. The hospitals shall in addition identify the date by which this monthly fund contribution has been transferred to the receiving hospital's segregated account.
- (f) The surcharge will be derived by the components of free care, bad debts, and shortfall for each participating hospital in the uncompensated and undercompensated pool.
  - (g) The pilot (demonstration) program, as previously described, shall terminate at the end of one year, or sooner, as specified by the commission's order.
- (Effective April 20, 1990.)**

**Sec. 19a-167g-94. The uniform reporting of discharge abstract and billing data.**

For the purpose of sections 3, 4, 5, 8, 12, 18, and 29 of public act 89-371, and section 11 of public act 90-134, the following section shall be used to report discharge abstract and billing data in fiscal year 1991 and thereafter. The provisions of this section shall supersede the provisions of 19a-165q-2 of the integrated prospective payment system regulations.

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(a) Definitions. For the purpose of this section and except as otherwise noted, the following words and phrases are defined below:

- (1) "Agent" means a person or entity which has entered into an agreement or contract with the commission to perform administrative, processing, management, analytical, evaluative, or other related services with the data collected pursuant to this section.
- (2) "Current hospitalization" or "hospitalization being recorded" refers to that episode of hospitalization defined by the patient's admission and discharge dates and the medical record number and patient control number associated with that episode. All the data being submitted by the hospital concerning the patient's hospitalization relate to this episode of hospitalization.
- (3) "Discharge" is defined according to subdivision 19a-167g-55(b) (22).
- (4) "Patient identification" means the unique designation or number assigned to each patient within a hospital that distinguishes by itself the medical record of an individual patient from the medical record of all other patients in that institution.
- (5) "Patient control number" means the unique designation or number assigned by the hospital to each patient's individual hospitalization that distinguishes by itself the medical and billing records of that hospitalization.
- (6) "Date of birth" means the month, day, and year on which the patient whose hospitalization is being recorded was born.
- (7) "Date of admission" means the month, day, and year on which the patient whose hospitalization is being recorded was admitted to the hospital.
- (8) "Date of discharge" means the month, day, and year on which the patient whose hospitalization is being recorded was discharged from the hospital.
- (9) "Sex" means a designation of the patient as:

| <u>designation</u> | <u>code</u> |
|--------------------|-------------|
| (A) Male           | = M         |



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- (B) Female = F
- (C) Not determined = U

The category "not determined" may only be used in rare instances where the sex of the patient either has not been or cannot be determined at the time of discharge.

- (10) "Zip code" means the zip code of the post office where the patient customarily receives mail. If the patient resides outside the United States or its territories, the zip code shall be "99998."
- (11) "Race" means a designation of the patient according to the categories listed below. For the purpose of reporting this information to the commission as part of this data set, each category is assigned the numeric codes listed below:

| CATEGORY                         | CODE |
|----------------------------------|------|
| (A) White                        | = 1  |
| (B) Black                        | = 2  |
| (C) American Indian/Eskimo/Aleut | = 3  |
| (D) Hawaiian/Pacific Islander    | = 4  |
| (E) Asian                        | = 5  |
| (F) Other Non-white              | = 6  |
| (G) Unknown                      | = 0  |

- (12) "Ethnicity" refers to the patient's cultural origin. The patient must be classified into one of the categories of ethnicity listed below. For the purpose of reporting this information to the commission as part of this data set, each ethnic category is assigned the numeric codes listed below:

| CATEGORY                            | CODE |
|-------------------------------------|------|
| (A) Spanish origin/Hispanic         | = 1  |
| (B) Non-Spanish origin/Non-Hispanic | = 2  |

- (13) "Previous admission" refers to the length of time between the date of admission for the hospitalization being recorded and the date of discharge for the

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patient's most recent previous inpatient hospitalization. For the purpose of reporting this information to the commission as part of this data set, the categories of previous admission are assigned the numeric codes listed below:

| CATEGORY                                | CODE |
|---|------|
| (A) Less than 31 days                   | = 1  |
| (B) More than 30 but less than 61 days  | = 2  |
| (C) More than 60 but less than 91 days  | = 3  |
| (D) More than 90 but less than 181 days | = 4  |
| (E) More than 180 days                  | = 5  |
| (F) No previous hospitalization         | = 6  |
| (G) Unknown                             | = 7  |

- (14) "Hospital ID code" refers to the last four digits of the hospital's Medicare provider number for the unit from which the patient was discharged for the hospitalization being recorded.
- (15) "Attending practitioner" means the physician, surgeon, homeopath, dentist, podiatrist, chiropractor, osteopath, or psychologist who was primarily responsible for the patient's care during the hospitalization being recorded. The attending practitioner will be designated by the hospital using the unique code established pursuant to subsection (e) of this section.
- (16) "Operating practitioner" means the physician, surgeon, homeopath, dentist, podiatrist, chiropractor, osteopath, or psychologist who performed the principal procedure during the hospitalization being recorded. The operating practitioner will be designated by the hospital using the unique code established pursuant to subsection (e) of this section.
- (17) "Principal diagnosis and secondary diagnoses" refer to diagnoses that affect the hospitalization being recorded.
- (A) "Principal diagnosis" refers to the condition which is established after study to be chiefly

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responsible for the admission of the patient to the hospital.

- (B) "Secondary diagnoses" refers to those conditions, exclusive of the principal diagnosis, which exist at the time of the patient's admission or which develop subsequently to the admission and which affect the patient's treatment or length of stay for the hospitalization being recorded. Diagnoses which are associated with an earlier hospitalization and which have no bearing on the current hospitalization shall not be recorded as secondary diagnoses.

(18) Procedures and procedure days.

- (A) "Procedure" means a significant procedure that is surgical in nature; carries a procedural or anesthetic risk; or requires specialized training or special facilities or equipment.

- (B) "Procedure day" refers to the day on which the procedure was performed. The procedure day equals the number of days after the admission date on which the procedure was performed. If the procedure was performed on the date of admission, then the procedure day = 0.

- (C) "Principal procedure" means that procedure most closely related to the principal diagnosis which is performed for the definitive treatment of the patient.

(i) The principal procedure cannot be a procedure which has been performed for a diagnostic or exploratory purpose only or to resolve a complication, unless these are the only types of procedures performed on the patient during the hospitalization being recorded.

(ii) "Complication" is defined in this section as any diagnosis other than the principal diagnosis.

- (D) "Other procedures" means other significant procedures in addition to the principal procedure. These are to be reported with the procedure day on which the procedure was performed.

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(19) "Admission status" describes the circumstances associated with the patient's admission and will be limited to the following:

| circumstance                                   | code |
|--|------|
| (A) Physician Referral                         | 1    |
| (B) Clinic Referral                            | 2    |
| (C) HMO Referral                               | 3    |
| (D) Transfer from a Hospital                   | 4    |
| (E) Transfer from a Skilled nursing facility   | 5    |
| (F) Transfer from another health care facility | 6    |
| (G) Emergency room                             | 7    |
| (H) Court/law enforcement                      | 8    |
| (I) Newborn                                    | 9    |

(20) "Discharge status" means a designation associated with the circumstances of the patient's discharge and will be limited to the following:

| designation                                      | code |
|--|------|
| (A) Home   | 01   |
| (B) Transferred to another short term hospital   | 02   |
| (C) Transferred to a skilled nursing facility    | 03   |
| (D) Transferred to an intermediate care facility | 04   |
| (E) Transferred to another type of institution   | 05   |
| (F) Discharged to home health service            | 06   |
| (G) Left against medical advice                  | 07   |
| (H) Expired                                      | 20   |

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- (21) "Expected principal source of payment" means that payment source that was expected at the time the data set was completed to provide the primary share of the payment for the hospitalization being recorded. These sources will be limited to the following:

| payment source                   | code |
|----------------------------------|------|
| (A) Self pay                     | A    |
| (B) Worker's Compensation        | B    |
| (C) Medicare                     | C    |
| (D) Medicaid                     | D    |
| (E) Other Federal Program        | E    |
| (F) Commercial Insurance Company | F    |
| (G) Blue Cross                   | G    |
| (H) CHAMPUS                      | H    |
| (I) Other                        | I    |
| (J) Title V                      | Q    |
| (K) No Charge                    | R    |
| (L) HMO                          | S    |
| (M) PPO                          | T    |

- (22) "CHAMPUS" is defined in 19a-167g-55(b) (13).
- (23) "Title V" means the Maternal and Child Health Services Block Grant as provided under Title V of the Social Security Act.
- (24) "HMO" and "PPO" refer to alternative delivery systems and are defined in 19a-167g-55(b) (3).
- (25) "Birthweight" means the weight in grams of a newborn infant recorded at birth. This value must be coded if the admission status is newborn.
- (26) "Total revenue center charges" means the total charges appearing on the patient's bill. This amount should correspond to revenue code "001" on a standard UB-82 bill.

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- (27) A "group of revenue data elements" means an individual, distinct revenue code and its corresponding units of service and charges for the hospitalization being recorded. One group of revenue data elements consists of the revenue center code, its units of service, and its total charges.
- (28) "UB-82 data" refers to those uniform billing data elements generated by hospitals for the purpose of billing hospital charges to patients for services rendered after September 30, 1984. These data elements are contained on a "UB-82 form" which is that version of the Uniform Hospital Billing Form promulgated by the National Uniform Billing Committee, established by the American Hospital Association, as from time to time amended. The UB-82 form has also been adopted as Health Care Financing Administration (HCFA) Form 1450 pursuant to Sections 1814(a) (1) and 1871 of the federal Social Security Act.
- (29) "Discharge abstract" refers to those items of medical and demographic information which are normally available in the patient's medical record and which may be abstracted from that medical record as data elements. The discharge abstract for the hospitalization being recorded summarizes the important clinical features of that patient's hospitalization. For the purpose of this section, the items of medical and demographic information referred to by the term "discharge abstract data" are data elements numbered 4, 6-12, 14-15, 17-18 on record type 2, items numbered 4, 6-14 on record type 3, and items numbered 4, 6-8, 10-11, 13-14, 16-17, 19-20, and 22-23 on record type 4 of subsection (h) (8), below. Some of these items may also be found on the patient's UB-82 billing form. These data elements may also be part of the UB-82 data.
- (30) A "test tape" is defined as the submission of a sample of a hospital's discharge abstract and billing data set as part of the initial submission of data pursuant to subsection (b) (5) or for the purpose of testing technical changes made by the hospital which affect the submission of its discharge abstract and billing data set on computer tape. The test tape shall conform exactly to all the technical specifications provided for in this section. The sample of the data set contained on a hospital's test tape shall not exceed one-twelfth (1/12) of that hospital's total discharges for fiscal year 1989.

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(31) Reports.

- (A) A "report" is defined as data or information extracted or prepared from the data collected under this section or section 19a-165q-2 of the commission's regulations. This includes data derived from other sources when such data are combined with the data collected under this section. The report may be presented in any form, either on paper or contained in computer-accessible files on- or off-line on magnetic media, such as magnetic tapes, disks, or drums.
- (B) If a report, either by itself or in combination with another report, can identify an individual patient or practitioner either by personal identification code, by name, or by a combination of data elements, then it will be considered "confidential."
- (C) If a report, either by itself or in combination with another report, cannot identify an individual patient or practitioner either by personal identification code, by name, or by a combination of data elements, then it will be considered "nonconfidential."

(32) "Data element" means an individual category of data taken from a discharge's medical record or hospital bill (UB-82 data). Data elements to be filed pursuant to this section are prescribed in subsection (h) (9), and, when appropriate, are defined in subsection (a).

(33) "Data record" refers to a 282-byte array of a computer file containing data elements specific to a hospital or to individual discharges from a hospital. Six types of data records shall be filed by a hospital pursuant to this section. They are referred to as data record type 1 through data record type 6. These data record types are described in subsections (h) (4) and (h) (9).

(34) "Data set" refers to the complete set of data records filed by a hospital for a reporting period. The data set shall contain the discharge abstract and billing data for each individual discharged from that hospital during the reporting period. The data set shall be composed of one header record (data record type 1), one trailer record (data record type 6) for each hospital, and a group of data records (data record types 2 through 5, inclusive) for each

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individual discharged from that hospital. These data records shall include the data elements prescribed in subsection (h) (9).

- (35) "Payer identification" means the code number or the payer name which identifies the payer organization from which the hospital expects at the time of discharge some payment for the bill. Up to three payer organizations shall be reported in order of their expected contributions to the payment of the hospital bill.
- (36) "Estimated responsibility" means the amount estimated by the hospital at the time of discharge to be paid by the indicated payer.
- (37) "Deductible" means that amount estimated by the hospital at the time of discharge to be applied to the patient's deductible amount for the indicated payer.
- (38) "Coinsurance" means that amount estimated by the hospital at the time of discharge to be applied to the patient's coinsurance amount for the indicated payer.
- (39) A "report cell" means the intersection of a row and column of data elements in a report.
- (b) Filing Requirements and Filing Periods.
- (1) Before the end of each calendar quarter after September 30, 1990, each hospital shall file with the commission or its agent a complete discharge abstract and billing data set, as specified in subsection (h).
- (2) This data set shall contain the data records for each individual discharged from that hospital during the preceding calendar quarter. The data set for a calendar quarter shall be filed prior to the end of the calendar quarter following the calendar quarter in which the discharges whose data are contained therein occurred. For example, the data set to be filed before March 31, 1991, shall contain the data records for each individual discharged from that hospital from October 1, 1990, until December 31, 1990. Nothing in this section is intended to alter the data filing requirements of section 19a-167g-42. Data for the calendar quarter July 1, 1990 through September 30, 1990 continues to be due the commission under section 19a-167g-42.



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- (3) For its first submission pursuant to this section, the hospital shall file a test tape pursuant to subsection (b) (5).
- (4) Ninety (90) days prior to the end of the filing periods specified in subsection (b) (1), the commission shall notify the hospital of any supplemental instructions for submission of the hospital discharge abstract and billing data set.
- (5) Submission of test tapes.
  - (A) The initial submission of discharge abstract and billing data sets under this section is due before April 1, 1991. As part of that submission, a hospital shall submit a test tape for its data set. Thereafter, when a change in the instructions or specifications for the submission of the hospital discharge abstract and billing data set occurs which requires a modification of the submission format of the data set, hospitals may submit up to three test tapes to verify that they have implemented the format changes correctly.
  - (B) The first test tape must be submitted within ninety (90) days following the first day of the fiscal quarter in which the specification changes are required to be initiated.
  - (C) The commission's agent will process the test tapes upon receipt, accept or reject the test tapes based upon their conformance to the specifications required, and notify each hospital or their designated data vendor with a written evaluation of each test tape.
  - (D) If a hospital's test tape is accepted by the agent, no additional test tapes will be processed by the agent for that hospital. If the hospital's test tape is rejected by the agent, the hospital shall submit a revised test tape for reevaluation within fifteen (15) business days of the hospital's or data vendor's receipt of the agent's evaluation of its rejected test tape.
  - (E) The submission of test tapes does not, in itself, exempt a hospital from the filing requirements of subsections (b) (1) and (b) (2).
  - (F) A hospital will not be considered to have violated the provisions of subsection (b) (2) if

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it has adhered to the testing schedule described in subsections (b) (5) (B) through (b) (5) (D) and has not submitted more than three test tapes.

- (G) If any hospital requests the submission of a test tape for any reason other than those specified in (b) (5) (A), or if a hospital is required to submit more than three test tapes for any filing period, then the cost of processing the additional test tapes shall be borne by the hospital.
- (6) Exemptions to the filing requirements.
- (A) A hospital may be granted a partial, temporary exemption from filing those data elements specified in (6) (F) if the data elements cannot be provided to the commission in a timely manner by the hospital.
- (B) The commission shall grant an exemption provided the hospital applies for it and the commission finds that the application demonstrates sufficient grounds for the exemption.
- (C) Specifically, if the hospital is not collecting the specified data elements on or about October 1, 1990, and cannot begin collecting them on that date due to computer software or data collection forms which do not provide for their collection, and the hospital's application sufficiently supports this claim, then the hospital shall be granted a partial exemption for those data elements until such time as the commission deems appropriate.
- (D) The application for exemption shall contain at least the following materials:
- (i) A statement of which data elements cannot be provided in a timely manner and why they cannot be provided.
  - (ii) Samples of the hospital's discharge abstract and UB-82 data element collection forms or other data element collection instruments with effective dates on or about October 1, 1990.
  - (iii) Sworn statements from the hospital's data processing vendor(s) and/or data processing manager stating that the hospital cannot

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provide the data elements to the commission in a timely manner and why it cannot.

- (iv) The earliest date on which the hospital expects to provide the data elements to the commission.
- (v) Any other supporting documentation considered relevant to the hospital's application by the hospital or the commission.
- (E) The exemption shall be partial and until such time as the commission determines is reasonably required for the hospital to comply.
- (F) The following data elements may be exempted from the filing requirements of this section until such date as the commission may deem appropriate, but no later than October 1, 1991: ethnicity, previous admission, secondary diagnosis 5, secondary diagnosis 6, secondary diagnosis 7, secondary diagnosis 8, secondary diagnosis 9, other procedure 5, other procedure 5 day, other procedure 6, other procedure 6 day, other procedure 7, other procedure 7 day, other procedure 8, other procedure 8 day, other procedure 9, other procedure 9 day, birthweight, payer identification 1, payer identification 2, payer identification 3. In addition, the data element race may be partially exempted, so that a hospital which receives such an exemption shall be required to collect that data element as required by the regulations in effect during fiscal year 1990.
- (G) The following data elements shall be exempted from the filing requirements of this section until October 1, 1991: estimated responsibility 1, deductible 1, coinsurance 1, estimated responsibility 2, deductible 2, coinsurance 2, estimated responsibility 3, deductible 3, and coinsurance 3.
- (H) Hospitals not granted an exemption by the commission shall begin gathering the specified data elements in their required formats, as prescribed in subsections (a) and (h), on October 1, 1990, for initial submission to the commission on April 1, 1991.

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- (7) Hospitals may request an extension of the filing periods in this section pursuant to section 19a-160-16 of the commission's regulations.
- (c) Billing data. As provided in subsection (h), the hospital shall report the detailed charges for each discharge in a group of data records that are already merged with the discharge abstract data elements. The charges shall be reported in detail, itemized by individual three-digit UB-82 revenue code in a manner consistent with the reporting of the charge data elements on the UB-82 form.
- (d) Standards for data; notification; response.
- (1) Each discharge abstract and billing data set submitted by a hospital for patients discharged after September 30, 1990, shall be evaluated by the commission or its agent according to the following standards:
- (A) For each data set submitted by a hospital, the values or codes for any data element within an individual discharge's data records shall be valid values or codes or contained within valid ranges of values for the data element. Invalid codes or values will be rejected as errors. Data elements and their valid values or codes are specified in subsections (a) and (h). Invalid codes are specified in subsection (h)(10).
- (B) Those data elements which are related to other data elements within an individual discharge's data records must be internally consistent in substantive content or they will be rejected as errors. Edits to be applied for consistency are specified in subsection (h)(11).
- (C) Coding values indicating "data not available", "data unknown", or any other such value or term indicating that the valid code, value, or range of values for particular data elements is not available will not be accepted for individual data items. Submission of such values for data elements will be rejected as errors.
- (D) Any discharge which is assigned to DRG 469 or 470 after grouping by the version of the Medicare grouper valid for the period in which the patient is discharged shall be rejected as an error. The hospital shall review the medical record for such discharge and modify the discharge data set

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accordingly so that the discharge is correctly assigned to a DRG other than 469 or 470.

- (2) Upon completion of this evaluation, the commission or its agent shall promptly notify each hospital whose data sets do not satisfy the standards for any filing period. This notification shall identify the discharge abstract or billing data elements for any discharge which are in error, suspected of being in error, or otherwise do not satisfy the standards.
    - (A) This notification will specify the problematic data elements.
    - (B) Error documentation and correction procedures will be provided to each hospital with each notification.
  - (3) Each hospital notified pursuant to subsection (d)(2) shall make the changes necessary to correct the errors and satisfy the standards and submit these changes to the commission or its agent within 30 days of the notification.
- (e) Central registry for practitioner codes.
- (1) All practitioners who provide services at a hospital within the state must be registered with the commission by means of a central registry.
  - (2) The registry will contain the practitioner's name, address, birthdate, state health department license number, any other information as may be required by the commission to uniquely distinguish the practitioner from any other practitioner providing services in the state, and an identification number which uniquely distinguishes the practitioner from any other practitioner providing services in the state.
  - (3) The commission designates the Connecticut Health Care Provider Billing Identification System (CHCPBIS) to be the central registry specified in subsection (1), above, and the CHCPBIS provider code number to be the identification number which the hospitals shall use for the attending and operating practitioner data elements described in (a)(15) and (a)(16), respectively. As designee, the CHCPBIS shall provide the information specified in subsection (e)(2) to the commission on a regular and timely basis.

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- (4) Should the designee cease to maintain this registry or fail to provide the specified information to the commission on a regular and timely basis, the commission shall declare the designation made in subsection (3) void. In this case, the identification number provided by the hospitals for the attending and operating practitioner data elements should be that practitioner code required by the Health Care Financing Administration (HCFA) in its administration of the Medicare Program.
- (5) Should HCFA cease to require a unique practitioner identifier for the Medicare program, then each hospital shall be responsible for providing the commission or its agent with the practitioner's name, current address, birthdate, and state health department license number or such other information as may be required by the commission to uniquely distinguish each practitioner from any other practitioner providing services in the state as new practitioners begin providing services to the hospital. Upon receipt of this information, the commission or its agent will assign each practitioner his or her own unique identification number.
- (f) Noncompliance.
- (1) Except as specified in subsection (f) (2), the failure to file, report or correct the discharge abstract or billing data sets according to the provisions of this section shall be considered a violation of public act 89-371 and these regulations. Any hospital determined by the commission to have violated the provisions of this section shall be subject to the provisions of Section 19a-160-120 of the commission's regulations and any other remedies or penalties available to the commission.
- (2) A hospital which files discharge abstract and billing data sets which do not satisfy the standards under subsection (d) of this section shall not be considered in violation of these regulations if:
- (A) the hospital corrects all such data sets as specified in subsection (d) (3) of this section; or
- (B) the number of individual discharges whose data records fail to meet the standards for the filing period does not exceed one percent of the total number of individual discharges required to be filed in that period.

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(g) Maintenance of confidentiality.

- (1) Only such data as are relevant and necessary to implement public acts 89-371 and 90-134 will be collected by the commission.
- (2) All data collected under this section of these regulations will be maintained accurately and diligently.
- (3) Only such members of the commission, its attorney, agents, or their employees who have a specific need to review discharge and billing data collected pursuant to this section or confidential reports prepared from such data will be entitled to access to such data or reports.
- (4) The commission, its attorney, agents, or their employees who are involved in the administration, management, processing, analysis, or other use of the discharge abstract and billing data shall not make public any confidential reports.
- (5) The following data elements are confidential and shall not be released to the public: patient identification number, patient control number, date of birth, date of admission, date of discharge, attending practitioner, and operating practitioner.
- (6) Notwithstanding the provision of subsection (g) (4), nonconfidential reports from which individual patient and practitioner data cannot be identified shall be made available to the public.
- (7) Data elements and suppression thresholds for nonconfidential reports.
  - (A) To create a nonconfidential report, the following data elements collected under this section will be replaced by substitute data elements which have been modified for purposes of confidentiality as follows:
    - (i) Birthdate will be replaced by age group. Age groups shall contain age ranges of no less than five years and must be compatible with those released by the U.S. Census Bureau. All ages greater than 90 years will be included in the same group.

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- (ii) Date of discharge will be replaced by fiscal quarter and year of discharge.
  - (iii) Admission date and discharge date will be replaced by average length of stay in aggregate reports and length of stay in other nonconfidential reports.
  - (iv) Zip code will be replaced by an aggregation of zip codes composed of at least two contiguous zip codes and subject to the provisions of subsection (7) (B).
  - (v) Birthweight will be replaced by birthweight group. Each birthweight group shall contain birthweight ranges of no less than 500 grams. These ranges must end in even hundred grams (e.g. 2,001-2,500 grams).
  - (vi) Payer identification will be aggregated to only those payer categories specified in subsection (a) (21), expected Principal Source of Payment.
  - (vii) All billing data elements related to patient charges will be replaced by the corresponding average charges in aggregate reports.
- (B) Thresholds for data suppression for nonconfidential reports.
- (i) Except for average length of stay and average charges, a nonconfidential, aggregated report shall not contain information or data based on fewer than six individual patients, as defined by the patient identification number, in a single report cell. In the case of average length of stay and average charges, if the average is based on fewer than six patients, the number of patients upon which it is based will not be released.
  - (ii) Except for average length of stay and average charges, a nonconfidential, aggregated report shall not contain information or data based on fewer than two individual practitioners, as defined by the attending or operating practitioner codes, in a single report cell.
  - (iii) An aggregated report shall not contain the payer data elements "estimated responsibility," "deductible," and



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"coinsurance" if the values of these data elements are based on fewer than two individual payers, as defined by the payer identification codes, in a single report cell.

- (iv) Any nonaggregated report which contains data elements by discharge shall not contain the data element "hospital code," and shall contain a substitute for the data element "zip code." This substitute shall be composed of an aggregation of zip codes equivalent to the health service areas created pursuant to the National Health Planning and Resources Development Act, Public Law 93-641.
- (C) Combinations of all other data elements not restricted by subsections (g) (4), (g) (5), and (g) (7) may be released in nonconfidential reports.
- (8) Procedures for requesting, producing, and releasing nonconfidential reports.
  - (A) All reports under consideration by the commission for public release shall be considered confidential until determined to be nonconfidential by the process described in this subsection.
  - (B) Requests for any data collected under this section must be made in writing to the chairman of the commission. The request shall contain a list of the data elements being sought, a detailed description of the content and organization of any report and an example of the report's layout showing how the data will be organized and presented. It shall also contain a statement by the requestor confirming that the request conforms to the confidentiality provisions of this subsection.
  - (C) A designated commissioner shall review the request and respond within four business days as follows:
    - (i) A request which seeks data elements deemed confidential by subsection (g) (7) (A) or which does not meet the thresholds of subsection (g) (7) (B) shall be denied within four (4) business days.

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- | \_\_\_\_\_ (ii) A request for data from which it can be readily determined from the face of the request that an individual patient or physician cannot be identified and that the request conforms to (g) (7) (A) and (g) (7) (B) will be approved for preparation. The requestor will be notified of such approval within four (4) business days. The requestor shall assume the cost of preparing a requested report not already in existence. Such cost may be required to be paid in whole or in part prior to the preparation of the report.
- (iii) A request for data from which it cannot be readily determined whether an individual patient or physician can be identified or whether the request conforms to (g) (7) (A) and (g) (7) (B) will be subjected to the procedure set forth in (E) below prior to a determination by a commissioner that the request will be approved for preparation. The requestor shall be notified within four (4) business days that the request will undergo such a procedure.
- (D) All requests for data will be publicly noticed as an addendum to the commission's calendar. This notice will contain the name of the requestor and the general nature of the request. If the request identifies the data as that of an individually identified hospital, the commission will notify the hospital at this time that a request for data collected pursuant to this section has been filed. Any person may obtain a copy of such request on application to the commission. Any person may raise concerns about whether the requested report conforms to the confidentiality requirements of this subsection but the raising of any concerns shall not toll any determination by a designated commissioner whether to approve or deny a request except as set forth in (E) below.
- (E) for requests which fall under subsection (g) (8) (C) (iii), any person may raise concerns about whether the requested report conforms to the confidentiality requirements of this subsection provided he or she does so in writing within ten (10) business days of the public notice given under (D). Any concerns will be

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considered by the designated commissioner before the request is approved for preparation.

- (i) A designated commissioner shall review such request. If the commissioner determines that such request conforms to the confidentiality requirements of this subsection, the request may be approved for preparation. The requestor shall assume the cost of preparing a requested report not already in existence. Such cost may be required to be paid in whole or in part prior to the preparation of the report.
- (F) When prepared, a copy of the report will be reviewed by the designated commissioner for conformity to the confidentiality requirements of this subsection. If the report conforms to these requirements, it shall be authorized for release.
- (G) The commission retains ownership rights to all data used in the report and will retain a copy of the final report. Nonconfidential reports approved for release will thereafter be available for copying by members of the public other than the original requestor.
- (H) The commission will maintain a record of all approved requests for reports. The record will be available to the public on request. This record will contain the name of the person or party making the request, the nature of the request, and the date the request was approved for release.
- (I) The commission reserves the right to refuse any request for a report which could threaten the confidentiality of an individual patient or practitioner.
- (9) The commission shall ensure that any contract into which it enters with an agent using confidential data collected under this section shall contain provisions requiring the agent to comply with the provisions of this subsection. The commission, not its agent, is the sole owner of the data collected under this section. No agent may release any data or report whatsoever, whether confidential or not, to any person or party, unless authorized in writing by the commission in accordance with this section.
- (10) Security of the discharge abstract and billing data.

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- (A) The commission shall ensure that steps are taken to control access to any confidential data collected under this section or reports developed from these data. These steps shall include the use of information systems software and other security procedures designed to protect against unauthorized access. These security procedures shall be available to the public.
  - (B) Any agent of the commission must provide a detailed description of its data security provisions and the policies and procedures it will employ to ensure the security and confidentiality of the data collected under this section.
  - (C) To the greatest extent practicable, confidential reports maintained at the commission will be kept in controlled access areas. Confidential reports will be kept in locked files when not in use. Confidential reports maintained on the commission's computer system will be stored in limited-access directories. Documents containing confidential reports will be clearly labeled as confidential.
- (11) The commission, its attorney, agents, and any of their employees who are involved in the collection, maintenance, analysis, or other use of the discharge abstract and billing data, will be informed of the policies and procedures contained in subsections (g)(1) through (g)(10) regarding the maintenance and use of these data.
- (h) Specifications for the submission of the discharge abstract and billing data sets.
- (1) Each hospital shall file with the commission or its agent a complete discharge abstract and billing data set on magnetic computer tape containing data records for each patient discharged from the hospital after September 30, 1990. The data records for each discharge shall contain complete discharge abstract and billing data for all the data elements specified in subsection (h)(9). When reported, the discharge abstract and billing data elements for each discharge shall already be merged into a single set of data records for that discharge, as prescribed in subsections (h)(2)(A) through (h)(2)(C).
  - (2) The organization of data records within a data set.

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- (A) For each discharge, the data elements to be filed shall be contained on one type 2 data record, one type 3 data record, one type 4 data record, and one or more type 5 data records. This means that multiple data records shall be filed for each discharge.
  - (B) The type 2 data record shall contain the discharge's demographic information. The type 3 data record shall contain the discharge's diagnostic information. The type 4 data record shall contain the discharge's procedural information. The type 5 data record(s) shall contain the discharge's revenue or billing information.
  - (C) All record types for an individual discharge shall follow one another immediately in sequence beginning with the type 2 data record for that discharge. Each discharge must have one type 2 data record followed by one type 3 data record, one type 4 data record, and at least one type 5 data record, in that order. For data record type 5, the sequence number shall reflect the order of appearance of type 5 records for an individual discharge.
  - (D) A type 1 data record must never immediately follow another type 1 data record. A type 2 data record for a given discharge must never immediately follow a type 2 data record for a different discharge.
  - (E) Each hospital shall submit a single header data record, data record type 1, and a single trailer data record, data record type 6, which will enclose the data records for all discharges contained in any submission, if more than one hospital's data set is submitted on a single tape, each hospital's data set shall be delimited by its own type 1 and type 6 data records.
- (3) Rules for coding revenue data elements.
- (A) The billing (or revenue) data elements shall be reported in a manner consistent with the reporting of UB-82 revenue data elements. Each revenue code for which the discharge has accrued charges must be reported along with the total charges corresponding to that revenue code. For each revenue code between 020 through 219,

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inclusive, for which the discharge has accrued charges, units of service corresponding to that revenue code must be reported.

- (B) Revenue codes shall be reported to the third digit. Each charge must correspond to a valid UB-82 revenue code. Revenue codes must be acceptable values in the range between 020-999, inclusive, that appear in the UB-82 billing manual, maintained by the Connecticut UB-82 billing committee. Total units of service and total charges corresponding to the individual revenue codes for the hospitalization being recorded are to be reported as they are reported on the UB-82 form.
  - (C) Each type 5 data record can hold up to 18 groups of revenue data elements (i.e. revenue code, units of service by revenue code, and charges by revenue code). No blanks shall occur prior to the end of the last group of data elements for the last revenue code. Unused space for revenue data elements in the last or only type 5 data record must be zero filled.
  - (D) There shall be only one occurrence of a unique revenue code on each discharge's set of type 5 data records. This means that charges and units must be aggregated to the revenue code level.
- (4) Rules for diagnosis and procedure coding.
- (A) Principal and secondary diagnoses shall be recorded according to the conventions governing the coding of diagnoses contained in the most current version of the International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM").
  - (B) Diagnoses shall be coded in the most specific category available for that diagnosis at the time of discharge. A diagnosis may not be assigned a less specific code if a more specific code is available for that diagnosis.
  - (C) The diagnosis codes must be legitimate, lowest-level, ICD-9-CM codes with decimal points omitted. Diagnosis codes shall be entered as a 5-digit code even though there may only be 3 or 4 significant digits. Decimal points are to be implied, not explicit. This means that all digits in the code must be entered, including

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leading and trailing zeros. If the lowest-level code for a diagnosis has only three or four significant digits, including leading and trailing zeros, blanks must be entered in positions 4 and/or 5 if necessary.

- (D) The first four secondary diagnoses recorded shall be consistent with those contained on the discharge's UB-82 bill for the hospitalization being recorded. The remaining five diagnoses shall be taken from either the discharge's UB-82 bill or the discharge abstract. If, for the hospitalization being recorded, a discharge has nine or more unique secondary diagnoses on either the UB-82 bill or the discharge abstract, then the hospital must report nine secondary diagnoses on the data record. If a discharge has fewer than nine unique secondary diagnoses on both the UB-82 bill and the discharge abstract, then the unused space reserved for the additional diagnoses shall be blank filled.
- (E) The reporting of procedure codes shall follow the same rules as those outlined for diagnosis codes in (A) through (C), above, except that the procedure codes shall be entered as a 4-digit instead of a 5-digit code. Procedure codes shall be entered as a 4-digit code even though there may only be 2 or 3 significant digits. The codes entered must be legitimate lowest level ICD-9-CM codes except that decimal points are to be implied, not explicit. This means that leading and trailing zeros must be entered and blanks must be entered in positions 3 and/or 4 if necessary. Other procedure fields are to be blank filled if not applicable.
- (F) The first two other procedures shall be consistent with those contained on the discharge's UB-82 bill for the hospitalization being recorded. The remaining seven procedures shall be taken from either the discharge's UB-82 bill or the discharge abstract.
- (G) If a discharge has nine or more unique other procedures on either the UB-82 bill or the discharge abstract for the hospitalization being recorded, then the hospital must report nine other procedures on the data record. If a discharge has fewer than nine other procedures on both the UB-82 bill and the discharge abstract for the hospitalization being recorded, then the

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unused space reserved for the additional procedures shall be blank filled.

- (H) For each procedure reported, the day on which the procedure was performed relative to the day of admission must also be reported. Procedures performed on day of admission shall reflect a procedure day of "000." Procedure day fields are to be blank filled if no corresponding procedure is recorded.
- (I) If a procedure has been reported to diagnose or treat a complication, as defined in subsection (a)(12)(B)(ii), then the complication must be reported as a secondary diagnosis.
- (5) Regarding the coding of admission status, if the discharge was admitted through the emergency room after having been transferred from any other health care facility, then this admission may not be coded as an emergency room admission.
- (6) Regarding the coding of payer identification, follow UB-82 instructions for completing the data field specified in (h)(9), including the use of the three-digit carrier code if the primary payer is a commercial carrier. Precede the three digit code by two zeros to completely fill the five-character, alpha-numeric field. Enter the expected primary payer as payer identification 1, and other payers as payer identification 2 and payer identification 3.
- (7) Regarding the coding of estimated responsibility, deductible, and coinsurance, follow UB-82 instructions for completing these data fields for each payer identification. Enter the values of these data elements for the expected primary payer as estimated responsibility 1, deductible 1, and coinsurance 1, respectively, and the values of these data elements for other payers as estimated responsibility 2, deductible 2, and coinsurance 2, and estimated responsibility 3, deductible 3, and coinsurance 3, respectively.
- (8) Magnetic Tape Specifications.
- | <u>(A) Characteristics</u> | <u>Specifications</u> |
|----------------------------|-----------------------|
| 1. Number of tracks        | 9 track               |
| 2. Parity                  | Odd                   |



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|                      |                                     |
|----------------------|-------------------------------------|
| 3. Label type        | OS Standard Labels or<br>Nonlabeled |
| 4. Density           | 1,600 BPI or 6,250 BPI              |
| 5. Character Code    | EBCDIC                              |
| 6. Record Format     | Fixed-Length, Fixed-<br>Blocked     |
| 7. Record Length     | 282 bytes                           |
| 8. Records per Block | 113                                 |
| 9. Block Size        | 31,866 Bytes                        |

(B) The logical data record length shall be 282 and the blocking factor shall be equal to 113. Therefore, the blocksize equals 31,866.

(C) The submission of a magnetic tape requires a Standard Tape Submittal Form, in all cases.

(D) The standard tape submittal form, which must always be used, must be supplemented by an attached document, as applicable, which clearly identifies the tape contents as to the reporting period submitted for each hospital.

(E) Each tape can contain data sets from one or more hospitals as long as each hospital's data records are preceded by a Header Data Record (data record type 1) and followed by a Trailer Data Record (data record type 6), as specified in subsections (h)(2) and (H)(9). The hospital data set can include data from one or more quarters within one fiscal year; data from multiple fiscal years cannot be mixed on one tape.

(9) Record layout and format.

| #     | Data Element Description | Format | Bytes | Start | Stop | Reference | #Instruction |
|-------|--------------------------|--------|-------|-------|------|-----------|--------------|
| ----- |                          |        |       |       |      |           |              |

**Data Record Type 1: Data Set Header Record**

|   |                       |      |   |   |   |    |    |
|---|-----------------------|------|---|---|---|----|----|
| 1 | Record Type Indicator | 9(2) | 2 | 1 | 2 | -- | 8  |
| 2 | FILLER                | X(2) | 2 | 3 | 4 | -- | -- |

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|   |                   |        |     |    |     |             |     |
|---|-------------------|--------|-----|----|-----|-------------|-----|
| 3 | Hospital ID code  | X(4)   | 4   | 5  | 8   | Definitions | 1,3 |
| 4 | Hospital Name     | X(40)  | 40  | 9  | 48  | --          | 1,3 |
| 5 | Processing Date   | 9(8)   | 8   | 49 | 56  | --          | 7   |
| 6 | Period Start Date | 9(8)   | 8   | 57 | 64  | --          | 7   |
| 7 | Period End Date   | 9(8)   | 8   | 65 | 72  | --          | 7   |
| 8 | FILLER            | X(210) | 210 | 73 | 282 | --          | --  |

**Data Record Type 2: Demographic Data Record**

|    |                               |       |    |    |    |             |     |
|----|-------------------------------|-------|----|----|----|-------------|-----|
| 1  | Record Type Indicator         | 9(2)  | 2  | 1  | 2  | --          | 8   |
| 2  | FILLER                        | X(2)  | 2  | 3  | 4  | --          | --  |
| 3  | Hospital ID code              | X(4)  | 4  | 5  | 8  | Definitions | 1,3 |
| 4  | Patient Identification Number | X(20) | 20 | 9  | 28 | Definitions | 1,3 |
| 5  | Patient Control Number        | X(20) | 20 | 29 | 48 | Definitions | 1,3 |
| 6  | Date of Birth                 | 9(8)  | 8  | 49 | 56 | Definitions | 7   |
| 7  | Date of Admission             | 9(8)  | 8  | 57 | 64 | Definitions | 7   |
| 8  | Date of Discharge             | 9(8)  | 8  | 65 | 72 | Definitions | 7   |
| 9  | Sex                           | X(1)  | 1  | 73 | 73 | Definitions | --  |
| 10 | Race                          | 9(1)  | 1  | 74 | 74 | Definitions | --  |
| 11 | Ethnicity                     | 9(1)  | 1  | 75 | 75 | Definitions | --  |
| 12 | Zip Code                      | X(5)  | 5  | 76 | 80 | Definitions | 1,3 |
| 13 | Filler                        | X(4)  | 4  | 81 | 84 | -           | -   |
| 14 | Admission Status              | 9(1)  | 1  | 85 | 85 | Definitions | 2,4 |
| 15 | Discharge Status              | 9(2)  | 2  | 86 | 87 | Definitions | 2,4 |
| 16 | Birthweight                   | 9(4)  | 4  | 88 | 91 | Definitions | 2,4 |
| 17 | Previous Admission            | 9(1)  | 1  | 92 | 92 | Definitions | -   |
| 18 | Principal Payment Source      | X(1)  | 1  | 93 | 93 | Definitions | 1,3 |
| 19 | Payer Identification 1        | X(5)  | 5  | 94 | 98 | Definitions | 2,4 |

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|----|--------------------------------|--------|-----|-----|-----|-------------|-------|
| 20 | Estimated Responsibility 1     | 9(6)   | 6   | 99  | 104 | Definitions | 2,4,9 |
| 21 | Deductible 1                   | 9(6)   | 6   | 105 | 110 | Definitions | 2,4,9 |
| 22 | Coinsurance 1                  | 9(6)   | 6   | 111 | 116 | Definitions | 2,4,9 |
| 23 | Payer Identification 2         | X(5)   | 5   | 117 | 121 | Definitions | 2,4   |
| 24 | Estimated Responsibility 2     | 9(6)   | 6   | 122 | 127 | Definitions | 2,4,9 |
| 25 | Deductible 2                   | 9(6)   | 6   | 128 | 133 | Definitions | 2,4,9 |
| 26 | Coinsurance 2                  | 9(6)   | 6   | 134 | 139 | Definitions | 2,4,9 |
| 27 | Payer Identification 3         | X(5)   | 5   | 140 | 144 | Definitions | 2,4   |
| 28 | Estimated Responsibility 3     | 9(6)   | 6   | 145 | 150 | Definitions | 2,4,9 |
| 29 | Deductible 3                   | 9(6)   | 6   | 151 | 156 | Definitions | 2,4,9 |
| 30 | Coinsurance 3                  | 9(6)   | 6   | 157 | 162 | Definitions | 2,4,9 |
| 31 | Revenue Center Code 001        | 9(3)   | 3   | 163 | 165 |             | 2,4   |
| 32 | Total Routine Units of Service | 9(4)   | 4   | 166 | 169 |             | 2,4   |
| 33 | Total Detailed Charges         | 9(8)   | 8   | 170 | 177 |             | 2,4,9 |
| 34 | FILLER                         | X(105) | 105 | 178 | 282 | --          | --    |

**Data Record Type 3: Diagnosis Data Record**

|    |                               |       |    |    |    |             |         |
|----|-------------------------------|-------|----|----|----|-------------|---------|
| 1  | Record Type Indicator         | 9(2)  | 2  | 1  | 2  | --          | 8       |
| 2  | FILLER                        | X(2)  | 2  | 3  | 4  | --          | --      |
| 3  | Hospital ID code              | X(4)  | 4  | 5  | 8  | Definitions | 1,3     |
| 4  | Patient Identification Number | X(20) | 20 | 9  | 28 | Definitions | 1,3     |
| 5  | Patient Control Number        | X(20) | 20 | 29 | 48 | Definitions | 1,3     |
| 6  | Attending physician           | X(9)  | 9  | 49 | 57 | Definitions | 1,3     |
| 7  | Principal diagnosis           | X(5)  | 5  | 58 | 62 | ICD-9-CM    | 1,3,5,6 |
| 8  | Secondary diagnosis 1         | X(5)  | 5  | 63 | 67 | ICD-9-CM    | 1,3,5,6 |
| 9  | Secondary diagnosis 2         | X(5)  | 5  | 68 | 72 | ICD-9-CM    | 1,3,5,6 |
| 10 | Secondary diagnosis 3         | X(5)  | 5  | 73 | 77 | ICD-9-CM    | 1,3,5,6 |

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|----|-----------------------|--------|-----|-----|-----|----------|---------|
| 11 | Secondary diagnosis 4 | X(5)   | 5   | 78  | 82  | ICD-9-CM | 1,3,5,6 |
| 12 | Secondary diagnosis 5 | X(5)   | 5   | 83  | 87  | ICD-9-CM | 1,3,5,6 |
| 13 | Secondary diagnosis 6 | X(5)   | 5   | 88  | 92  | ICD-9-CM | 1,3,5,6 |
| 14 | Secondary diagnosis 7 | X(5)   | 5   | 93  | 97  | ICD-9-CM | 1,3,5,6 |
| 15 | Secondary diagnosis 8 | X(5)   | 5   | 98  | 102 | ICD-9-CM | 1,3,5,6 |
| 16 | Secondary diagnosis 9 | X(5)   | 5   | 103 | 107 | ICD-9-CM | 1,3,5,6 |
| 17 | FILLER                | X(175) | 175 | 108 | 282 | --       | --      |

**Data Record Type 4: Procedure Data Record**

|    |                               |       |    |     |     |             |       |
|----|-------------------------------|-------|----|-----|-----|-------------|-------|
| 1  | Record Type Indicator         | 9(2)  | 2  | 1   | 2   | --          | 8     |
| 2  | FILLER                        | X(2)  | 2  | 3   | 4   | --          | --    |
| 3  | Hospital ID code              | X(4)  | 4  | 5   | 8   | Definitions | 1,3   |
| 4  | Patient Identification Number | X(20) | 20 | 9   | 28  | Definitions | 1,3   |
| 5  | Patient Control Number        | X(20) | 20 | 29  | 48  | Definitions | 1,3   |
| 6  | Operating physician           | X(9)  | 9  | 49  | 57  | Definitions | 1,3   |
| 7  | Principal procedure           | X(4)  | 4  | 58  | 61  | ICD-9-CM    | 1,3,5 |
| 8  | Principal proc. day           | 9(3)  | 3  | 62  | 64  | Definitions | 2,3   |
| 9  | FILLER                        | X(9)  | 9  | 65  | 73  | --          | --    |
| 10 | Other procedure 1             | X(4)  | 4  | 74  | 77  | ICD-9-CM    | 1,3,5 |
| 11 | Other proc. 1 day             | 9(3)  | 3  | 78  | 80  | Definitions | 2,3   |
| 12 | FILLER                        | X(9)  | 9  | 81  | 89  | --          | --    |
| 13 | Other procedure 2             | X(4)  | 4  | 90  | 93  | ICD-9-CM    | 1,3,5 |
| 14 | Other proc. 2 day             | 9(3)  | 3  | 94  | 96  | Definitions | 2,3   |
| 15 | FILLER                        | X(9)  | 9  | 97  | 105 | --          | --    |
| 16 | Other procedure 3             | X(4)  | 4  | 106 | 109 | ICD-9-CM    | 1,3,5 |
| 17 | Other proc. 3 day             | 9(3)  | 3  | 110 | 112 | Definitions | 2,3   |

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|----|-------------------|-------|----|-----|-----|-------------|-------|
| 18 | FILLER            | X(9)  | 9  | 113 | 121 | --          | --    |
| 19 | Other procedure 4 | X(4)  | 4  | 122 | 125 | ICD-9-CM    | 1,3,5 |
| 20 | Other proc. 4 day | 9(3)  | 3  | 12  | 128 | Definitions | 2,3   |
| 21 | FILLER            | X(9)  | 9  | 129 | 137 | --          | --    |
| 22 | Other procedure 5 | X(4)  | 4  | 138 | 141 | ICD-9-CM    | 1,3,5 |
| 23 | Other proc. 5 day | 9(3)  | 3  | 142 | 144 | Definitions | 2,3   |
| 24 | FILLER            | X(9)  | 9  | 145 | 153 | --          | --    |
| 25 | Other procedure 6 | X(4)  | 4  | 154 | 157 | ICD-9-CM    | 1,3,5 |
| 26 | Other proc. 6 day | 9(3)  | 3  | 158 | 160 | Definitions | 2,3   |
| 27 | FILLER            | X(9)  | 9  | 161 | 169 | --          | --    |
| 28 | Other procedure 7 | X(4)  | 4  | 170 | 173 | ICD-9-CM    | 1,3,5 |
| 29 | Other proc. 7 day | 9(3)  | 3  | 174 | 176 | Definitions | 2,3   |
| 30 | FILLER            | X(9)  | 9  | 177 | 185 | --          | --    |
| 31 | Other procedure 8 | X(4)  | 4  | 186 | 189 | ICD-9-CM    | 1,3,5 |
| 32 | Other proc. 8 day | 9(3)  | 3  | 190 | 192 | Definitions | 2,3   |
| 33 | FILLER            | X(9)  | 9  | 193 | 201 | --          | --    |
| 34 | Other procedure 9 | X(4)  | 4  | 202 | 205 | ICD-9-CM    | 1,3,5 |
| 35 | Other proc. 9 day | 9(3)  | 3  | 206 | 208 | Definitions | 2,3   |
| 36 | FILLER            | X(74) | 74 | 209 | 282 | --          | --    |

**Data Record Type 5: Billing Data Record(s)**

|   |                               |       |    |    |    |              |        |
|---|-------------------------------|-------|----|----|----|--------------|--------|
| 1 | Record Type Indicator         | 9(2)  | 2  | 1  | 2  | --           | 8      |
| 2 | Record Sequence Number        | 9(2)  | 2  | 3  | 4  | (h) (2) (C)  | 2,4,10 |
| 3 | Hospital ID code              | X(4)  | 4  | 5  | 8  | Definitions  | 1,3    |
| 4 | Patient Identification Number | X(20) | 20 | 9  | 28 | Definitions  | 1,3    |
| 5 | Patient Control Number        | X(20) | 20 | 29 | 48 | Definitions  | 1,3    |
| 6 | Revenue Code #1               | 9(3)  | 3  | 49 | 51 | UB-82 Manual | 2,4    |

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|----|-------------------------------------|------|---|-----|-----|--------------|-------|
| 7  | Units of Service by Revenue Code #1 | 9(4) | 4 | 52  | 55  | UB-82 Manual | 2,4   |
| 8  | Charges by Revenue Code #1          | 9(6) | 6 | 56  | 61  | UB-82 Manual | 2,4,9 |
| 9  | Revenue Code #2                     | 9(3) | 3 | 62  | 64  | UB-82 Manual | 2,4   |
| 10 | Units of Service by Revenue Code #2 | 9(4) | 4 | 65  | 68  | UB-82 Manual | 2,4   |
| 11 | Charges by Revenue Code #2          | 9(6) | 6 | 69  | 74  | UB-82 Manual | 2,4,9 |
| 12 | Revenue Code #3                     | 9(3) | 3 | 75  | 77  | UB-82 Manual | 2,4   |
| 13 | Units of Service by Revenue Code #3 | 9(4) | 4 | 78  | 81  | UB-82 Manual | 2,4   |
| 14 | Charges by Revenue Code #3          | 9(6) | 6 | 82  | 87  | UB-82 Manual | 2,4,9 |
| 15 | Revenue Code #4                     | 9(3) | 3 | 88  | 90  | UB-82 Manual | 2,4   |
| 16 | Units of Service by Revenue Code #4 | 9(4) | 4 | 91  | 94  | UB-82 Manual | 2,4   |
| 17 | Charges by Revenue Code #4          | 9(6) | 6 | 95  | 100 | UB-82 Manual | 2,4,9 |
| 18 | Revenue Code #5                     | 9(3) | 3 | 101 | 103 | UB-82 Manual | 2,4   |
| 19 | Units of Service by Revenue Code #5 | 9(4) | 4 | 104 | 107 | UB-82 Manual | 2,4   |
| 20 | Charges by Revenue Code #5          | 9(6) | 6 | 108 | 113 | UB-82 Manual | 2,4,9 |
| 21 | Revenue Code #6                     | 9(3) | 3 | 114 | 116 | UB-82 Manual | 2,4   |
| 22 | Units of Service by Revenue Code #6 | 9(4) | 4 | 117 | 120 | UB-82 Manual | 2,4   |
| 23 | Charges by Revenue Code #6          | 9(6) | 6 | 121 | 126 | UB-82 Manual | 2,4,9 |
| 24 | Revenue Code #7                     | 9(3) | 3 | 127 | 129 | UB-82 Manual | 2,4   |
| 25 | Units of Service by Revenue Code #7 | 9(4) | 4 | 130 | 133 | UB-82 Manual | 2,4   |
| 26 | Charges by Revenue Code #7          | 9(6) | 6 | 134 | 139 | UB-82 Manual | 2,4,9 |
| 27 | Revenue Code #8                     | 9(3) | 3 | 140 | 142 | UB-82 Manual | 2,4   |
| 28 | Units of Service by Revenue Code #8 | 9(4) | 4 | 143 | 146 | UB-82 Manual | 2,4   |
| 29 | Charges by Revenue Code #8          | 9(6) | 6 | 147 | 152 | UB-82 Manual | 2,4,9 |
| 30 | Revenue Code #9                     | 9(3) | 3 | 153 | 155 | UB-82 Manual | 2,4   |
| 31 | Units of Service by Revenue Code #9 | 9(4) | 4 | 156 | 159 | UB-82 Manual | 2,4   |
| 32 | Charges by Revenue Code #9          | 9(6) | 6 | 160 | 165 | UB-82 Manual | 2,4,9 |

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|----|--------------------------------------|------|---|-----|-----|--------------|-------|
| 33 | Revenue Code #10                     | 9(3) | 3 | 166 | 168 | UB-82 Manual | 2,4   |
| 34 | Units of Service by Revenue Code #10 | 9(4) | 4 | 169 | 172 | UB-82 Manual | 2,4   |
| 35 | Charges by Revenue Code #10          | 9(6) | 6 | 173 | 178 | UB-82 Manual | 2,4,9 |
| 36 | Revenue Code #11                     | 9(3) | 3 | 179 | 181 | UB-82 Manual | 2,4   |
| 37 | Units of Service by Revenue Code #11 | 9(4) | 4 | 182 | 185 | UB-82 Manual | 2,4   |
| 38 | Charges by Revenue Code #11          | 9(6) | 6 | 186 | 191 | UB-82 Manual | 2,4,9 |
| 39 | Revenue Code #12                     | 9(3) | 3 | 192 | 194 | UB-82 Manual | 2,4   |
| 40 | Units of Service by Revenue Code #12 | 9(4) | 4 | 195 | 198 | UB-82 Manual | 2,4   |
| 41 | Charges by Revenue Code #12          | 9(6) | 6 | 199 | 204 | UB-82 Manual | 2,4,9 |
| 42 | Revenue Code #13                     | 9(3) | 3 | 205 | 207 | UB-82 Manual | 2,4   |
| 43 | Units of Service by Revenue Code #13 | 9(4) | 4 | 208 | 211 | UB-82 Manual | 2,4   |
| 44 | Charges by Revenue Code #13          | 9(6) | 6 | 212 | 217 | UB-82 Manual | 2,4,9 |
| 45 | Revenue Code #14                     | 9(3) | 3 | 218 | 220 | UB-82 Manual | 2,4   |
| 46 | Units of Service by Revenue Code #14 | 9(4) | 4 | 221 | 224 | UB-82 Manual | 2,4   |
| 47 | Charges by Revenue Code #14          | 9(6) | 6 | 225 | 230 | UB-82 Manual | 2,4,9 |
| 48 | Revenue Code #15                     | 9(3) | 3 | 231 | 233 | UB-82 Manual | 2,4   |
| 49 | Units of Service by Revenue Code #15 | 9(4) | 4 | 234 | 237 | UB-82 Manual | 2,4   |
| 50 | Charges by Revenue Code #15          | 9(6) | 6 | 238 | 243 | UB-82 Manual | 2,4,9 |
| 51 | Revenue Code #16                     | 9(3) | 3 | 244 | 246 | UB-82 Manual | 2,4   |
| 52 | Units of Service by Revenue Code #16 | 9(4) | 4 | 247 | 250 | UB-82 Manual | 2,4   |
| 53 | Charges by Revenue Code #16          | 9(6) | 6 | 251 | 256 | UB-82 Manual | 2,4,9 |
| 54 | Revenue Code #17                     | 9(3) | 3 | 257 | 259 | UB-82 Manual | 2,4   |
| 55 | Units of Service by Revenue Code #17 | 9(4) | 4 | 260 | 263 | UB-82 Manual | 2,4   |
| 56 | Charges by Revenue Code #17          | 9(6) | 6 | 264 | 269 | UB-82 Manual | 2,4,9 |
| 57 | Revenue Code #18                     | 9(3) | 3 | 270 | 272 | UB-82 Manual | 2,4   |
| 58 | Units of Service by Revenue Code #18 | 9(4) | 4 | 273 | 276 | UB-82 Manual | 2,4   |





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10. For Data Record Type 5, the sequence number shall reflect the order of appearance of Type 5 data records for each discharge. The sequence number for a discharge's first Type 5 data record equals 01; the sequence number for a discharge's second Type 5 data record equals 02; the sequence number for a discharge's third Type 5 data record equals 03; and so on.
11. Total hospital discharges shall equal the total number of patients discharged from the hospital during the reporting period and shall equal the total number of Type 2 data records filed in the hospital's data set. Total hospital patient days shall equal the sum of the lengths of stay for all hospital patients discharged from the hospital during the reporting period. Total hospital charges shall equal the total charges billed to all hospital patients discharged from the hospital during the reporting period.

(10) Required characteristics for the discharge and billing data elements.

(A) Invalid values for data fields.

| <b>Number</b> | <b>Fieldname</b>       | <b>Invalid Field Coding</b>                                     |
|---------------|------------------------|---|
| -----         | -----                  | -----   |
| 1.            | Patient Identification | All zeros; all spaces; all nines                                |
| 2.            | Patient Control Number | All zeros; all spaces; all nines                                |
| 3.            | Date of Birth          | Non-numeric data  |
| 4.            | Date of Admission      | Non-numeric data; invalid year                                  |
| 5.            | Date of Discharge      | Non-numeric data; invalid year                                  |
| 6.            | Previous Admission     | Non-numeric data; all zeros                                     |
| 7.            | Patient Sex            | Any designation code not found in definitions                   |
| 8.            | Race                   | Non-numeric data; any designation code not found in definitions |
| 9.            | Ethnicity              | Non-numeric data; any designation code not found in definitions |
| 10.           | Patient Zip Code       | Non-numeric data; all zeros                                     |
| 11.           | Hospital ID Code       | Any designation code not found in definitions                   |

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- |     |                            |  |
|-----|----------------------------|--|
| 12. | Attending Practitioner No. | All zeros; all spaces; all nines; any code not found on the Connecticut Health Care Provider Identification List |
| 13. | Operating Practitioner No. | All zeros; all nines; any code not found on the Connecticut Health Care Provider Identification List             |
| 14. | Principal Diagnosis Code   | All spaces; first digit is E; invalid ICD-9-CM diagnosis code  |
| 15. | Secondary Diagnosis Codes  | Missing Principal Diagnosis Code; invalid ICD-9-CM diagnosis code  |
| 16. | Principal Procedure        | Invalid ICD-9-CM procedure code  |
| 17. | Principal Procedure Day    | Non-numeric data; number exceeding length-of-stay  |
| 18. | Other Procedures           | Invalid ICD-9-CM procedure code; missing Principal Procedure   |
| 19. | Other Procedure Days       | Non-numeric data; number exceeding length-of-stay  |
| 20. | Admission Status           | Non-numeric data; any designation code not found in definitions  |
| 21. | Discharge Status           | Non-numeric data; any designation code not found in definitions  |
| 22. | Expected Principal Source  | Any designation of Payment code not found in definitions   |
| 23. | Birthweight                | Non-numeric data   |
| 24. | Payer Identification       | Any designation code not found in UB-82 Manual   |
| 25. | Estimated Responsibility   | Non-numeric data   |
| 26. | Deductible                 | Non-numeric data   |
| 27. | Coinsurance                | Non-numeric data   |
| 28. | Total Actual Charges       | Non-numeric data; all detail charges missing; total not in   |

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|     |                               |  |
|-----|-------------------------------|--|
|     |                               | aggreement with sum of individual detail charges     |
| 29. | Revenue Codes                 | Valid UB-82 revenue center codes between 001 and 999 |
| 30. | Revenue Code Units of Service | Non-numeric data                                     |
| 31. | Detailed Revenue Code Charges | Non-numeric data                                     |

(B) The following edits from the Medicare Code Editor will be applied to the data. Data elements failing these edits will be rejected as errors.

- (i) Invalid diagnosis or procedure code
- (ii) Invalid fourth or fifth digit
- (iii) E-code as principal diagnosis
- (iv) Duplicate of principal diagnosis
- (v) Manifestation code as principal diagnosis
- (vi) Invalid age

(11) Consistency edits. The following edits will be applied to each patient data record to ensure the internal consistency of the patient data.

(A) The following edits from the Medicare Code Editor will be applied to the data. Data elements failing these edits will be rejected as errors.

- (i) Age conflict
- (ii) Sex conflict

(B) The following additional edits will be applied to the data. Data elements failing these edits will be rejected as errors.

- (i) The sum of all charges for individual revenue codes must equal the total charges reported.
- (ii) The total charges reported cannot be negative.
- (iii) If a revenue code is reported, then charges must be reported for that revenue code.

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- (iv) If a revenue code between the values of 020 and 219 is reported, units of service must be reported for that revenue code.
- (v) If a valid procedure code is reported, then a procedure day value which is less than or equal to the length of stay must be reported.
- (vi) An operating practitioner must be reported for every principal procedure reported.
- (vii) Birthweight must be coded if the Admission Status is newborn.

**(Effective July 1, 1991.)**

**Secs. 19a-167g-95 -- 19a-167g-99 Reserved**

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