



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
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MEMORANDUM

TO: Office of the Secretary of State via regulations.sots@ct.gov

FROM: Lara Stauning, Staff Attorney
Department of Social Services

DATE: September 16, 2013

RE: Operational Policy Number: 09-17, Definition of Medical Necessity
Adoption of Operational Policy: October 1, 2013

In accordance with sections 17b-259b (d) and 17b-10 of the Connecticut General Statutes, the Department of Social Services hereby electronically submits the above-referenced policy for posting online.

On and after the above referenced adoption date, the Department shall implement and operate under the said policy while it is in the process of adopting it in regulation form pursuant to Chapter 54 of the Connecticut General Statutes.

Not later than 20 days after the policy adoption date, the Department shall publish the Notice of Intent to adopt regulations in the Connecticut Law Journal.

R-39 REV. 04/04
IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

STATE OF CONNECTICUT
REGULATION
OF

Department of Social Services

Subject Matter of Regulation:

Definition of Medical Necessity¹

Section 1. Sections 17-134d-43; 17-134d-63(a); 17-134d-63(e); 17-134d-80(a) to 17-134d-80(b)(2)(E), inclusive; 17-134d-86(a); 17b-262-214; 17b-262-218(c); 17b-262-300; 17b-262-453; 17b-262-456; 17b-262-457; 17b-262-458(a); 17b-262-462; 17b-262-468; 17b-262-471(a); 17b-262-473(a) to 17b-262-473(b)(1)(B)(iii), inclusive; 17b-262-478; 17b-262-500; 17b-262-503; 17b-262-504(a); 17b-262-508(a) to 17b-262-508(b)(2), inclusive; 17b-262-513; 17b-262-516; 17b-262-517; 17b-262-523; 17b-262-527; 17b-262-528(a); 17b-262-531(a) to 17b-262-531(g), inclusive; 17b-262-536; 17b-262-539; 17b-262-541; 17b-262-542(a); 17b-262-548; 17b-262-551; 17b-262-553; 17b-262-554(a); 17b-262-560; 17b-262-563; 17b-262-565; 17b-262-574; 17b-262-577; 17b-262-579; 17b-262-580(a); 17b-262-598; 17b-262-601(a); 17b-262-604(d); 17b-262-608; 17b-262-611(a) to 17b-262-611(b)(4)(B), inclusive; 17b-262-612; 17b-262-613; 17b-262-614(a); 17b-262-620; 17b-262-623; 17b-262-624; 17b-262-625; 17b-262-628(1); 17b-262-642; 17b-262-645; 17b-262-646; 17b-262-647; 17b-262-652; 17b-262-655; 17b-262-656(a) to 17b-262-656(b), inclusive; 17b-262-673; 17b-262-685; 17b-262-688; 17b-262-689; 17b-262-694; 17b-262-697(a); 17b-262-698; 17b-262-702; 17b-262-707(a); 17b-262-713; 17b-262-716; 17b-262-725; 17b-262-728(a) to 17b-262-728(b)(1), inclusive; 17b-262-729; 17b-262-731(a); 17b-262-737; 17b-262-740(a)(1); 17b-262-748; 17b-262-751(1); 17b-262-759; 17b-262-780; 17b-262-783; 17b-262-805; 17b-262-809(a); 17b-262-812; 17b-262-830; and 17b-262-842 of the Regulations of Connecticut State Agencies are amended as follows:

Section 17-134d-43. Medicaid requirements for organ transplantation

(a) Organ transplantations are covered under the Medicaid program if they are of demonstrated therapeutic value, medically necessary [and medically appropriate,] and likely to result in the prolongation and the improvement in the quality of life of the applicant.

Sec. 17-134d-63. Medicaid payment to out-of-state and border hospitals

¹ Copy with OPM rev 7.15.13

(a) Definitions

For the purposes of [this regulation] section 17-134d-63 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Allowed [Cost] cost” means the Medicaid costs reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

(2) “Border [Hospital] hospital” means an out-of-state general hospital which has a common medical delivery area with the [State] state of Connecticut and is deemed a border hospital by the [Department] department on a hospital by hospital basis.

(3) “Connecticut [In-state Hospital] in-state hospital” means a general hospital located within the boundaries of the [State] state of Connecticut and licensed by the [Connecticut State] Department of Public Health [Services].

(4) “Department” means the [State of Connecticut] Department of [Income Maintenance] Social Services.

(5) “Department's [Manual] manual” means the [Department's] department's Connecticut Medical Assistance Provider Manual which contains the Medical Services Policy[as amended from time to time].

(6) “Emergency” means a medical condition, [(including labor and delivery,)] manifesting itself by acute symptoms of sufficient severity, [(including severe pain,)] such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions[,], or serious dysfunction of any bodily organ or part.

(7) “General [Hospital] hospital” means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital, [which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries.]

(8) “Inpatient” means a patient who has been admitted to a general hospital for the purpose of receiving medically necessary [, appropriate,] and quality medical, dental[,], or other health related services and is present at midnight for the census count.

(9) “Medical [Necessity]” means medical care provided to:

- (A) Correct or diminish the adverse effects of a medical condition;
- (B) Assist an individual in attaining or maintaining an optimal level of well-being;
- (C) Diagnose a condition; or
- (D) Prevent a medical condition from occurring.] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.
- (10) [“Out-of-State Hospital”] “Out-of-state hospital” means a general hospital located outside of the [State] state of Connecticut and is not deemed by the [Department] department to be a border hospital.
- (11) “Outpatient” means a person receiving medical, dental[,] or other health related services in the outpatient department of an approved general hospital which is not providing room and board and professional services on a continuous 24-hour-a-day basis.
- (12) “Prior [Authorization] authorization” means approval for a service from the [Department] department or the [Department's] department's agent which may be required by the [Department] department before the provider actually provides the service. Prior authorization is necessary in order to receive reimbursement from the [Department] department. The [Department] department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request.
- (13) “Provider [Agreement] agreement” means the signed written contractual agreement between the [Department] department and the provider of medical services or goods. It is signed by the provider upon application for enrollment and is effective on the approved date of enrollment. The provider is mandated to adhere to the terms and conditions set forth in the provider agreement in order to participate in the program.
- (14) “Rate [Year] year” means the twelve (12) month period beginning on October 1st of each year.
- (15) “Total [Customary Charges] customary charges” means the revenue generated by the aggregate of the total customary charges reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

Sec. 17-134d-63. Medicaid payment to out-of-state and border hospitals

(e) Need for Service

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

(2) The Connecticut [Title XIX] Medicaid program reimburses for medically necessary [and appropriate] services provided in out-of-state hospitals, other than border hospitals as defined in subsection (a) of this [regulation] section, under the following conditions:

(A) For emergency cases, as defined in subsection (a) of this [regulation] section, and necessitating the use of the most accessible general hospital available that is equipped to furnish the services; or

(B) For non-emergency cases, when prior authorization is granted by the [Department] department, for the following reasons:

(i) Medical services are needed because the recipient's health would be endangered if they were required to travel to Connecticut; or

(ii) On the basis of the attending physician's medical advice that the needed medical services or necessary supplementary resources are more readily available in the other [State] state.

Sec. 17-134d-80. Title XIX utilization review requirements for [medicaid] Medicaid services in general hospitals

(a) Definitions

For purposes of [this regulation] section 17-134d-80 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Acute [Care] care” means the medical care needed for an illness, episode[,], or injury which requires [short term] short-term, intense care and hospitalization for a short period of time.

(2) “Admission” means the formal acceptance by a hospital of a patient who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services.

(3) “Admitting diagnosis” means the patient's condition that necessitated or prompted the admission to the hospital and coded according to International Classification of Diseases.

Clinical Modification.

[(3)] (4) “Adverse [Determination] determination” means the initial negative decision by a reviewing body regarding the medical necessity[, or quality[, or appropriateness] of health care services provided or proposed to be provided to a patient.

[(4)] (5) “Appropriateness of [Setting Review] setting review” means the review of services provided or proposed to be provided to determine if the services could have been delivered safely, effectively and more economically in another setting.

[(5)] (6) “Criteria” means the pre-determined measurement variables on which judgment or comparison of necessity [, appropriateness] or quality of health services may be made.

[(6)] (7) “Department” means the [State of Connecticut] Department of [Income Maintenance] Social Services or its agent.

[(7)] (8) “Department's [Manual] manual” means the [Department's] department's Connecticut Medical Assistance Provider Manual, which contains the Medical Services Policy [, as amended from time to time].

[(8) Diagnosis

(A) Admitting Diagnosis means the patient's condition which necessitated or prompted the admission to the hospital, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(B) Principal Diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care and coded using International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.]

(9) “Emergency” means a medical condition, [(including labor and delivery,)] manifesting itself by acute symptoms of sufficient severity, [(including severe pain,)] such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions[, or serious dysfunction of any bodily organ or part.

(10) “Evaluation” means an assessment or examination in which actions and their results are measured against predetermined criteria in order to verify medical necessity [, appropriateness,] and quality.

(11) “Free [Standing Clinic] standing clinic” means a facility providing medical or medically related clinic outpatient services or clinic off-site services by or under the direction of a physician or dentist and the facility is not part of, or related to, a hospital. Such facilities provide mental health, rehabilitation, dental and medical services and are subject to [Sections] sections 171 [through] to 171.4, inclusive, of the [Department's

Manual, as may be amended from time to time] department's manual.

(12) “General [Hospital] hospital” [for purposes of this regulation] means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital [which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries. It shall also include] or a border hospital as defined in [Section 150.1] section 150.1B. of the [Department's Manual, as may be amended from time to time] department's manual.

(13) “Inpatient” means a [recipient] patient who has been admitted to a general hospital for the purpose of receiving medically necessary[, appropriate,] and quality medical, dental or other health related services and is present at midnight for the census count.

[(14) Medical Appropriateness means medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting.]

[(15)] (14) “Medical [Necessity means medical care provided to:

(A) Correct or diminish the adverse effects of a medical condition;

(B) Assist an individual in attaining or maintaining an optimal level of well being;

(C) Diagnose a condition; or

(D) Prevent a medical condition from occurring.] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(16)] (15) “Override [Option] option” means a decision, used in utilization review, when “overriding” circumstances of clinical significance justify changing the conclusion of the objective criteria.

[(17)] (16) “Patient” means an individual who receives a health care service from a provider and is also a Medicaid recipient.

[(18)] (17) “Preadmission [Review] review” means a review prior to a patient's admission to a hospital, or in the case of an emergency admission, immediately thereafter, [a patient's admission to a hospital] to determine the medical necessity[, appropriateness,] and quality of the health care services proposed to be delivered, or in the case of an emergency, delivered in the hospital.

(18) “Principal diagnosis” means the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care and coded using International Classification of Diseases, Clinical Modification.

(19) “Principal [Procedure] procedure” means the procedure most closely related to the principal diagnosis, that is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes [and/or] or was necessary to care for a complication, and coded according to International Classification of Diseases[, 9th Revision], Clinical Modification[, and as amended from time to time].

(20) “Prior [Authorization] authorization” means approval for a service from the [Department] department or the [Department's] department's agent before the provider actually provides the service. [In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.] In the case of an emergency admission to a general hospital, prior authorization means approval obtained within two business days of admission.

(21) “Quality of [Care] care” means the evaluation of medical care to determine if it meets the professionally recognized [standard(s)] standards of acceptable medical care for the condition and the patient under treatment.

(22) “Recipient” means an individual who has been determined eligible for Medicaid.

(23) “Reliability” means a measure of the consistency of a method in producing results. A reliable test gives the same results when applied more than once under the same conditions.

(24) “Retrospective [Review] review” means the review conducted after services are provided to a patient, to determine the medical necessity[, appropriateness,] and quality of the services provided.

(25) “Utilization [Review] review” means the evaluation of the necessity [, appropriateness,] and quality of the use of medical services, procedures and facilities. Utilization review evaluates the medical necessity[, and medical appropriateness] of admissions, the services performed or to be performed, the length of stay and the discharge practices. [It] Utilization review is conducted on a prospective [and/or] or retrospective basis.

(26) “Validity” means a measure of the extent to which an observed situation reflects the true situation or an indication of medical quality measures what it purports to measure.

(b) Utilization Review Program in General Hospitals

(1) The [Department's] department's [Utilization Review Program] utilization review program conducts utilization review activities for services delivered to general hospital inpatients, where Medicaid has been determined to be the appropriate payer.

(2) The [Department's] department's objectives for performing utilization review

[include] are to:

(A) [To determine] Determine the medical necessity [and appropriateness] of general hospital inpatient services;

(B) [To assure] Assure that the quality of service meets accepted and established standards;[:]

(C) [To safeguard] Safeguard against unnecessary and inappropriate utilization;

(D) [To effectively] Effectively monitor provider patterns of utilization;[:] and

(E) [To identify] Identify inappropriate patterns and services.

Sec. 17-134d-86. Medicaid payment for general hospital outpatient emergency and non-emergency visits to a hospital emergency room and outpatient clinic visits

(a) Definitions

(1) “Department” means [The State of Connecticut] the Department of [Income Maintenance] Social Services or its agent.

(2) “Emergency room” means that part of a general hospital that is designed, organized, equipped[,], and staffed to provide initial diagnosis and treatment of patients requiring immediate physician, dental[,], or allied services.

(3) “Emergency visit” means an urgent encounter requiring the immediate decision-making and medically necessary action to prevent death or any further disability for patients in health crises, [(including labor and delivery)]. Such medical conditions are manifested by acute symptoms of sufficient severity, [(including severe pain,)] such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions[,], or serious dysfunction of any bodily organ or part. In order to be considered urgent, the encounter must occur within seventy-two (72) hours from the onset of the presenting medical condition.

(4) “General hospital” means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital [which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries].

(5) “Medically necessary” [means medical care provided to:

- (A) Correct or diminish the adverse effects of a medical condition;
- (B) Assist an individual in attaining or maintaining an optimal level of well being;
- (C) Diagnose a condition; or
- (D) Prevent a medical condition from occurring.] or “medical necessity” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

(6) “Non-emergency visit” means a medically necessary non-urgent encounter presenting a medical condition which does not meet the requirements for an emergency visit as defined in this section but, rather, requires a routine level of ambulatory health care. Such conditions may be characterized by the fact that they may also be treated in an alternate health care setting, such as: community-based physician's office[,]; walk-in clinic[,]; comprehensive health center[,]; neighborhood health center; and other free-standing primary health care clinics because such medical conditions do not require the skills, resources and equipment of a hospital emergency room. Such visits may include primary health care or the initial diagnosis and treatment of routine acute or chronic illnesses whether on a scheduled or unscheduled basis.

(7) “Outpatient” means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does not receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

(8) “Outpatient clinic visit rate” means the rate set by the [Department] department using the methodology as required by [subsection 17-312 (d) of the General Statutes of the State of Connecticut] subsection 17b-239(d) of the Connecticut General Statutes.

Sec. 17b-262-214. Definitions

For purposes of section 17b-262-213 [through] to [17b-262-224] 17b-262-223, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) “Allied [Health Professional] health professional” or “AHP” means an individual who is licensed or certified by the Department of Public Health [(DPH)] or the [SDE] State Department of Education to provide school based child health services as defined within the context of [this regulation] sections 17b-262-213 to 17b-262- 223, inclusive of the Regulations of Connecticut State Agencies.

(2) “Child” [means an individual as defined in subsection (e) of section 10-76a of the Connecticut General Statutes (CGS)] has the same meaning as provided in section 10-76a of the Connecticut General Statutes.

(3) “Children [Requiring Special Education] requiring special education” [means an

individual as defined in subsection (e) of section 10-76a of the CGS] has the same meaning as provided in section 10-76a of the Connecticut General Statutes.

(4) “Department” means the [State of Connecticut] Department of Social Services [(DSS)] or its [designated] agent.

(5) “DPH” means the Department of Public Health.

[(5)] (6) “Diagnostic [Services] services” means those services as defined in [the Code of Federal Regulations (CFR) under 42 CFR, Part 440, subsection (a) of section 440.130] 42 CFR 440.130(a), as amended from time to time.

[(6) “Individualized Education Program (IEP)” means the ongoing plan of treatment services as defined in section 10-76d-11 of the Regulations of Connecticut State Agencies, and Part B of IDEA, as amended from time to time.]

(7) “Evaluation” [is] means the process defined under section 10-76d-9 of the Regulations of Connecticut State Agencies.

(8) “Individualized Education Program” or “IEP” means the ongoing plan of treatment services as defined in section 10-76d-11 of the Regulations of Connecticut State Agencies, and 20 USC 1414(d)(1)(A), as amended from time to time.

[(8)] (9) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means those practitioners [as] defined in section 20-1 of the [CGS] Connecticut General Statutes.

[(9)] (10) “Local Educational Agencies” or “LEAs” [or “Board of Education”] means local or regional boards of education as defined in [subsection (b) of] section 10-76a-1 of the Regulations of Connecticut State Agencies and in [Part B of IDEA] 20 USC 1414(d), as amended from time to time.

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

(11) “Medically [Necessary] means medical care provided to correct or diminish the adverse affects of a medical condition, assist an individual in attaining or maintaining an optimal level of well being, diagnose a condition or prevent a medical condition from occurring] necessary” or “medical necessity” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

(12) “Planning and [Placement Team] placement team” or “PPT” [means the definition contained] has the same meaning as provided in [subsection (p) of] section 10-76a-1 of the Regulations of Connecticut State Agencies.

(13) “Provider” means the [local educational agencies] LEAs [or boards of education] that participate in the [medicaid] Medicaid program as providers of school based child health [“(SBCH”)] services.

(14) “Qualified [SBCH Service Providers] school based child health service providers” include, but[,] are not limited to: licensed physician[,]; licensed osteopath[,]; licensed optometrist[,]; licensed chiropractor[,]; licensed naturopath[,]; licensed audiologist[,]; speech therapy assistants working under the direction of licensed speech pathologists[,]; licensed speech pathologist[,]; licensed advanced practice registered nurse [(APRN),]; licensed registered nurse [(RN),]; licensed physician assistant[,]; licensed practical nurse [(LPN),]; licensed psychologist[,]; certified family and marital counselors[,]; [SDE] State Department of Education certified school psychologist[,]; [SDE] State Department of Education certified school social worker[,] DPH certified independent social worker, DPH certified substance abuse counselor, DPH certified marital and family therapist, [SDE] State Department of Education certified school counselor, [SDE] State Department of Education certified guidance counselor, licensed occupational therapist, licensed occupational therapy assistant, licensed physical therapist, physical therapist assistant meeting requirements of section 20-66 of the [CGS] Connecticut General Statutes, licensed respiratory care practitioner and licensed optometrist.

(15) “Rehabilitative [Services] services” are those services as defined [under 42 CFR, Part 440, subsection (d) of section 440.130] in 42 CFR 440.130(d), as amended from time to time.

(16) “School Based Child Health Services” or “SBCH Services” are those diagnostic and rehabilitative treatment services which are medically necessary [and appropriate] and which meet the needs of children as in accordance with [Part B of IDEA] 20 USC 1400 to 20 USC 1482, inclusive, as amended from time to time, [and] section 10-76d of the [CGS] Connecticut General Statutes and [supporting regulations] sections 10-76a-1 to 10-76l-1, inclusive of the Regulations of Connecticut State Agencies, and are recommended in writing by a licensed practitioner of the healing arts within each respective practitioner's scope of practice as defined under state law in accordance with [42 CFR, Part 440, subsections (a) and (d) of section 440.130] 42 CFR 440.130(a) and (b), as amended from time to time.

(17) “Triennial [Reevaluation] reevaluation” is the process of reevaluation at least once every three years as described [under] in section 10-76d-9 of the Regulations of Connecticut State Agencies.

(18) “Type of [Placement] placement” means [, for the purposes of this regulation,] the type of setting in which the child receives special education services. These settings may include, but are not limited to: in-district[,]; out-of-district public residential[,]; out-of-district private residential[,]; out-of-district public day; and out-of-district private day.

Sec. 17b-262-218. Services covered

(c) Durable Medical Equipment, Other Medical Supplies and Devices

Durable medical equipment means [the purchase or rental of] medically necessary [and appropriate] assistive devices, purchased or rented, such as: (1) augmentative communication device; (2) crouch screen voice synthesizer; (3) prone stander; (4) corner chair; (5) wheel-chair; (6) crutches; (7) walkers; (8) auditory trainers; and (9) suctioning machines. Other medical supplies and devices [means] may include supplies and devices necessary, [and] or incidental to, IEP related services.

Sec. 17b-262-300. Definitions

As used in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

- (1) “Active treatment” means the treatment [as] described in 42 CFR 483.440(a), as amended from time to time;
- (2) “Applied income” means the amount of income that each client receiving [ICF/MR] services in an Intermediate Care Facility for Individuals with Intellectual Disabilities [services] is expected to pay each month toward the cost of [his or her] care, calculated according to the [DSS] Department of Social Services’ Uniform Policy Manual, section 5045.20;
- (3) “Client” means a person eligible for services under the Connecticut Medicaid program;
- (4) [“DMR” means the Department of Mental Retardation] “DDS” means the Department of Developmental Services or its agent;
- (5) “DPH” means the Department of Public Health or its agent;
- (6) “Department” or “DSS” means the Department of Social Services or its agent;
- (7) “Discharge” means the movement of a client out of an [ICF/MR] intermediate care facility for individuals with intellectual disabilities;
- (8) “Home leave” means an overnight absence from the [ICF/MR] intermediate care facility for individuals with intellectual disabilities for any reason other than admission to a hospital[. It is], taken at the discretion of the client;
- (9) “Hospital” means a general hospital, special hospital or chronic disease hospital as defined in section 19-13-D1(b) of the Regulations of Connecticut State Agencies;

(10) “Interdisciplinary team” or “IDT” means a group of persons, as described in 42 CFR 483.440(c)(2), as amended from time to time;

(11) "Intermediate care facility for [the mentally retarded" or "ICF/MR"] individuals with intellectual disabilities” or “ICF/IID” means a residential facility for [the mentally retarded] persons with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified and enrolled to participate in Medicaid as an [intermediate care facility for the mentally retarded] ICF/IID pursuant to 42 CFR 442.101, as amended from time to time;

[(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;]

[(13)] (12) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(14)] (13) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist a client in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(15)] (14) “Objective information” means an estimate of the client's projected length of hospital stay obtained by the ICF/MR from a hospital staff person. This prognosis may be obtained from the client's record or the overall plan of service [(OPS)] or given by a physician or other health professional under [his or her] their direction or by another qualified professional such as a social worker or discharge planner;

[(16)] (15) “Overall plan of services” or “OPS” means a document that specifies a strategy to guide the delivery of services to a client for up to one year. [It] The OPS is the document required for a client that meets the federal requirements for a plan of care as outlined in 42 CFR 456.380, as amended from time to time, and an individual program plan as outlined in 42 CFR 483.440, as amended from time to time; and

[(17)] (16) “Provider” means an ICF/MR that is enrolled in the Medicaid program.

Sec. 17b-262-453. Definitions

For the purposes of sections 17b-262-452 [through] to 17b-262-463, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Acute” means having rapid onset, severe symptoms[,] and a short course.
- (2) “Acute [Care] care” means medical care needed for an illness, episode[,] or injury which requires short-term, intense care[,] and hospitalization for a short period of time.
- (3) “Allied Health Professional [(AHP)]” or “AHP” means a professional or paraprofessional individual who is qualified by special training, education, skills[,] and experience in mental health care and treatment and shall include, but is not limited to: psychologists[,]₂ social workers[,]₂ psychiatric nurses[,]₂ and other qualified therapists.
- (4) “By or [Under the Supervision] under the supervision” means the psychiatrist shall assume professional responsibility for the service performed by the [allied health professional] AHP, overseeing or participating in the work of the [allied health professional] AHP including, but not limited to:
 - (A) [availability] Availability of the psychiatrist to the [allied health professional] AHP in person and within five minutes;
 - (B) [availability] Availability of the psychiatrist on a regularly scheduled basis to review the practice, charts[,] and records of the [allied health professional] AHP and to support the [allied health professional] AHP in the performance of services; and
 - (C) [a] A predetermined plan for emergency situations, including the designation of an alternate psychiatrist in the absence of the regular psychiatrist.
- (5) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.
- (6) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner's agent.
- (7) “Consultation” means those services rendered by a psychiatrist whose opinion or advice is requested by another physician or an agency in the evaluation and treatment of a client's illness.
- (8) “Department” means the Department of Social Services or its agent.
- (9) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- (10) “Estimated Acquisition Cost [(EAC)]” or “EAC” means the department's best estimate of the price generally and currently paid by providers for a drug marketed or

sold by a particular manufacturer.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary [and medically appropriate] health care, diagnostic services, treatment[,] or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

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

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

(13) "Home" means the client's place of residence which includes a boarding home or home for the aged. Home does not include a hospital or long-term care facility; long-term care facility includes a nursing facility, chronic disease hospital[, and intermediate care facility for the mentally retarded (ICF/MR)] or an intermediate care facility for individuals with intellectual disabilities.

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

(15) "Legend [Drug] drug" [means the definition contained] has the same meaning as provided in section 20-571 of the Connecticut General Statutes.

(16) "Licensed [Practitioner of the Healing Arts] practitioner of the healing arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

(17) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) [nursing] Nursing facilities[,];

(B) Inpatient chronic disease hospitals[—inpatient,]; and

(C) [intermediate] Intermediate care facilities for [the mentally retarded (ICFs/MR)]

individuals with intellectual disabilities.

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

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

[(20)] (19) ["Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] "Medically necessary" or "medical necessity" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(21)] (20) "Medical [Record] record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies[, which is part of the Public Health Code].

[(22)] (21) "Prior [Authorization] authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(23)] (22) "Provider" means a psychiatrist.

[(24)] (23) "Provider [Agreement] agreement" means the signed, written, contractual agreement between the department and the provider [of services or goods].

[(25)] (24) "Psychiatric [Services] services" means services provided to individuals, groups[,] and families, by or under the supervision of a licensed psychiatrist in private or group practice. In such a setting the psychiatrist retains the primary medical and clinical responsibility for work up of the initial evaluation, diagnosis[,] and prescription of the treatment plan, rehabilitation[,] and discharge of the client. Such services include the diagnosis of specific mental and social problems which disrupt [an individual's] a client's daily functioning and provide treatment to reduce the symptoms and signs associated with these disturbances.

[(26)] (25) "Psychiatrist" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who specializes in the study, diagnosis, treatment[,] and prevention of mental and social disorders.

[(27)] (26) "State Plan" means the document which contains the services covered by the

Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

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

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

(a) The department shall pay for:

(1) [psychiatric] Psychiatric evaluation;

(2) [psychotherapy] Psychotherapy, including: individual, group, family, hypnosis[,] and electroshock;

(3) [psychiatric] Psychiatric consultation;

(4) [drugs] Drugs, as limited in subsection (b) of section 17b-262-456 of the Regulations of Connecticut State Agencies;

(5) [all] All admitting and inpatient services performed by the admitting psychiatrist in an acute care hospital after the psychiatrist has received prior authorization for the admission pursuant to the department's utilization review program as delineated in section 17-134d-80 of the Regulations of Connecticut State Agencies; and

(6) HealthTrack Services and HealthTrack Special Services.

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

(1) [a] A psychiatric evaluation shall be limited to one evaluation in any twelve month period per client per provider;

(2) [only] Only one unit of therapy of the same type shall be paid for on the same day;

(3) [group] Group psychiatric sessions shall be limited in size to a maximum of eight [persons] participants per group session regardless of the payment source of each participant;

(4) [services] Services covered shall be limited to those listed in the department's

applicable fee schedule; and

(5) [hypnosis] Hypnosis and electroshock therapy shall be personally provided by a psychiatrist.

(c) Services Not Covered

The department shall not pay for the following psychiatric services:

(1) [information] Information or services furnished by the provider to the client over the telephone;

(2) [concurrent] Concurrent services for the same client involving the same services or procedure;

(3) [office] Office visits to obtain a prescription, the need for which has already been ascertained;

(4) [procedures] Procedures performed in the process of preparing [an individual] a client for transsexual surgery; and

(5) [cancelled] Cancelled office visits or appointments not kept.

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

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

Sec. 17b-262-458. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for all clients, including clients originally referred by another state agency for:

(1) [treatment] Treatment services in excess of thirteen visits in a calendar quarter;

(2) [treatment] Treatment services to hospitalized clients from the date of admission; and

(3) Health Track Special Services. HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice

as defined under state law, justifying the need for the item or service requested;

(ii) [a] A description of the outcomes of any alternative measures tried; and

(iii) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-462. Payment limitations

(a) Psychiatrists' services shall be performed at the psychiatrist's private or group practice location, hospital, long-term care facility, clinic[,] or the client's home.

(b) The psychiatrist who employs allied health professionals shall personally conduct the evaluation and, accordingly, develop the treatment plan in all cases.

(c) In situations where the psychiatrist employs allied health professionals on a salary or fee-for-service basis, the psychiatrist shall be paid at the psychiatrists' rate only under the following conditions:

(1) [for] For clients personally being treated by the psychiatrist; and

(2) [when] When the psychiatrist personally interviews the client as part of the psychiatrist's supervisory responsibilities, but only at that rate which corresponds to the time or service [he or she] the psychiatrist actually provides to the client.

(d) Services provided by allied health professionals shall be billed at the rate for allied health professionals established by the department and not at the scheduled rate for psychiatrists.

(e) Fees for psychiatric evaluations include an allowance for the preparation of a full written report.

(f) When a psychiatrist renders consultation services and thereafter assumes the continuing care of the client, any subsequent services rendered by the psychiatrist or the psychiatrist's staff shall no longer be considered as a consultation and shall be billed at the rate applicable for the ongoing service.

(g) The fee for any procedure, as stipulated in the fee schedule for psychiatric services published by the department, represents the maximum amount payable per day regardless of the time it takes to complete the procedure.

(h) Payment for hospital inpatient services shall be limited to admissions to acute care hospitals.

(i) Payment for services provided by the admitting psychiatrist in an acute care hospital

shall not be made, or shall be recouped, if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity[, medical appropriateness], appropriateness of setting[,] or quality of care.

(j) The department shall pay psychiatrists for drugs which are administered or dispensed directly to a client under the following conditions:

(1) [excluding] Excluding oral medications, payment shall be made to a psychiatrist for the estimated acquisition cost as determined by the department for drugs which are administered directly to the client; and

(2) [for] For legend drugs which [must] are required to be administered by a psychiatrist, the department shall reimburse the psychiatrist for the estimated acquisition cost as determined by the department for the amount of the drug which is administered.

Sec. 17b-262-468. Definitions

For the purposes of sections 17b-262-467 [through] to 17b-262-478 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(2) "Commissioner" means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner's agent.

(3) "Department" means the Department of Social Services or its agent.

(4) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(5) "HealthTrack Special Services" means medically necessary [and medically appropriate] health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

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

(B) [services] Services covered under the State Plan and contained in a fee schedule

published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

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

(7) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(9)] (8) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes [(CGS)] and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.

[(10)] (9) “Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(11)] (10) “Prior [Authorization] authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(12)] (11) “Provider” means a psychologist.

[(13)] (12) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider [of services or goods].

[(14)] (13) “Psychologist” means a health professional, licensed by the Board of Examiners of Psychologists of Connecticut pursuant to section 20-186 [and under Chapter 383] of the Connecticut General Statutes, who is engaged in private practice and has clinical training and experience approved by the department to provide psychological services to clients eligible under Connecticut's Medical Assistance Program.

[(15)] (14) “Psychologists' [Services” that are permitted] services” means clinical, diagnostic[,] and remedial services personally performed by a psychologist. Services include:

(A) [counseling] Counseling and psychotherapy to [individuals] clients who are experiencing problems of a mental or behavioral nature; and

(B) [measuring] Measuring and testing of personality, aptitudes, emotions[,] and attitudes.

[(16)] (15) “Qualified [Neuropsychologist] neuropsychologist” means a psychologist who:

(A) [documents] Documents completion of a Ph.D. or Psy.D. degree in clinical psychology from a program approved by the American Psychological Association with extensive pre-or post-doctoral coursework in basic neurosciences, neuroanatomy, neuropathology, clinical neurology, psychological assessment, clinical neuropsychological assessment, psychopathology and psychological intervention; and either:

(B) [has] Has completed one year of full-time supervised clinical neuropsychological experience at the post-doctoral level and at least one year of independent professional experience as a clinical neuropsychologist, or, in lieu of (B), has

(C) [the] The equivalent of three years of unsupervised post-doctoral experience as a clinical neuropsychologist within the past ten years.

[(17)] (16) “Neuropsychological [Evaluation] evaluation” means a full battery of tests used to develop a diagnosis. The evaluation is the sum of all the testing and diagnostic interview sessions. The components of the neuropsychological evaluation are: patient history; assessment of perceptual motor functions; language functions; attention; memory, learning, intellectual processes and level; and emotional, behavioral, and personality functioning. The evaluation must be accomplished by means of appropriate psychological procedures administered by a qualified neuropsychologist.

[(18)] (17) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

Sec. 17b-262-471. Services covered and limitations

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

(a) The department shall pay for the following psychological services:

(1) Psychodiagnostic [Evaluations] evaluations

(A) Intellectual [Evaluation – Individual] evaluations of individuals

Evaluation of intellectual functioning by means of appropriate psychological procedures, such as: the Wechsler Adult Intelligence Scale[,]; Wechsler Intelligence Scale for Children[,]; and Stanford-Binet Intelligence Scale;

(B) Scholastic [Achievement or Group Intelligence] achievement of group intelligence

(i) Scholastic [Achievement] achievement: Determination of acquired abilities in areas of educational achievement through the administration and evaluation of tests[,], such as the California Reading Test[,] and Wide Range Achievement Test; and

(ii) Group [Intellectual Evaluation] intellectual evaluation: Determination of intellectual functioning by means of group intelligence tests such as the Lorge-Thorndike Intelligence Test, Otis Quick-Scoring Mental Ability Test, and California Short-Form Test of Mental Maturity;

(C) Personality [Diagnosis and Evaluation] diagnosis and evaluation

Study of personality dynamics, interpersonal relations, emotional adjustment[,], and stability, through the utilization of psychological procedures such as Rorschach, MMPI, Thematic Apperception Test, Children's Apperception Test, and Figure-Drawing;

(D) Evaluation of [Organic Brain Involvement] organic brain involvement: Organicity

Assessment of functions requiring memory, concept formation, visual motor skills, by means of psychological procedures such as the Wechsler Memory Scale, Goldstein-Scheerer Battery Graham-Kendall Memory for Designs, and Bender Visual Motor Gestalt Test;

(E) Evaluation of [Aptitudes, Interests, and Educational Adjustment] aptitudes, interests and educational adjustment

Assessment of vocational aptitudes and interests and educational achievement by means of such procedures as manipulation tests of dexterity and coordination, vocational aptitude tests, interest tests[,], and achievement tests; and

(F) Neuropsychological [Evaluation] evaluation

Assessment of perceptual or motor functions; attention; memory; and learning; intellectual processes; and emotion, behavior, and personality by means of appropriate

psychological procedures administered by a qualified neuropsychologist, such as the Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, and the Halstead-Reitan Neuropsychological Battery.

(2) Counseling and [Psychotherapy] psychotherapy

(A) Diagnostic [Interview] interview;

Initial contact, review of available records[,] and personal interview with subject.
Applicable only when formal testing is not possible;

(B) Individual [Counseling] counseling or [Psychotherapy] psychotherapy; and

(C) Group [Counseling] counseling or [Psychotherapy.] psychotherapy;

(3) Staff [Consultation] consultation

Attendance at staff conferences to present and to discuss psychological findings in planning for the individual; and

(4) [Health Track] HeathTrack Services and [Health Track] HealthTrack Special Services.

Sec. 17b-262-473. Need for service and authorization process

(a) Need for Service

The department shall pay for psychological services which are provided by a licensed psychologist and are medically necessary [and medically appropriate] for the prevention, diagnosis[,] and treatment of intellectual functioning and mental illness.

(b) Prior Authorization

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

(A) [all] All clients for all counseling and psychotherapy interviews in excess of thirteen visits in a calendar quarter, per type of treatment for the same provider and client; and

(B) Health Track Special Services. HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) [a] A written statement from the prescribing physician, or other licensed practitioner

of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) [a] A description of the outcomes of any alternative measures tried; and

(iii) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-478. Documentation

(a) Psychologists shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name[.]; address[.]; birth date[.]; Medical Assistance Program identification number[.]; pertinent diagnostic information[.]; a current treatment plan signed by the psychologist[.]; documentation of services provided[.]; and the dates the services were provided.

(b) The evaluation report for psychodiagnostic tests, including the [Aptitudes, Interests, and Education Adjustment Evaluation] aptitudes, interests and education adjustment evaluation, shall be on file with the psychologist to justify medical necessity [and medical appropriateness] of treatment.

[(b)] (c) All required documentation shall be maintained for at least five years in the psychologist's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

[(c)] (d) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the psychologist for which the required documentation is not maintained and provided to the department upon request.

Sec. 17b-262-500. Definitions

For the purposes of sections 17b-262-499 [through] to 17b-262-510, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Active [Treatment] treatment” [means the definition contained in 42 Code of Federal Regulations (CFR), Part 441, section 441.154] has the same meaning as provided in 42 CFR 441.154.

(2) “Acute” means having rapid onset, severe symptoms[,], and a short course.

(3) “Acute [Care] care” means medical care needed for an illness, episode[,], or injury which requires short-term, intense care[,], and hospitalization for a short period of time.

(4) “Allied Health Professional [(AHP)]” or “AHP” means a professional or paraprofessional individual who is qualified by special training, education, skills[,] and experience in mental health care and treatment and shall include, but shall not be limited to: psychologists[,] social workers[,] psychiatric nurses[,] and other qualified therapists.

(5) “Certification of [Need Review] need review” means an evaluation process for clients under the age of twenty-one who are requesting inpatient admission to a psychiatric hospital. This evaluation is conducted by the department acting as the independent team.

(6) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.

(7) “Client [Age Sixty-Five or Over] age sixty-five or over” [means the definition contained in 42 CFR, Part 441, section 441.100] has the same meaning as provided in 42 CFR 441.100.

(8) “Client [Under Age Twenty-One] under the age of twenty-one” [means the definition contained in 42 CFR, Part 441, section 441.151] has the same meaning as provided in 42 CFR 441.151.

(9) “Department” means the Department of Social Services or its agent.

(10) “Elective [Admission] admission” means any psychiatric admission to a psychiatric hospital or psychiatric facility that is nonemergency, including urgent admissions and transfers from one facility to another.

(11) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment[,] or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) [service] Services not covered under the State Plan or contained in a fee schedule published by the department; or

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

(13) “Independent [Team] team” means the definition contained in 42 CFR, Part 441, section 441.153] has the same meaning as provided in 42 CFR 441.153. In addition, the independent team may not include anyone who is related, in any way, to the admitting

facility, or who is directly responsible for the care of [patients] a client's whose care is being reviewed[,] or has a financial interest in the admitting facility. The department performs the functions of the independent team.

(14) "Inpatient" [means the definition contained in 42 CFR, Part 440, section 440.2] has the same meaning as provided in 42 CFR 440.2. The client [must] shall also be present in the hospital at midnight for the census count.

(15) "Interdisciplinary [Team] team" [for review of clients under the age of twenty-one, means the definition contained in 42 CFR, Part 441, section 441.156] has the same meaning as provided in 42 CFR 441.156 and applies only to the review of clients under the age of twenty-one (21).

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

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

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

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

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

[(21)] (20) "Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

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

meaning as provided in 42 CFR 482.61, as amended from time to time.

[(23)] (22) “Plan of [Care]care” [means the definitions contained in 42 CFR, Part 441, Subpart D, and Part 456, sections 456.180 [through] to 456.181.] has the same meaning as provided in 42 CFR 456.180 to 456.181, inclusive, as amended from time to time.

[(24)] (23) “Preadmission [Review] review” means a review prior to[,] or, in the case of an emergency admission, within fourteen (14) days after a client's admission to an inpatient psychiatric facility with the purpose of determining the medical necessity[, appropriateness,] and quality of the health care services to be delivered, or in the case of an emergency, delivered in the hospital.

[(25)] (24) “Prior [Authorization] authorization” means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(26)] (25) “Provider” means a psychiatric hospital or psychiatric facility.

[(27)] (26) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(28)] (27) “Psychiatric [Emergency] emergency” means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability[,] or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a Physician Emergency Certificate are not automatically deemed to qualify as a psychiatric emergency.

[(29)] (28) “Psychiatric [Facility] facility” means an institution which is not a hospital and is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHO[]), to provide inpatient psychiatric services under the direction of a physician to clients who are under the age of twenty-one (21) or age sixty-five (65) or over, and meets specific conditions [contained at 42 CFR, Part 435, section 435.1009] in 42 CFR 435.1109.

[(30)] (29) “Psychiatric [Hospital] hospital” means an accredited or state licensed institution which is engaged in providing hospital level psychiatric services, under the supervision of a physician, for the diagnosis and treatment of mentally ill persons. Specific conditions for psychiatric hospital [contained at 42 CFR, Part 482, sections 482.60 through 482.62, and at 42 CFR, Part 435, section 435.1009] in 42 CFR 482.60 to 482.62, inclusive, and 42 CFR 435.1009 shall be implemented. Psychiatric units or beds in a general, acute care hospital are not included in this definition.

[(31)] (30) “Quality of [Care] care” means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the

condition and the client under treatment.

[(32)] (31) “Retrospective [Review] review” means the review conducted after services are provided to a client, to determine the medical necessity[, appropriateness,] and quality of the services provided.

[(33)] (32) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations] 42 CFR 430, Subpart B.

[(34)] (33) “Transfer” means that [an individual] a client is discharged from the hospital or facility and directly admitted to another.

[(35)] (34) “Under the [Direction of a Physician] direction of a physician” means that health services may be provided by allied health professionals whether or not the physician is physically present at the time that the services are provided. The physician shall:

(A) [assume] Assume professional responsibility for the services provided;

(B) [assure] Assure that the services are medically [appropriate] necessary; and

(C) [be] Be readily available within five minutes but not necessarily on the premises.

[(36)] (35) “Urgent [Admission] admission” means an elective, nonemergency admission.

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

Sec. 17b-262-503. Services covered

The department shall pay for the following:

(a) [medically] Medically necessary [and medically appropriate] inpatient psychiatric services for clients under age twenty-one (21) or age sixty-five (65) or over when the need for services as stated in section 17b-262-499 [through] to [section] 17b-262-511, inclusive, of the Regulations of Connecticut State Agencies, are met and provided by an enrolled Medical Assistance Program provider;

(b) [inpatient] Inpatient hospital tests when the tests are specifically ordered by the attending physician or other licensed practitioner who is responsible for the diagnosis and treatment of the client, and who is acting within the scope of practice as defined under state law;

(c) HealthTrack Services; and

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

Sec. 17b-262-504. Services not covered

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

(a) [procedures] Procedures or services of an unproven, educational, social, research, experimental[,] or cosmetic nature or for any diagnostic, therapeutic[,] or treatment procedures in excess of those deemed medically necessary [and appropriate] by the department to treat the client's condition;

Sec. 17b-262-508. Utilization review program for inpatient psychiatric services for clients under age twenty-one or age sixty-five or over

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

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

(1) [require] Require preadmission review or prior authorization of each inpatient psychiatric hospital admission, including a certificate of need review, for clients under age twenty-one (21), unless the department notifies the providers that a specific admission, diagnosis[,] or procedure does not require such authorization; and

(2) [perform] Perform retrospective reviews at the department's discretion which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the [appropriateness,] necessity[,] or quality of the health care services provided.

Sec. 17b-262-513. Definitions

For the purposes of sections 17b-262-512 [through] to 17b-262-520, inclusive, of the

Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Acute” means having rapid onset, severe symptoms[,] and a short course.
- (2) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.
- (3) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner’s agent.
- (4) “Department” means the Department of Social Services or its agent.
- (5) “Electrocardiogram [(EKG)] Services” or “EKG Service” means diagnostic services derived from an electrocardiogram device which measures the electrical variations in heart muscles.
- (6) “Electroencephalogram [(EEG)] Services” or “EEG Services” means diagnostic services derived from an electroencephalogram instrument which records the electrical activity of the brain.
- (7) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions[,] or serious dysfunction of any bodily organ or part.
- (8) “Freestanding [Radiology or Ultrasound Center] radiology or ultrasound center” means those centers which offer radiology or ultrasound services but which are not part of a physician's office nor an inpatient or outpatient hospital service.
- (9) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.
- (10) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:
 - (A) [services] Services not covered under the State Plan or contained in a fee schedule published by the department; or
 - (B) [services] Services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established

by the department that are contained in regulation.

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

(12) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(14)] (13) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.

[(15)] (14) “Medical [Necessity or Medically Necessary]” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(16)] (15) “Prior [Authorization] authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(17)] (16) “Provider” means a radiology or ultrasound center which provides professional and technical services and which is independent of a physician's office or an inpatient or outpatient hospital department or clinic.

[(18)] (17) “Provider [Agreement] agreement” means the signed, written, contractual, agreement between the department and the provider of services or goods.

[(19)] (18) “Radiology” means any diagnostic and treatment service administered through the use of radiant energy.

[(20)] (19) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

[(21)] (20) “Ultrasound [Services] services” means diagnostic and therapeutic services

administered by ultrasound equipment--equipment emitting inaudible sound frequencies in the approximately 20,000 to 10,000,000,000 cycles per second range.

Sec. 17b-262-516. Services covered

The department shall pay for:

(a) [medically appropriate and medically] Medically necessary radiology or ultrasound center services as published in the department's fee schedule when ordered by a licensed physician or other licensed practitioner of the healing arts; and

(b) HealthTrack Services and HealthTrack Special Services.

Sec. 17b-262-517. Need for service and authorization process

(a) Need for Service

The department shall pay for independent radiology and ultrasound center services which are ordered by a [duly] licensed physician or other licensed practitioner of the healing arts and [which] that the department deems to be medically necessary [and medically appropriate].

(b) Prior Authorization

Prior authorization, on forms and in a manner as specified by the department, shall be required for HealthTrack Special Services:

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

(2) [the] The request for Health Track Special Services shall include:

(A) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(B) [a] A description of the outcomes of any alternative measures tried; and

(C) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

(c) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior

authorization does not, however, guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-523. Definitions

For the purposes of sections 17b-262-522 [through] to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies the following definitions apply:

- (1) “Acute” means symptoms that are severe and have a rapid onset and a short course;
- (2) “Border provider” means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents[,] and that is enrolled as and treated as a Connecticut Medical Assistance Program provider. Such providers are certified, accredited[,] or licensed by the applicable agency in their state and are deemed border providers by the department on a [case by case] case-by-case basis;
- (3) “Claim” means a request for payment submitted by a provider to the department, or its fiscal agent, in accordance with the billing requirements set forth by the department;
- (4) “Client” means a person eligible for goods or services under the department's Medical Assistance Program;
- (5) “Commissioner” means the commissioner of the Connecticut Department of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner’s agent;
- (6) “Copayment” means a nominal fee, chargeable to the client and not payable from the department, for specified goods or services and [which] that meets the requirements of section 1916 of the Social Security Act, [and] 42 CFR 447.15 and 42 CFR 447.50 to 42 CFR 447.58, inclusive;
- (7) “Coverable Medical Assistance Program good or service” means any good or service which is payable by the Medical Assistance Program under its regulations;
- (8) “Department” means the [Connecticut] Department of Social Services or its agent;
- (9) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;
- (10) “Free of charge” means a good or service for which no individual client has an obligation to pay and for which no third party payment is ever sought;

(11) “Lock-in” means the department's restriction of a client to a specific provider for certain Medical Assistance Program goods or services under the authority of section 17-134d-11 of the Regulations of Connecticut State Agencies;

[(12) “Medical appropriateness or medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;]

[(13)] (12) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid;

[(14)] (13) “Medical Assistance Program goods or services” means medical care or items that are furnished to a client to meet a medical necessity in accordance with applicable statutes or regulations that govern the Medical Assistance Program;

[(15)] (14) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(16)] (15) “Medicare” means the federal health care program authorized by [Title] title XVIII of the Social Security Act;

[(17)] (16) “Out-of-state provider” means a provider who is licensed, certified[,] or accredited in a state other than Connecticut; has a business address outside of Connecticut; and does not meet the definition of "border provider";

[(18)] (17) “Overpayment” means any payment that represents an excess over the allowable payment under state law including, but not limited to, amounts obtained through fraud and abuse;

[(19)] (18) “Point of sale” or “POS” means the department's on-line, real time pharmacy electronic claims transmission. This process also includes prospective drug utilization review;

[(20)] (19) “Prior authorization” means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(21)] (20) “Prospective drug utilization review” or “pro-DUR” means a client-specific drug utilization review prior to dispensing;

[(22)] (21) “Provider” means any individual or entity that furnishes Medical Assistance

Program goods or services pursuant to a provider agreement with the department and is duly enrolled and in good standing or, as the context may require, an individual or entity applying for enrollment in the Medical Assistance Program;

[(23)] (22) “Provider agreement” means the signed, written, contractual agreement between the department and the provider of services or goods;

[(24)] (23) “Provider enrollment or reenrollment form” means the department's form which requests the provider's data such as, but not limited to: name[,]; address[,]; licensure or certification information[,]; service protocols[,]; and any other information required by the department to assess provider eligibility for participation in the Medical Assistance Program;

[(25)] (24) “Suspension” means limiting program participation of providers who, although not convicted of program-related crimes, are found by the department to have violated rules, regulations, standards or laws governing any such program;

[(26)] (25) “Termination” means precluding medical assistance program participation by providers that have been convicted of a crime involving [medicaid] Medicaid or [medicare] Medicare;

[(27)] (26) “Third party” means any individual, private or public organization, or entity that is or may be liable to pay all or part of the medical costs of injury, disease[,] or disability for a client pursuant to 42 CFR 433.136;

[(28)] (27) “Third party liability” as it applies to Medical Assistance Program claims processing, means payment resources available from both private and public health insurance that can be applied toward Medical Assistance Program clients' medical and health benefit expenses. A pending tort recovery or cause of action, worker's compensation or accident insurance settlement is not a third party liability; and

[(29)] (28) “Type and specialty” means the department's categorization of Medical Assistance Program providers according to the type and specialty of the goods or services furnished by the provider.

Sec. 17b-262-527. Need for goods or services

The department shall review the [medical appropriateness and] medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such goods and services.

Sec. 17b-262-528. Prior authorization

(a) Prior authorization, to determine [medical appropriateness and] medical necessity,

shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

Sec. 17b-262-531. Payment limitations

Payment, by the department, to all providers shall be limited to [medically appropriate and] medically necessary goods or services furnished to Medical Assistance Program clients. The following payment limitations shall also apply:

- (a) [the] The department shall not make payment for any claim for Medical Assistance Program goods or services for persons not eligible for the Medical Assistance Program on the date the good or service is provided, except for those medical services required and requested by the department to determine a person's eligibility for the program;
- (b) [the] The department shall not make payment for any Medical Assistance Program goods or services which are not covered under, and furnished in accordance with federal and state statutes and regulations including 42 USC 1396b(f);
- (c) [the] The department shall not make an additional payment when a third party payment is equal to or greater than the department's schedule of payment for the same Medical Assistance Program good or service, except to meet the department's obligations as defined by federal and state laws and regulations;
- (d) [the] The department shall not make payment for Medical Assistance Program goods or services furnished by a provider after the date of termination of the provider, or during a period of suspension, from the Medical Assistance Program, except as may be determined by the commissioner;
- (e) [the] The department shall make payment only to [a duly] an enrolled provider;
- (f) [the] The department shall not pay for goods or services that are furnished to providers or clients free of charge;
- (g) [the] The department shall not pay for any procedures, goods[,] or services of an unproven, educational, social, research, experimental[,] or cosmetic nature; for any diagnostic, therapeutic[,] or treatment goods or services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms[,] or medical history;

Sec. 17b-262-536. Definitions

For the purposes of sections 17b-262-535 [through] to 17b-262-545, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

- (1) “Acute” means having rapid onset, severe symptoms[,] and a short course.
- (2) “Chiropractic” means the services described in [Title] title 42 of the Code of Federal Regulations (CFR), Part 440, section 440.60 and subsection (1) of] has the same meaning as provided in section 20-24 of the Connecticut General Statutes.
- (3) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.
- (4) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner's agent.
- (5) “Department” means the Department of Social Services or its agent.
- (6) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions[,] or serious dysfunction of any bodily organ or part.
- (7) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.
- (8) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment[,] or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:
 - (A) [services] Services not covered under the State Plan or contained in a fee schedule published by the department; or
 - (B) [services] Services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.
- (9) “Interperiodic [Encounter] encounter” means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited

to:[,] physician's office visits;[,] clinic visits;[,] and other primary care visits.

(10) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(12)] (11) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes [(CGS)] and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.

[(13)] (12) "Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(14)] (13) “Medical [Record] record” [means the definition contained] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies[, which is also the Public Health Code].

[(15)] (14) “Prior [Authorization] authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(16)] (15) “Provider” means one who is licensed to practice chiropractic.

[(17)] (16) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(18)] (17) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

[(19)] (18) “Subluxation” means an incomplete dislocation, off centering, misalignment fixation of a joint or abnormal spacing of a vertebra as used by the practitioner of chiropractic.

Sec. 17b-262-539. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for the following:

(1) [the] The manual manipulation of the spine, but not for any procedures or services of an unproven, educational, social, research, experimental[,] or cosmetic nature; for services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms[,] or medical history;

(2) [services] Services provided in the provider's office, client's home, hospital, nursing facility, rest home, home for the aged, boarding home[,] or intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities; and

(3) Health Track Services and HealthTrack Special Services.

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

(1) [those] Those services listed in the department's fee schedule and within the scope of the provider's practice;

(2) [the] The department shall pay for no more than one visit per day₁ per client₁ per provider; and

(3) [the] The department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home[,] or intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities.

Sec. 17b-262-541. Need for service

The department shall pay for medically necessary [and medically appropriate] treatment only when:

(a) [provided] Provided by a licensed practitioner of chiropractic and the services are within the scope of practice of the practitioner[,]₂ and

(b) [the] The services are made part of the client's medical record.

Sec. 17b-262-542. Prior authorization

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

(1) [manipulation] Manipulation of the spine in excess of five per client₁ per provider₁ per

month; and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis. The request for HealthTrack Special Services shall include:

(A) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within [his or her] the provider's respective scope of practice as defined under state law, justifying the need for the item or service required;

(B) [a] A description of the outcomes of any alternative measures tried; and

(C) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-548. Definitions

For the purposes of sections 17b-262-547 [through] to 17b-262-557, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Acute” means having rapid onset, severe symptoms[,] and a short course.

(2) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.

(3) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner's agent.

(4) “Department” means the Department of Social Services or its agent.

(5) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions[,] or serious dysfunction of any bodily part or organ.

(6) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.

(7) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment[,] or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic

encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

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

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

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

(9) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(11)] (10) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes [(CGS)] and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.

[(12)] (11) "Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(13)] (12) “Medical [Record” means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code] record” has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies.

[(14)] (13) “Natureopathy” means the practice of natureopathy as defined in subsections (a) and (b) of section 20-34 of the Connecticut General Statutes.

[(15)] (14) “Prior [Authorization] authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(16)] (15) “Provider” means one who is licensed to practice natureopathy.

[(17)] (16) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(18)] (17) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of [Title] title 42 of the Code of Federal Regulations [(CFR)].

Sec. 17b-262-551. Services covered and limitations

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

(a) The department shall pay for the following:

(1) [services] Services provided in the provider's office[or], client's home, hospital, nursing facility, rest home, home for the aged, boarding home[,] or intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities and

(2) HealthTrack Services and HealthTrack Special Services.

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

(1) [services] Services covered shall be limited to those listed in the department's fee schedule and within the scope of the provider's practice;

(2) [only] Only one visit per day, per client, per provider shall be paid for; and

(3) [the] The department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home[,] or intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities.

Sec. 17b-262-553. Need for service

The department shall pay for medically necessary [and medically appropriate] treatment

only when:

(a) [provided] Provided by a licensed natureopath and the services are within the scope of the natureopath's scope of practice, and

(b) [the] The services are made part of the client's medical record.

Sec. 17b-262-554. Prior authorization

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

(1) [professional] Professional office or home visits in excess of five per client, per provider, per month[,]; and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within [his or her] the provider's respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) [a] A description of the outcomes of any alternative measures tried; and

(iii) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-560. Definitions

For the purposes of sections 17b-262-559 [through] to 17b-262-571, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms[,], and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner's agent.

- (4) “Department” means the Department of Social Services or its agent.
- (5) “Doctor of [Osteopathy] osteopathy” means a doctor of osteopathy licensed pursuant to section [20-17] 20-13 of the Connecticut General Statutes.
- (6) "Early and [Periodic Screening, Diagnostic and Treatment Services (EPSDT)] periodic screening, diagnostic and treatment services", "EPSDT Services" or "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.
- (7) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions[,] or serious dysfunction of any bodily organ or part.
- (8) “Fees” means the rates for services, treatments[,] and drugs administered by ophthalmologists, optometrists[,] and opticians which shall be established by the commissioner of the department and contained in the department's fee schedules.
- (9) “Incomplete [Eye Exam] eye exam” means an annual eye exam which is not completed since the preliminary findings reveal that visual analysis is not indicated.
- (10) “Interperiodic [Encounter] encounter” means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to:[,] physician's office visits;[,] clinic visits;[,] and other primary care visits.
- (11) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].
- [(12) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.]
- [(13)] (12) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes [(CGS)] and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.
- [(14)] (13) “Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut

General Statutes.

[(15)] (14) “Medical [Record] means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code] record” has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies.

[(16)] (15) “Modified [Lens Prescription] lens prescription” means a prescription given to a client because of:

(A) [a] A radical change in the prescription;

(B) [a] A large initial prescription; or

(C) [amblyopia] Amblyopia, latent hyperopia, or inadequate care previously received.

[(17)] (16) “Ophthalmologist” means a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes, who within his or her scope of practice as defined by state law, specializes in the branch of medicine dealing with the structure, functions, pathology[,] and treatment of the eyes. The practice includes the use of surgery, x-ray, photocoagulation, ionizing radiation[,] and drugs for examination of the eyes.

[(18)] (17) “Optician” means an individual licensed pursuant to section 20-145 of the Connecticut General Statutes having a knowledge of optics and is skilled in the technique of producing and reproducing ophthalmic lenses and kindred products and who, within his or her scope of practice as defined by state law, prepares and dispenses ophthalmic lenses and products to correct visual defects.

[(19)] (18) “Optometrist” means an individual licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as [delineated in subsections (a) (1) and (2) of] provided in section [20-127] 20-127(a) of the Connecticut General Statutes.

[(20)] (19) “Physician” means [a physician] an individual licensed pursuant to section [20-10] 20-13 of the Connecticut General Statutes.

[(21)] (20) “Prior [Authorization] authorization” means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(22)](21) “Progressive [Myopia] myopia” means a known progressive myopia, changing .75 diopters in the past six months.

[(23)] (22) “Provider” means a licensed ophthalmologist, optometrist[,] or optician.

[(24)] (23) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(25)] (24) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

[(26)] (25) “Usable [Lens] lens” means a lens which is not scratched or otherwise defective so as to impair use or endanger the wearer.

[(27)] (26) “Usual and [Customary Charge] customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. When calculating the median charge, token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-563. Services covered and limitations

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

(b) The department shall pay providers for:

(1) [only] Only those procedures listed in the provider's fee schedule and within the scope of the provider's practice;

(2) [services] Services provided in the provider's office, client's home, hospital, nursing facility, rest home, intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities, chronic disease hospital, boarding home, state-owned or state-operated institution[,] or home for the aged;

(3) [two] Two pairs of eyeglasses, distance and near, permitted in lieu of bifocals, when need for same is substantiated in the client's medical record by clinical data from the provider; and

(4) [Early] early periodic screening, diagnostic and treatment services.

Sec. 17b-262-565. Need for service

The department shall pay for medically necessary [and medically appropriate] vision care services for Medical Assistance Program eligible clients, in relation to the diagnosis for which care is required, provided that:

- (a) [the] The services are within the scope of the provider's practice;
- (b) [the] The services are made part of the client's medical record; and
- (c) [for] For contact lenses, glasses[,] or vision training, only when prescribed by a physician, doctor of osteopathy[,] or optometrist.

Sec. 17b-262-574. Definitions

For the purposes of sections 17b-262-573 [through] to 17b-262-585, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Acute” means having rapid onset, severe symptoms[,] and a short course.
- (2) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.
- (3) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner’s agent.
- (4) “Consultation and [Collaborative Management] collaborative management” means those services rendered by the obstetrician-gynecologist who is part of the health care team whose opinion or advice is requested by the client's nurse-midwife in the evaluation or treatment of the client. The consultant obstetrician-gynecologist may prescribe a course of treatment provided by the nurse-midwife. It does not necessarily mean the client shall be seen by the obstetrician-gynecologist.
- (5) “Department” means the Department of Social Services or its agent.
- (6) “Directed” means a nurse-midwife shall always function within a health care system in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.
- (7) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions[,] or serious dysfunction of any bodily organ or part.
- (8) “Essentially [Normal] normal” means a philosophic view of childbirth as a natural,

normal process. Essentially normal means that if a client develops complications, the nurse-midwife either consults or collaborates with the physician in the management of care of the client or, depending on the severity of the complication, refers the client to the physician. This reflects again the team relationship with the physician, because normal is defined by the [nurse-midwives] nurse-midwives and physicians in a particular practice setting.

(9) “Family [Planning Services] planning services” means any medically approved diagnostic procedure, treatment, counseling, drug, supply[,] or device which is prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

(10) “Health [Care Team] care team” means the nurse-midwife shall function in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.

(11) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment[,] or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

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

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

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

(14) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

(15) “[Long-Term Care Facility] Long-term care facility” means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) [nursing] Nursing facilities[,];

(B) Inpatient chronic disease hospitals[—inpatient,]; and

(C) [intermediate] Intermediate care facilities for [the mentally retarded (ICFs/MR)] individuals with intellectual disabilities.

(16) “Management of [Care] care” means the responsibilities and accountability the nurse-midwife shall assume and the mandatory relationship this shall require with a physician. This management is independent in the fact that a client who experiences an essentially normal maternity cycle or requires well-woman gynecological care may have her care provided entirely by the nurse-midwife.

(17) “Maternity [Cycle] cycle” means a period limited to:

(A) [pregnancy,] Pregnancy;

(B) [labor,] Labor;

(C) [birth,] Birth; and

(D) [the] The immediate postpartum period, not to exceed six weeks from the child's date of birth.

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

[(19)] (18) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes [(CGS)] and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.

[(20)] (19) “Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(21)] (20) “Medical [Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code] record” has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies.

[(22)] (21) “Nurse-midwife” means a person who meets all of the conditions established

in subsection (2) of section 20-86a of the Connecticut General Statutes.

[(23)] (22) “Nurse-midwifery [Services] services” are the services established in subsection (1) of section 20-86a and [section] 20-86b of the Connecticut General Statutes.

[(24)] (23) “Physician” means a physician licensed pursuant to section [20-10] 20-13 of the Connecticut General Statutes who practices as an obstetrician-gynecologist.

[(25)] (24) “Prior [Authorization] authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(26)] (25) “Provider” means a licensed nurse-midwife.

[(27)] (26) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(28)] (27) “Referral” means the nurse-midwife requests a consultation and collaboration with the physician on a client which results in the physician providing the care for the client.

[(29)] (28) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

Sec. 17b-262-577. Services covered and limitations

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

(a) The department shall pay for the following:

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

(2) [family] Family planning services as described in section 17b-262-574 of the Regulations of Connecticut State Agencies; and

(3) HealthTrack Services and HealthTrack Special Services.

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

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

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

Sec. 17b-262-579. Need for service

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

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

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

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

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

Sec. 17b-262-580. Prior authorization

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

(1) [more] More than one visit per day per client; and

(2) HealthTrack Special Services.

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

(B) [the] The request for HealthTrack Special Services shall include:

(i) [a] A written statement from the prescribing physician, or other licensed practitioner

of the healing arts, performing such services within [his or her] the provider's respective scope of practice as defined under state law, justifying the need for the item or services required;

(ii) [a] A description of the outcomes of any alternative measures tried; and

(iii) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-598. Definitions

For the purposes of section 17b-262-597 [through] to 17b-262-605, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) “Allied Health Professional” or “AHP” means an individual who is licensed or certified or who is qualified by special training, education, skills[,] and experience to provide early intervention services. Such individuals include, but are not limited to: nurses[,] physician assistants[,] masters level social workers[,] special education teachers[,] speech therapy assistants[,] nutritionists[,] and family therapists.

(2) “Assessment” [means the definition contained in Part H of the Individuals with Disabilities Education Act (IDEA), Title 20 United States Code (USC), section 1477(a), and at Title 34 Code of Federal Regulations (CFR), Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322, and at subdivision (2) of subsection (b) of section 303.322] has the same meaning as provided in 34 CFR 303.322(a)(2).

(3) “Assessment [Team] team” means a multidisciplinary team of qualified[, as defined in Title 34 CFR, Part 303, section 303.21,] service providers selected by the performing provider, based on results of the child's evaluation, to perform an assessment to determine the service needs of the child based on the diagnosis of the evaluation team.

(4) “Assistive [Technology Devices]” means the assistive technology devices as defined in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (1) of subsection (d) of section 303.12] technology devices” has the same meaning as provided in 34 CFR 303.13(b)(1).

(5) “Assistive [Technology Services]” means the assistive technology services defined in Part H of IDEA, 20 USC et seq., and at Title 34 CFR, Part 303, subdivision (1) of subsection (d) of section 303.12] technology services” has the same meaning as provided in 34 CFR 303.13(b)(1).

(6) “Audiology” [means the definition contained in Part H of IDEA, Title 20 USC et seq., and at Title 34 CFR, Part 303, subdivision (2) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(2).

(7) “Audiologist” means one who is licensed to practice audiology pursuant to Chapter 399 of the Connecticut General Statutes.

(8) “Billing [Provider] provider” means [DMR] the Department of Developmental Services or another state agency responsible for coordinating and delivering early intervention services to Birth to Three eligible children. Billing providers may also be responsible for service coordination and may be a performing provider.

(9) “Birth to Three [Eligible Child] eligible child” means a child from birth to age three who is:

(A) [experiencing] Experiencing a significant developmental delay as measured by standardized diagnostic test or clinical opinion in one or more of the following areas:

(i) [cognitive] Cognitive development;

(ii) [physical] Physical development, including vision or hearing;

(iii) [communication] Communication development; or

(iv) [adaptive] Adaptive skills; or

(B) [diagnosed] Diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay; and

(C) [qualified] Qualified to receive services under the Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

(10) “Birth to Three System” means a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities.

(11) “Child” means a person who is under twenty-one years of age.

(12) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner’s agent.

(13) “Department” means the Department of Social Services or its agent.

(14) “Developmental [Delay] delay” means a significant delay in one or more of the following areas: cognitive development; communication development; physical development, including vision or hearing; social or emotional development; or adaptive skills or development.

- (15) “Developmental [Therapy] therapy” means special instruction.
- (16) "DMR" [means] or “DDS” means the Department of Developmental Services. [the Department of Mental Retardation.]
- (17) “Early [Intervention Record] intervention record” means the written record maintained for both the eligible child and the [noneligible] non-eligible child for the Birth to Three System.
- (18) “Early [Intervention Services]” means services which are defined in Part H of IDEA, Title 20 USC 1471 et seq., and those listed explicitly in Title 34 CFR, Part 303, subsection (d) of section 303.12] intervention services” has the same meaning as provided in 20 USC 1432.
- (19) “Evaluation” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322, and subdivision (1) of subsection (b) of section 303.322, and as defined] has the same meaning as provided in section 17a-248 of the Connecticut General Statutes.
- (20) “Evaluation [Team] team” means two or more qualified allied health professionals[, as defined in Title 34 CFR, Part 303, section 303.21], selected by the performing provider, from different disciplines matched to the needs of the child based on available information, to perform an evaluation.
- (21) “Family [Training, Counseling, and Home Visits]” means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (3) of subsection (d) of section 303.12] training, counseling, and home visits” has the same meaning as provided in 34 CFR 303.13(b)(3).
- (22) “Health Care Financing Administration”, [or] “HCFA”, “Centers for Medicare and Medicaid Services” or “CMS” means the federal agency within the Department of Health and Human Services which administers both the Medicaid and Medicare programs.
- (23) “Health [Services]” means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (4) of subsection (d) of section 303.13] services” has the same meaning as provided in 34 CFR 303.16.
- (24) “Individualized Family Service Plan” or “[(IFSP)]” [means the definition contained under in Part H of IDEA, Title 20 USC 1471 et seq., and Title 20 USC, section 1477(d), and at Title 34 CFR, Part 303, subsection (b) of section 303.340] has the same meaning as provided in 34 CFR 303.340.
- (25) “Lead [Agency] agency” means the Department of [Mental Retardation (DMR)] Developmental Services pursuant to [Title 34 of the CFR, Part 303, section 303.500] 34 CFR 303.22.

(26) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(28)] (27) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319V of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act. The program is also referred to as Medicaid.

[(29)] (28) “Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(30)] (29) “Medical [Services] services” [means the definition contained in Part H of IDEA and at Title 34 CFR, Part 303, subdivision (5) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(5).

[(31)] (30) “Multidisciplinary [Team] team” means [the definition contained in Part H of IDEA, Title 20 USC, and at Title 34 CFR, Part 303, section 303.17, and] a team of two or more persons from different disciplines, one of whom shall be an allied health professional.

[(32)] (31) “Natural [Environments] environments” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subsection (b) of section 303.12] has the same meaning as provided in 34 CFR 303.26.

[(33)] (32) “Nursing [Services] services” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (6) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(6).

[(34)] (33) “Nutrition [Services]services” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and [at Title 34 CFR, Part 303, subdivision (7) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(7).

[(35)] (34) “Occupational [Therapy] therapy” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (8) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR

303.13(b)(8).

[(36)] (35) "Part H of IDEA" means Part H of the Individuals with Disabilities Education Act [(IDEA)], [Title] title 20 United States Code [(USC)], section 1471 et seq.

[(37)] (36) "Performing [Provider] provider" means:

(A) [any] Any billing provider;

(B) [any] Any independent provider under contract with a billing provider; or

(C) [any] Any state agency under contract with a billing provider providing diagnostic services or treatment services recommended by a licensed practitioner of the healing arts and in accordance with the IFSP.

[(38)] (37) "Physician" means an individual licensed under Chapter 370 or 371 of the Connecticut General Statutes as a doctor of medicine or osteopathy.

[(39)] (38) "Physical [Therapy] therapy" [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (9) of subsection (d) of section 303.12, and section 20-74 of the Connecticut General Statutes] has the same meaning as provided in 34 CFR 303.13(b)(9).

[(40)] (39) "Provider [Agreement] agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

[(41)] (40) "Psychological [Services] services" [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (10) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(10).

[(42)] (41) "Service [Coordination] coordination" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34, CFR Part 303, subdivision (11) of subsection (d) of section 303.12] coordination" has the same meaning as provided in 34 CFR 303.34(a) .

[(43)] (42) "Service [Coordinator] coordinator" means the person from the profession most immediately relevant to the child's or family's needs who is employed or contracted by the performing provider to provide service coordination [as defined in Title 34 CFR, Part 303, subsection (g) of section 303.344].

[(44)] (43) "Service [Page] page" means the section of the Individualized Family Service Plan [(IFSP)] which specifies service information [as delineated in Part H of IDEA, Title 20 of the USC, section 1477 (d)(4), (5), and (6)].

[(45)] (44) "Social [Work Services] work services" means the definition contained in Part H of IDEA,

Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (d) of subsection (12) of section 303.12] work services” has the same meaning as provided in 303.13(b)(13).

[(46)] (45) “Special [Instruction] means the services described in Part H of IDEA, Title 20 of the USC, and at Title 34 CFR, Part 303, subdivision (13) of subsection (d) of section 303.12] instruction” has the same meaning as provided in 34 CFR 303.13(b)(14), when delivered by a multidisciplinary team.

[(47)] (46) “[Speech-Language Pathology] Speech-language pathology” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (14) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(15).

[(48)] (47) “Transportation and [Related Costs] related costs” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (15) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(16).

[(49)] (48) “Vision [Services] services” [means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (16) of subsection (d) of section 303.12] has the same meaning as provided in 34 CFR 303.13(b)(17).

Sec. 17b-262-601. Services covered and limitations

(a) The department shall pay for the following:

(1) [evaluations] Evaluations and assessments;

(2) [early] Early intervention services, [which] that are [medically appropriate and] medically necessary as follows:

(A) [assistive] Assistive technology devices and assistive technology services;

(B) [audiology] Audiology;

(C) [family] Family training, counseling[,] and home visits;

(D) [health] Health services;

(E) [medical] Medical services;

(F) [nursing] Nursing services;

- (G) [nutrition] Nutrition services;
 - (H) [occupational] Occupational therapy;
 - (I) [physical] Physical therapy;
 - (J) [psychological] Psychological services;
 - (H) [service] Service coordination;
 - (I) [social] Social work services;
 - (J) [special] Special instruction;
 - (K) [speech-language] Speech-language pathology;
 - (L) [transportation] Transportation and related costs;
 - (M) [vision] Vision services; and
- (3) [services] Services provided in the child's natural environment to the maximum extent appropriate to the needs of the child.

Sec. 17b-262-604. Documentation requirements

(d) Progress Notes

(1) Progress notes shall be kept in a form and manner as specified by the department. They shall provide a comprehensive treatment narrative of the contacts with the child and family throughout the month, highlighting activities, nature and extent of the contacts, and relationship of activities to the medical necessity [and medical appropriateness] of the early intervention services in relation to the outcomes specified in the evaluation, assessment reports[,] and the service page as delineated in the IFSP.

(2) Any changes or differences in treatment shall be noted and related to the dates of services. Any increases in services shall meet signature requirements contained in [these regulations] this section. If a child is seen more than once during the same week, a summary and progress note for the month is acceptable if any changes in progress or treatment are documented each time they occur with the specific date that they occurred. The progress notes at a minimum shall:

(A) [include] Include a summary of progress made according to the IFSP;

(B) [include] Include a summary statement of service delivered noting any significant changes in the child's condition;

(C) [be] Be kept by the performing provider or the state agency in a form and manner to be determined, as specified by the department; and

(D) [include] Include the signature of the AHP providing the service.

Sec. 17b-262-608. Definitions

For the purposes of sections 17b-262-607 [through] to 17b-262-618, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) “Acute” means having rapid onset, severe symptoms[,] and a short course.

(2) “Allied Health Professional” or “[(AHP)]” means a professional or paraprofessional individual who is qualified by special training, education, skills[,] and experience in providing health care and treatment and shall include, but shall not be limited to: licensed practical nurses, certified nurse assistants[,] and other qualified therapists.

(3) “By or [Under] under the [Supervision] supervision” means the nurse practitioner shall assume professional responsibility for the service performed by the allied health professional, overseeing or participating in the work of the allied health professional including, but not limited to:

(A) [availability] Availability of the nurse practitioner to the allied health professional in person and within five minutes;

(B) [availability] Availability of the nurse practitioner on a regularly scheduled basis to review the practice, charts[,] and records of the allied health professional and to support the allied health professional in the performance of services; and

(C) [a] A predetermined plan for emergency situations, including the designation of an alternate nurse practitioner in the absence of the regular nurse practitioner.

(4) “Child” means a person who is under twenty-one years of age.

(5) “Client” means a person eligible for goods or services under the department's Medical Assistance Program.

(6) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes] or the Commissioner's agent.

(7) “Concurrent [Review] review” means the review of the medical necessity [and appropriateness] of admission upon or within a short period following an admission and the periodic review of services provided during the course of treatment.

(8) “Consultation” means those services rendered by a nurse practitioner whose opinion or advice is requested by the client's nurse practitioner or agency in the evaluation or treatment of the client's illness.

(9) “CPT” or “Physician's Current Procedural Terminology” means a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by licensed practitioners as published by the American Medical Association[, as amended from time to time].

(10) “Criteria” means the predetermined measurement variables on which judgment or comparison of necessity[, appropriateness .] or quality of health services shall be made.

(11) “Department” means the Department of Social Services or its agent.

(12) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(13) “Family [Planning Services] planning services” means any medically approved diagnostic procedure, treatment, counseling, drug, supply[,] or device [which] that is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

(14) “Fees” means the rates for services, treatments[,] and drugs administered by nurse practitioners which shall be established by the commissioner and contained in the department's fee schedules.

(15) “HealthTrack Services” means the services described in subsection (r) of section 1905 of the Social Security Act.

(16) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

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

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

(17) “Home” means the client's place of residence which includes a boarding home or home for the aged. Home does not include a hospital or long-term care facility; long-term care facility includes a nursing facility, chronic disease hospital[,] and intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities.

(18) “Hospital” means a facility licensed by the Department of Public Health as a general short-term hospital or a hospital for mental illness as defined in section 17a-495 of the Connecticut General Statutes, or a chronic disease hospital as defined in subdivision (2) of subsection (b) of section 19-13-D1 of the Regulations of Connecticut State Agencies [, which is part of the Public Health Code].

(19) “Inpatient” means a client who has been admitted to a general hospital for the purpose of receiving medically necessary [and appropriate] medical, dental[,] and other health related services and is present at midnight for the census count.

(20) “Institution” [means the definition contained in Title 42 of the CFR, Part 435, section 435.1009] has the same meaning as provided in 42 CFR 435.1009.

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

(22) “Legend [Device] device” [means the definition contained] has the same meaning as provided in section 20-571 of the Connecticut General Statutes.

(23) “Legend [Drug] drug” [means the definition contained] has the same meaning as provided in section 20-571 of the Connecticut General Statutes.

(24) “Licensed [Practitioner] practitioner” means any Connecticut medical professional granted prescriptive powers within the scope of his or her professional practice as defined and limited by federal or state law.

(25) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

(26) “Long-Term Care Facility” means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) [nursing] Nursing facilities[,];

(B) Inpatient chronic disease hospitals[—inpatient,]; and

(C) [intermediate] Intermediate care facilities for [the mentally retarded (ICFs/MR)] individuals with intellectual disabilities.

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

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

[(29)] (28) "Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(30)] (29) "Medical [Record" means the definition contained] record" has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies[, which is also the Public Health Code].

[(31)] (30) "Nurse [Practitioner] practitioner" or "APRN" means an advanced practice registered nurse [(APRN)] who holds a current license as such issued by the Department of Public Health [(DPH)] under Chapter 378 of the Connecticut General Statutes, and who performs within the scope of practice for APRNs established pursuant to the Connecticut General Statutes and all relevant regulations.

[(32)] (31) "Panel" or "Profile Tests" means certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple tests performed on an individual, immediate[,] or "stat" reporting basis.

[(33)] (32) "Physician" means an individual licensed under Chapter 370 [or 371] of the Connecticut General Statutes as a doctor of medicine or osteopathy.

[(34)] (33) "Plan of [Care] care" [means the definitions contained] has the same meaning as provided in [Title 42 of the CFR, Part 441, sections] 42 CFR 441.102[,] and 441.103, or 42 CFR 441.155, and 441.156.

[(35)] (34) "Prescription" means an order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order. The prescription needs to be renewed six months from the date of issuance. In long-term care facilities the signed order of a licensed practitioner shall be accepted in lieu of a written or oral prescription. The written prescription shall include:

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

[(36)] (35) “Prior [Authorization] authorization” means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(37)] (36) “Provider” means a nurse practitioner who is enrolled in the Medical Assistance Program.

[(38)] (37) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(39)] (38) “Quality of [Care] care” means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment.

[(40)] (39) “Retrospective [Review] review” means the review conducted after services are provided to a client, to determine the medical necessity [, appropriateness,] and quality of the services provided.

[(41)] (40) “Routine [Medical Visits] medical visits” means visits intended to check a client's general medical condition rather than visits which are medically

necessary to treat a specific medical problem. For clients under twenty-one years of age, this can mean a HealthTrack interperiodic encounter or a periodic comprehensive health screening.

[(42)] (41) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with [Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR)] 42 CFR 430, Subpart B.

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

Sec. 17b-262-611. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for:

(1) [medically] Medically necessary [and medically appropriate] professional services of a nurse practitioner which conform to accepted methods of diagnosis and treatment;

(2) [services] Services provided in the practitioner's office, client's home, hospital, long-term care facility[, or other medical care facility;

(3) [family] Family planning services as described in section 17b-262-608 of the Regulations of Connecticut State Agencies;

(4) [unless] Unless defined elsewhere, CPT descriptive terms used by the department as standards;

(5) [medical] Medical and surgical supplies used by the provider in the course of treatment of a client;

(6) [injectable] Injectable drugs which are payable by the department and administered by a provider; and

(7) HealthTrack Services and HealthTrack Special Services.

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

(1) The department reserves the right to review the medical necessity [and medical appropriateness] of visits and to disallow payment for those visits it determines are not medically necessary [or medically appropriate].

(2) A nurse practitioner who is fully or partially salaried by a general hospital, public or private institution, group practice[,] or clinic shall not receive payment from the department unless the nurse practitioner maintains an office for private practice at a separate location from the hospital, institution, group[,] or clinic in which the nurse practitioner is employed. Nurse practitioners who are solely hospital, institution, group[,] or clinic based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(3) Nurse practitioners who maintain an office for private practice separate from the hospital, institution, group[,] or clinic, shall be able to bill for services provided at the private practice location or for services provided to the nurse practitioner's private practice clients in the hospital, institution, group[,] or clinic.

(4) The department shall pay nurse practitioners for drugs or devices which are administered or dispensed directly to a client under the following conditions:

(A) [excluding] Excluding oral medications, payment shall be made to a nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drugs or devices which are administered directly to the client; and

(B) [for] For legend drugs or legend devices which shall be administered by a nurse practitioner, the department shall pay the nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drug or device which is administered.

Sec. 17b-262-612. Services not covered

The department shall not pay for the following:

(a) [any] Any procedures or services of an unproven, educational, social, research, experimental[,] or cosmetic nature; for any diagnostic, therapeutic[,] or treatment procedures in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms[,] or medical history;

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

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

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

- (e) [cancelled] Cancelled office visits and appointments not kept;
- (f) [cosmetic] Cosmetic surgery;
- (g) [services] Services provided in an acute care hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies;
- (h) [services] Services provided by the admitting provider in an acute care hospital shall not be made or may be recouped if it is determined by the department's utilization review, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity[, medical appropriateness], appropriateness of setting[,] or quality of care;
- (i) [a] A laboratory charge for laboratory services performed by a laboratory outside of the nurse practitioner's office.[-the] The laboratory shall bill the department for services rendered when a nurse practitioner refers a client to a private laboratory;
- (j) [the] The following routine laboratory tests which shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy[,]; hemoglobin determination[,]; and urine glucose; and
- (k) [transsexual] Transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone treatment and electrolysis.

Sec. 17b-262-613. Need for service

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

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

Sec. 17b-262-614. Prior authorization

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

- (1) [more] More than one visit on the same day for the same client by the same provider. Authorization for additional visits need not be submitted in advance of the service, but

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

(2) [admissions] Admissions to acute care hospitals pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies;

(3) [electrolysis] Electrolysis epilation;

(4) [physical] Physical therapy services in excess of two treatments per calendar week per client per provider;

(5) [physical] Physical therapy services in excess of nine treatments per calendar year per client per provider, involving the following primary diagnoses:

(A) [all] All mental disorders including diagnoses related to [mental retardation] intellectual disabilities and specific delays in development covered by the International Classification of Diseases [(ICD), as amended from time to time];

(B) [cases] Cases involving musculoskeletal system disorders covered by [ICD, as amended from time to time] International Classification of Diseases; and

(C) [cases] Cases involving symptoms related to nutrition, metabolism[,] and development covered by [ICD, as amended from time to time] the International Classification of Diseases;

(6) [reconstructive] Reconstructive surgery, including breast reconstruction following mastectomy;

(7) [plastic] Plastic surgery;

(8) [transplant] Transplant procedures; and

(9) HealthTrack Special Services.

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

(B) [the] The request for HealthTrack Special Services shall include:

(i) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service required;

(ii) [a] A description of the outcomes of any alternative measures tried; and

(iii) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-620. Definitions

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

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

the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

(12) “Freestanding clinic” means “freestanding clinic” as defined in section 171B of the department's Medical Services Policy for clinic services;

(13) “General hospital” means “general hospital” as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(14) “Home” means the client's place of residence, including, but not limited to, a boarding home, community living arrangement or residential care home. “Home” does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for [the mentally retarded (ICFs/MR)] individuals with intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(15) “Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities” or [“ICF/MR”] “ICF/IID” means a residential facility for persons with [mental retardation] intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(16) “Legend device” [means “legend device” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

(17) “Legend drug” [means “legend drug” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

(18) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act, as amended from time to time;

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

[(20)] (19) “Medical necessity” or “medically necessary” [means health care provided; to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(21)] (20) “Medical record” means [“medical record” as defined] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;

[(22)] (21) “Nursing facility” [means “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;

[(23)] (22) “Out-of-state provider” means a provider that is located outside Connecticut and is not a border provider;

[(24)] (23) “Physician” means a person licensed pursuant to chapter 370 of the Connecticut General Statutes;

[(25)] (24) “Podiatric [Services] services” means services provided by a podiatrist within the scope of practice as defined by state law, including chapter 375 of the Connecticut General Statutes;

[(26)] (25) “Podiatrist” means a doctor of podiatric medicine licensed pursuant to section 20-54 of the Connecticut General Statutes;

[(27)] (26) “Prior authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(28)] (27) “Provider” means a podiatrist or a podiatrist group enrolled in Medicaid;

[(29)] (28) “Quality of care” means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;

[(30)] (29) “Routine foot care” means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryphosis or onychia; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;

[(31)] (30) “Simple foot hygiene” means self-care including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;

[(32)] (31) “Systemic condition” means the presence of a metabolic, neurologic[,] or peripheral vascular disease, including, but not limited to: diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neuropathies involving the feet, which would justify coverage of routine foot care;

[(33)] (32) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary”

shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

[(34)] (33) “Utilization review” means the evaluation of the necessity [and appropriateness] of medical services and procedures as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies.

Sec. 17b-262-623. Services covered and limitations

Subject to the limitations and exclusions identified in sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay providers for podiatric services provided by podiatrists for:

- (1) [only for] Only those procedures listed in the provider's fee schedule that are medically necessary [and medically appropriate] to treat the client's condition;
- (2) [for podiatric] Podiatric services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;
- (3) [for laboratory] Laboratory services provided by a podiatrist in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- (4) [for medical] Medical and surgical supplies used by the podiatrist in the course of treatment of a client;
- (5) [for drugs] Drugs and supplies administered by a podiatrist;
- (6) [for a] A second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation; and
- (7) [for] EPSDT services including, but not limited to, treatment services which are indicated following screening but not otherwise covered, provided that prior authorization is obtained.

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

The department shall not pay a podiatrist for:

- (1) [for information] Information or services provided to a client by a podiatrist over the telephone;

- (2) [for any] Any product available to podiatrists free of charge;
- (3) [for more] More than one visit per day per client to the same podiatrist;
- (4) [for cosmetic] Cosmetic surgery;
- (5) [for simplified] Simplified tests requiring minimal time or equipment and employing materials nominal in cost, including, but not limited to, urine testing for glucose, albumin and blood;
- (6) [for simple] Simple foot hygiene;
- (7) [for repairs] Repairs to devices judged by the department to be necessitated by willful or malicious abuse on the part of the client;
- (8) [for repairs] Repairs to devices under guarantee or warranty. The podiatrist shall first seek payment from the manufacturer;
- (9) [for an] An office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;
- (10) [for cancelled] Cancelled services and appointments not kept;
- (11) [for services] Services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-1 34d-80 of the Regulations of Connecticut State Agencies; or
- (12) [for any] Any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

Sec. 17b-262-625. Need for service

Payment for an initial office visit and continuing services which the department deems medically necessary [and medically appropriate], in relation to the diagnosis for which care is required, is available provided that:

- (1) [the] The services are within the scope of the podiatrist's practice; and
- (2) [the] The services are made part of the client's medical record.

Sec. 17b-262-628. Payment

(l) Admission to a general hospital

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

Sec. 17b-262-642. Definitions

For the purposes of sections 17b-262-641 [through] to 17b-262-650, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

- (1) “Client” means a person eligible for goods or services under the department's Medicaid Program.
- (2) “Commissioner” means the Commissioner of Social Services [appointed pursuant to section 17b-1(a) of the Connecticut General Statutes] or the Commissioner’s agent.
- (3) “Department” means the Department of Social Services or its agent.
- (4) “Health Track Services” means the services described in section 1905(r) of the Social Security Act.
- (5) “Health Track Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:
 - (A) [services] Services not covered under the State Plan or contained in a fee schedule published by the department; or
 - (B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.
- (6) “Interperiodic [Encounter] encounter” means any medically necessary visit to a Connecticut Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits[,] and other primary care visits.

(7) "Laboratory" means a licensed clinical laboratory as defined in section 19a-30 of the Connecticut General Statutes and [which] that is independent of a physician's, nurse-midwife's, or nurse practitioner's office[.]; or an inpatient or outpatient hospital department or clinic.

(8) "Licensed [Practitioner of the Healing Arts] practitioner of the healing arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(10)] (9) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act.

[(11)] (10) "Medical [Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(12)] (11) "Panel" or "Profile Tests" means certain multiple tests performed on a single specimen or material derived from the human body which are related to a condition, disorder[,], or family of disorders, [which] that when combined mathematically or otherwise, comprise a finished identifiable laboratory study or studies.

[(13)] (12) "Prior [Authorization] authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(14)] (13) "Provider" means a laboratory which provides testing and analysis services and which is independent of a physician's, nurse-midwife's[,], or nurse practitioner's office[.]; or an inpatient or outpatient hospital department.

[(15)] (14) "Provider [Agreement] agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

[(16)] (15) "State Plan" means the document which contains the services covered by the Connecticut Medicaid Program in compliance with 42 CFR 430(B).

Sec. 17b-262-645. Services covered and limitations

(a) The department shall pay for the following:

(1) [medically appropriate and medically] Medically necessary clinical laboratory services, for which the laboratory holds certification according to the provisions of CLIA, which are listed in the department's fee schedule; and

(2) [for] HealthTrack and HealthTrack Special Services.

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

(1) [payment] Payment shall not be made for laboratory fees to the physician, nurse-midwife, nurse practitioner[,] or referring laboratories for services performed in a separate private laboratory;

(2) [when] When laboratory services are performed in a private laboratory, billing for the service shall be made by the laboratory. Payment shall not be made to the referring physician, nurse-midwife, nurse practitioner[,] or to another laboratory which has referred the specimen to the performing laboratory for testing;

(3) [payment] Payment shall not be made for testing and analysis which is available free of charge; and

(4) [payment] Payment shall not be made for any procedures or services of an unproven, educational, social, research, experimental[,] or cosmetic nature; for services in excess of those deemed medically necessary [and medically appropriate] to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms[,] or medical history.

Sec. 17b-262-646. Need for service

The department shall pay for medically necessary [and medically appropriate] testing and analysis services only when ordered by a licensed physician or other licensed practitioner of the healing arts.

Sec. 17b-262-647. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for HealthTrack Special Services. HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis. The request for HealthTrack Special Services shall include:

(1) [a] A written statement from the prescribing physician, or other licensed practitioner

of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(2) [a] A description of the outcomes of any alternative measures tried; and

(3) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

(b) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-652. Definitions

For the purposes of sections 17b-262-651 [through] to 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) “Border [Hospital] hospital” means an out-of-state general hospital which has a common medical delivery area with the [State] state of Connecticut and is deemed a border hospital by the department on a hospital by hospital basis.

(2) “Client” means a person eligible for goods or services under the department's Medicaid Program.

(3) “Commissioner” means the Commissioner of Social Services [appointed pursuant to section 17b-1(a) of the Connecticut General Statutes] or the Commissioner’s agent.

(4) “Department” means the Department of Social Services or its agent.

(5) “Dialysis” [means dialysis as defined] has the same meaning as provided in 42 CFR 405.2102, as amended from time to time.

(6) “Freestanding [Dialysis Clinic] dialysis clinic” means those centers licensed by the Department of Public Health [(DPH)] and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

(7) “General [Hospital] hospital” means a short-term acute care hospital having facilities, medical staff[,], and all necessary personnel to provide diagnosis, care[,], and treatment of a wide range of acute conditions, including injuries. [This includes a children's general hospital. It shall also include a border hospital.] “General hospital” shall include a children’s general hospital or a border hospital.”

(8) “HealthTrack Services” means the services described in section 1905(r) of the Social

Security Act.

(9) “HealthTrack Special Services” means medically necessary [and medically appropriate] health care, diagnostic services, treatment[,] or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:

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

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

(10) “Home” means the client's place of residence which includes a boarding home or residential care home. Home does not include a hospital, chronic disease hospital, nursing facility or intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities.

(11) “Interperiodic [Encounter] encounter” means any medically necessary visit to a Connecticut Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits[,] and other primary care visits.

(12) “Licensed [Practitioner of the Healing Arts] practitioner of the healing arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health [(DPH)].

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

[(14)] (13) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act.

[(15)] (14) “Medical [Necessity or Medically Necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

[(16)] (15) “Medical [Record] record” [means medical record as defined] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies[, which is part of the Public Health Code].

[(17)] (16) “Physician” means a physician licensed pursuant to section [20-1] 20-13 of the Connecticut General Statutes [or a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes].

[(18)] (17) “Prior [Authorization] authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

[(19)] (18) “Provider” means:

(A) [a] A physician;

(B) [a] A general hospital[~~-~~], inpatient or outpatient; or

(C) [a] A freestanding dialysis clinic licensed by the Department of Public Health [(DPH)] and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

[(20)] (19) “Provider [Agreement] agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

[(21)] (20) “State Plan” means the document which contains the services covered by the Connecticut Medicaid Program in compliance with [42 CFR(430)(B)] 42 CFR 430, Subpart B.

Sec. 17b-262-655. Services covered and limitations

Subject to the limitations and exclusions listed below and those set forth in the Regulations of Connecticut State Agencies dealing with physicians, general hospitals[,] and freestanding dialysis clinics, the department shall pay for dialysis services which conform to accepted methods of diagnosis and treatment.

(a) The department shall pay for the following:

(1) [for services] Services provided by an enrolled provider in a home, clinic, hospital[,] or institution having an organized and approved dialysis program; and

(2) [for] HealthTrack Services and HealthTrack Special Services.

(b) The department shall not pay for the following:

- (1) [cancelled] Cancelled office visits and appointments not kept;
- (2) [information] Information or services provided to a client by a provider over the telephone;
- (3) [any] Any examinations, laboratory tests, biological products, immunizations[,] or other products which are furnished free of charge; and
- (4) [for any] Any procedures or services of an unproven, educational, social, research, experimental[,] or cosmetic nature; for any diagnostic, therapeutic[,] or treatment services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms[,] or medical history.

Sec. 17b-262-656. Need for service and authorization process

(a) The department shall pay for medically necessary [and medically appropriate] dialysis services for Medicaid Program clients, in relation to the diagnosis for which care is required, provided that:

- (1) [the] The services are within the scope of the provider's practice;
- (2) [a] A physician documents the need in writing and orders the service; and
- (3) [the] The services are made part of the client's medical record.

(b) Prior authorization, on forms and in a manner as specified by the department, is required for Health Track Special Services;

- (1) HealthTrack Special Services are determined medically necessary [and medically appropriate] on a case-by-case basis; and
- (2) [the] The request for HealthTrack Services shall include:
 - (A) [a] A written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her scope of practice as defined under state law, justifying the need for the item or services requested;
 - (B) [a] A description of the outcomes of any alternative measures tried; and
 - (C) [if] If applicable and requested by the department, any other documentation required in order to render a decision.

Sec. 17b-262-673. Definitions

For the purposes of sections 17b-262-672 [through] to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Chronic disease hospital” means an institution as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;
- (2) “Client” means a person eligible for goods or services under the Medicaid program;
- (3) “Certificate of Medical Necessity” or “CMN” means an approved Medicare form or a similar form which has been submitted to and approved by the department for use. This form shall contain all the documentation required for [DME] durable medical equipment;
- (4) “Commissioner” means the [commissioner of social services] Commissioner of Social Services or the Commissioner’s agent ;
- (5) “Customized equipment” means devices or equipment prescribed by a licensed practitioner which is specifically manufactured to meet the special medical, physical[,] and psychosocial needs of the client. The equipment shall be individualized to preclude its use by any other person except the client for whom it was originally developed;
- (6) “Department” means the [department of social services] Department of Social Services or its agent;
- (7) “Documented in writing” means that the prescription has been handwritten, typed [,] or computer printed;
- (8) “Durable medical equipment” or “DME” means equipment that meets all of the following requirements:
 - (A) [can] Can withstand repeated use;
 - (B) [is] Is primarily and customarily used to serve a medical purpose;
 - (C) [generally] Generally is not useful to a person in the absence of an illness or injury; and
 - (D) [is nondisposable] Is non-disposable;
- (9) “Equipment replacement” means any item that takes the place of original equipment lost, destroyed[,] or no longer medically useable or adequate;
- (10) “Home” means the client's place of residence which includes a boarding home, community living arrangement[,] or residential care home. “Home” does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care

facilities for the [mentally retarded (ICFs/MR),] individuals with intellectual disabilities or other facilities that are paid an all inclusive rate directly by Medicaid for the care of the client;

(11) “Hospital” means an institution as defined in [Section] section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) “Intermediate care facility for [the mentally retarded” or “ICF/MR”] individuals with intellectual disabilities” or “ICF/IID” means an institution licensed by, or operated by, the [department of mental retardation (DMR)] Department of Developmental Services according to state law, and certified as a Medicaid intermediate care facility for the [mentally retarded] developmentally disabled by the [department of public health (DPH)] Department of Public Health to provide health or rehabilitative services for individuals with [mental retardation] intellectual disabilities or related conditions who, because of their mental or physical condition, require care and services, above the level of room and board, which can be made available to them only through a residential facility. Individuals residing in an ICF/MR shall be receiving active treatment pursuant to 42 CFR 483.440(a);

(13) “Licensed practitioner” means any person licensed by the state of Connecticut, any other state, District of Columbia[,], or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(14) “Manufactured” means constructed or assembled;

[(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;]

[(16)] (15) “Medicaid” means the program operated by the [department of social services] Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(17)] (16) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(18)] (17) “Nursing facility” or “NF” [means an institution as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;

[(19)] (18) “Prescription” means an original order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order;

[(20)] (19) “Prior authorization” or “PA” means approval for the service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(21)] (20) “Provider” means the vendor or supplier of durable medical equipment who is enrolled with the department as a medical equipment, devices[,] and supplies supplier; and

[(22)] (21) “Provider agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

Sec. 17b-262-685. Definitions

As used in sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) “Administrative lock-in” means the restriction by the department of an enrollee to a provider of the enrollee's choice pursuant to section 17b-275 of the Connecticut General Statutes;

(2) “Average wholesale price” or “AWP” means the published wholesale price as listed by one or more national drug databases which obtain their pricing information either directly from the manufacturer or by surveying drug wholesalers;

(3) “Brand name” [means “brand name” as defined] has the same meaning as provided in section 20-619 of the Connecticut General Statutes;

(4) “Commissioner” means the Commissioner of [the Department of] Social Services or [his or her] the Commissioner’s agent;

(5) “ConnPACE” means the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program as described in section 17b-491 of the Connecticut General Statutes;

(6) “Copayment” means the dollar amount which is required under section 17b-491 of the Connecticut General Statutes to be paid to providers by enrollees for each prescription;

(7) “Department” means the Department of Social Services or its agent;

(8) “Dispensing fee” means an amount of money paid to a pharmacy for rendering a professional service involving the preparation and dispensing of a prescribed drug ordered by a prescribing practitioner;

(9) “Drug efficacy study implementation” or “DESI” means the review through which the

United States Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved [indication(s)] indications;

(10) “Drug utilization review program” or “DUR” means the prospective and retrospective utilization review as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1990 (P.L. 101-508);

(11) “Enrollee” means a person who meets the relevant requirements specified in the department's Uniform Policy Manual, section 8075 and whose application for enrollment in the ConnPACE program has been approved by the department;

(12) “Estimated acquisition cost” or “EAC” means the department's best estimate of the price as related to the average wholesale price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler, as identified by the national drug code [(NDC)];

(13) “Experimental drug” means a drug currently being administered under an investigational new drug application as required by the United States Food and Drug Administration under 21 CFR 312;

(14) “Federal upper limit” or “FUL” means the listing of multiple source drugs and pricing according to criteria set forth in 42 CFR 447.332;

(15) “Generic name” [means “generic name” as defined] has the same meaning as provided in section 20-619 of the Connecticut General Statutes;

(16) “Generically equivalent drug” means a therapeutically equivalent generic drug product which may be substituted for a brand name drug under section 20-619(b) of the Connecticut General Statutes;

(17) “Legend drug” [means “legend drug” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

(18) “Manufacturer rebate program” [means the program as described] has the same meaning as provided in section 17b-491(d) of the Connecticut General Statutes;

(19) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(20) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;]

[(21)] (20) “Medical necessity” or “medically necessary” [means health care provided to

correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(22)] (21) “National drug code” or “NDC” means the numeric characters identifying a drug product by labeler code, product name and package size;

[(23)] (22) “Pharmaceutical manufacturer” means any entity holding legal title to or possession of a national drug code issued by the United States Food and Drug Administration;

[(24)] (23) “Pharmacy” [means “pharmacy” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

[(25)] (24) “Prescribing practitioner” [means “prescribing practitioner” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

[(26)] (25) “Prescription” [means “prescription” as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

[(27)] (26) "Prescription drugs" [means "prescription drugs" as defined] has the same meaning as provided in section 17b-490 of the Connecticut General Statutes;

[(28)] (27) “Provider” means a pharmacy that is enrolled with the department as a ConnPACE provider;

[(29)] (28) “Unit” means the lowest identifiable amount of a drug, for example: tablet or capsule for solid dosage forms, milliliter for liquid forms, gram for ointments or creams; and

[(30)] (29) “Usual and customary charge” means an enrolled provider's charge to the general public for a prescription drug, in a specific strength and quantity on the day the prescription is dispensed. In determining such charges all charges made to third party payers shall be excluded.

Sec. 17b-262-688. Services covered and limitations

(a) The department shall pay for prescription drugs dispensed under the ConnPACE program:

(1) [that] That are medically necessary [and appropriate] and listed in section 17b-490(b) of the Connecticut General Statutes; and

(2) [that] That do not exceed the recommended dosage level and duration as approved by

the United States Food and Drug Administration and presented in the manufacturer's literature, and as monitored and operationalized in the department's drug utilization review program.

(b) The department shall pay for any number of authorized refills by the prescribing practitioner for a maximum period of six (6) months. The exception is controlled substances that are regulated by 21 USC 829(b) and section 21a-249(h) of the Connecticut General Statutes.

(c) A provider shall substitute a therapeutically equivalent generic drug product for a prescribed drug product unless the prescribing practitioner has written on the prescription "brand medically necessary" in accordance with sections 17b-274 and 17b-493 of the Connecticut General Statutes.

(d) The department shall pay at the estimated acquisition cost for the generic drug only when available but not yet on the federal upper limit list.

Sec. 17b-262-689. Services not covered

The department shall not pay providers for:

- (1) [the] The replacement of lost or destroyed prescription drugs;
- (2) [any] Any prescription drug of a manufacturer that does not participate in the manufacturer rebate program, unless the department determines the prescription drug is medically necessary [and medically appropriate] for the program enrollees;
- (3) [any] Any drugs excluded pursuant to section 17b-490(b) of the Connecticut General Statutes. The department shall pay for amphetamines and amphetamine-like drugs for specific diagnoses as specified in the billing instructions;
- (4) [over] Over the counter preparations;
- (5) DESI drugs;
- (6) [prescriptions] Prescriptions dispensed but not received by the enrollee;
- (7) [drugs] Drugs for an administrative lock-in enrollee who is not locked in to the billing pharmacy;
- (8) [anything] Anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary [and medically appropriate] by the department to meet the enrollee's condition or for services not directly related to the enrollee's diagnosis, symptoms or medical history;

(9) [claims] Claims of quantities which exceed 120 oral dosage units or a 30 day supply, whichever is greater; and

(10) [claims] Claims for services which are covered by other insurance.

Sec. 17b-262-694. Definitions

As used in sections 17b-262-693 to 17b-262-700, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Client” means a person eligible for services under the department's Medicaid program;

(2) “Clinic” means an “outpatient clinic” as defined in section 19-13-D45 of the Regulations of Connecticut State Agencies;

(3) “Commissioner” means the Commissioner of Social Services or [his or her] the Commissioner’s agent;

(4) “Community health center” [means a “community health center” as defined] has the same meaning as provided in section 19a-490a of the Connecticut General Statutes;

(5) “Dental examination” means inspecting and charting of the oral structures;

(6) “Dental hygienist” means a dental hygienist licensed to practice dental hygiene pursuant to sections 20-126h to 20-126x, inclusive, of the Connecticut General Statutes;

(7) “Dental hygienist services” means “the practice of dental hygiene” as defined in section 20-1261(a)(3) of the Connecticut General Statutes;

(8) “Dentist” means a dentist licensed to practice dentistry pursuant to section 20-108 of the Connecticut General Statutes or who is licensed to practice dentistry in another state;

(9) “Department” means the Department of Social Services or its agent;

(10) “Group home” means a “community residential facility” as defined in section 17a-220 of the Connecticut General Statutes or a “community residence” as defined in section 19a-507a of the Connecticut General Statutes;

(11) “Hospital” means a “general hospital” or “special hospital” as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) “Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities” or [“ICF/MR”] “ICF/IID” means a residential facility for persons with [mental retardation] intellectual disabilities licensed pursuant to section 17a-227 of the

Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(13) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(14) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and, is the least costly of multiple, equally effective alternative treatments or diagnostic modalities;]

[(15)] ~~(14)~~ “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(16)] ~~(15)~~ “Medical record” [means a medical record as set forth] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;

[(17)] ~~(16)~~ “Nursing facility” or “NF” [means an institution as defined] has the same meaning as provided in 42 USC 1396(r)(a), as amended from time to time;

[(18)] ~~(17)~~ “Provider” means a “public health dental hygienist” as defined in subsection [(19)] ~~(18)~~ of this section;

[(19)] ~~(18)~~ “Public health dental hygienist” means a dental hygienist who is providing services in accordance with section 20-1261(b)(1)(B) of the Connecticut General Statutes;

[(20)] ~~(19)~~ “School” means any preschool, elementary or secondary school or any college, vocational, professional or graduate school; and

[(21)] ~~(20)~~ “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary” means the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-697. Services covered and limitations

(a) Services Covered

(1) The department shall pay for medically necessary [and medically appropriate] public health dental hygienist services provided to clients subject to the limitations listed in subsection (b) of this section.

(2) The department shall pay providers only for those procedures listed in the provider's fee schedule.

Sec. 17b-262-698. Services not covered

The department shall not pay for:

(1) [anything] Anything not explicitly allowed pursuant to section 17b-262-697 of the Regulations of Connecticut State Agencies;

(2) [information] Information provided to the client over the telephone;

(3) [cancelled] Cancelled visits or services not provided;

(4) [any] Any services provided by a public health dental hygienist free of charge to non-Medicaid clients;

(5) [anything] Anything of an unproven, experimental or research nature, or for services in excess of those deemed medically necessary [or medically appropriate] by the department to treat a client's condition, or for services not directly related to the client's diagnosis, symptoms[,] or medical history; or

(6) [any] Any services provided by a public health dental hygienist in a dental office, a dental clinic or a location other than those set forth in section 17b-262-697(b)(5) of the Regulations of Connecticut State Agencies.

Sec. 17b-262-702. Definitions

For the purposes of sections 17b-262-701 to 17b-262-711, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Applied income” means the amount of income that each client receiving nursing facility services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) “Client” means a person eligible for goods or services under the department's Medicaid program;

(3) “Chronic disease hospital” means “chronic disease hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(4) “Commissioner” means the Commissioner of Social Services, or the [commissioner's designee] Commissioner’s agent;

(5) “Department” means the Department of Social Services or its agent;

(6) “DMHAS” means the Department of Mental Health and Addiction Services or its agent;

(7) [“DMR” means the “Department of Mental Retardation”,] “DDS” means the Department of Developmental Services” or its agent;

(8) “Home leave” means an absence from the nursing facility for any reason other than admission to a hospital. It is taken at the discretion of the resident;

(9) “Hospital” means “hospital” as defined in section 19a-537 of the Connecticut General Statutes;

(10) “Institution for Mental Diseases” or “IMD” [means “institution for mental diseases” as defined] has the same meaning as provided in 42 CFR 435.1009, as amended from time to time;

(11) “Licensed practitioner” means any person licensed by the state of Connecticut, any other state, District of Columbia[,] or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

[(12) “Medical appropriateness” or “medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;]

[(13)] (12) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(14)] (13) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(15)] (14) “Nursing facility” or “NF” [means “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;

[(16)] (15) “Preadmission screening and resident review” or “PASRR” means the

program defined in 42 USC 1396r(e)(7) and 42 CFR [Part] 483, Subpart C, as amended from time to time;

[(17)] (16) “Preadmission MI/MR screen” means the level I screen required under the PASRR program and described in 42 CFR 483.106 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

[(18)] (17) “Preadmission screening level II evaluation” means the level II screen as described in 42 CFR 483.112 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

[(19)] (18) “Provider” means a nursing facility that is enrolled in the Medicaid program;

[(20)] (19) “Provider agreement” means the signed, written, contractual agreement between the department and the provider;

[(21)] (20) “Reserve bed day” means a day when a nursing facility client is temporarily absent from the nursing facility and for which payment is made by the department in accordance with section 19a-537 of the Connecticut General Statutes;

[(22)] (21) “Resident” means a person living in a nursing facility; and

[(23)] (22) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-707. Need for service and authorization process

(a) The department shall pay for an admission that is medically necessary [and medically appropriate] as evidenced by the following:

(1) [certification] Certification by a licensed practitioner that a client admitted to a nursing facility meets the criteria outlined in section 19-13-D8t(d)(1) of the Regulations of Connecticut State Agencies. This certification of the need for care shall be made prior to the department's authorization of payment. The licensed practitioner shall use and sign all forms specified by the department;

(2) [the] The department's evaluation and written authorization of the client's need for nursing facility services as ordered by the licensed practitioner;

(3) [a] A health screen for clients eligible for the Connecticut Home Care Program for Elders as described in section 17b-342-4(a) of the Regulations of Connecticut State

Agencies;

(4) [a] A preadmission MI/MR screen signed by the department; or an exemption form, in accordance with 42 CFR 483.106(b), as amended from time to time, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen was not completed; and

(5) [a] A preadmission screening level II evaluation for any individual suspected of having mental illness or [mental retardation] intellectual disabilities as identified by the preadmission MI/MR screen.

Sec. 17b-262-713. Definitions

As used in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Chronic disease hospital” means “chronic disease hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) “Client” means a person eligible for goods or services under the Medicaid program;

(3) “Commissioner” means the Commissioner of Social Services or [his or her designee] the Commissioner’s agent;

(4) “Department” means the Department of Social Services or its agent;

(5) “Documented in writing” means handwritten, typed or computer printed;

(6) “Early and periodic screening, diagnostic and treatment special services”, “EPSDT [Early & Periodic Screening & Diagnostic Treatment] special services” means services provided in accordance with subdivision 1905 (r) of the Social Security Act;

(7) “Home” means the client's place of residence, including a boarding home, community living arrangement or residential care home. “Home” does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(8) “Hospital” means “short-term hospital” as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(9) “Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities” or [“ICF/MR”] “ICF/IID” means a residential facility for [the mentally retarded] persons with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an

intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(10) “Licensed practitioner” means an individual who is licensed by the Connecticut Department of Public Health, [.] another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing a medical or surgical supply;

(11) “Medical and surgical supplies” or “supply” means treatment products that are:

(A) [are fabricated] Fabricated primarily and customarily to fulfill a medical or surgical purpose;

(B) [are used] Used in the treatment or diagnosis of specific medical conditions;

(C) [are generally] Generally not useful in the absence of illness or injury; and

(D) [are generally] Generally not reusable and are disposable.

(12) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act, as amended from time to time;

[(13) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care: is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;]

[(14)] (13) “Medical necessity” or “medically necessary” [means health care needed to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General statutes;

[(15)] (14) “Nursing facility” or “NF” [means “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;

[(16)] (15) “Prescription” means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

[(17)] (16) “Prior authorization” or “PA” means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

[(18)] (17) “Provider” means a vendor or supplier of medical and surgical supplies who is

enrolled with the department as a supplier of medical and surgical supplies;

[(19)] (18) “Provider agreement” means the signed, written contractual agreement between the department and the provider; and

[(20)] (19) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-716. Supplies covered and limitations

(a) Supplies covered

(1) The department shall pay for the purchase of medical and surgical supplies, except as limited by sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies, that conform to accepted methods of diagnosis and treatment and are medically necessary [and medically appropriate].

(2) Payment for medical and surgical supplies is available only to clients who live at home.

(3) The department shall maintain a non-exclusive fee schedule of supplies which it has determined meet the department's definition of medical and surgical supplies and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

(4) When the supply for which coverage is requested is not on the department's fee schedule, prior authorization is required for that supply. The provider requesting coverage for a prescribed supply not on the list shall submit a prior authorization request to the department through an enrolled provider of medical and surgical supplies. Such request shall include a prescription and documentation showing the client's medical necessity for the prescribed supply. The provider also shall include documentation showing that the supply meets the department's definition of a medical and surgical supply and is medically [appropriate] necessary for the client requesting coverage of such supply.

(5) The department shall pay for medical and surgical supplies for EPSDT special services.

Sec. 17b-262-725. Definitions

As used in section 17b-262-724 to section 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Activity of daily living” or “ADL” means any activity necessary for self care including bathing, dressing, toileting, transferring and feeding;
- (2) “Acute” means symptoms that are severe and have a rapid onset and a short course;
- (3) “Care plan” means the patient care plan as set forth in section 19-13-D73 of the Regulations of Connecticut State Agencies;
- (4) “Chronic disease hospital” means “chronic disease hospital” as defined in section 19-13-D1(b)(2) of the Regulations of Connecticut State Agencies;
- (5) “Client” means a person eligible for goods or services under Medicaid;
- (6) “Commissioner” means the Commissioner of Social Services or [his or her designee] the Commissioner’s agent;
- (7) “Concurrent” means in the same time period covered by the care plan;
- (8) “Department” means the Department of Social Services or its agent;
- (9) “Early and periodic screening, diagnostic, and treatment services” or “EPSDT services” means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;
- (10) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;
- (11) “Extended nursing services” means nursing care services that are required for more than two continuous, consecutive hours on any given day;
- (12) “Hands on care” means the assistance with activities of daily living provided most often, but not exclusively, by home health aides. The assistance includes the prompting and cueing necessary for a client to perform an activity of daily living;
- (13) “Home” means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. “Home” does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for [the mentally retarded (ICFs/MR)] individuals with

intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(14) “Home health aide” means “homemaker-home health aide” as defined in section 19-13-D66 of the Regulations of Connecticut State Agencies;

(15) “Home health care agency” [means “home health care agency” as defined] has the same meaning as provided in section 19a-490 of the Connecticut General Statutes and which:

(A) [is] Is licensed by the Department of Public Health pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(B) [meets] Meets the requirements of 42 CFR Parts 440, 441 and 484, as amended from time to time; and

(C) [is] Is enrolled in Medicaid;

(16) “Home health care services” means the services provided by a licensed home health care agency on a part-time or intermittent basis in the client's home;

(17) “Hospice” means “hospice” as defined in section 19-13-D1(b)(1)(C) of the Regulations of Connecticut State Agencies;

(18) “Hospital” means “short-term hospital” as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(19) “Household” means a situation where two or more people are living: (A) [in] In a group home, a residential care home or other group living situation; (B) at the same street address if it is a single family house that is not divided into apartments or units; or (C) at the same apartment number or unit number if clients live in a building that is divided into apartments or units;

(20) “Instrumental activity of daily living” or “IADL” means any activity related to a person's ability to function in the home, including, but not limited to, meal preparation, housework, laundry and use of the telephone;

(21) “Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities” or [“ICF/MR”] “ICF/IID” means a residential facility for persons with [mental retardation] intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes, if applicable, and certified to participate in Medicaid as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(22) “Intermittent” means less than twenty-four hour care within a twenty-four hour period;

(23) “Licensed practical nurse” or “LPN” [means “licensed practical nurse” as defined] has the same meaning as provided in [chapter 378] section 20-87a of the Connecticut General Statutes;

(24) “Licensed practitioner” means a physician who orders home health care services in accordance with sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(25) “Licensed practitioner order” means an order that directs the home health care agency to provide services according to the licensed practitioner's care plan;

(26) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act, as amended from time to time;

[(27) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;]

[(28)] (27) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(29)] (28) “Medical record” [means “medical record” as defined] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;

[(30)] (29) “Medication administration” means the administration of oral, intramuscular or subcutaneous medication and also those procedures used to assess the client's medical or behavioral health status as ordered by the prescribing practitioner. Such procedures include, but are not limited to, glucometer readings, pulse rate checks, blood pressure checks or brief mental health assessments;

[(31)] (30) “Normal life activities” means any activity that the client attends or in which he participates in the community including, but not limited to, school, work and day care;

[(32)] (31) “Nursing care services” means the services provided by a registered nurse or a licensed practical nurse;

[(33)] (32) “Nursing facility” or “NF” [means “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;

[(34)] (33) “Occupational therapy” means the services provided by an occupational

therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

[(35)] (34) “Physical therapy” means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

[(36)] (35) “Physician” means a physician or surgeon licensed pursuant to sections 20-8 to 20-14k, inclusive, of the Connecticut General Statutes;

[(37)] (36) “Postpartum” means the sixty-day time period immediately following childbirth;

[(38)] (37) “Prenatal” means the time period between the beginning of a pregnancy and the end of a pregnancy;

[(39)] (38) “Prior authorization” or “PA” means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(40)] (39) “Provider” means a home health care agency;

[(41)] (40) “Registered nurse” [means “registered nurse” as defined] has the same meaning as provided in [chapter 378] section 20-87a of the Connecticut General Statutes;

[(42)] (41) “Speech therapy” or “speech pathology” means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes;

[(43)] (42) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

[(44)] (43) “Week” means a calendar week beginning on Sunday and ending on Saturday.

Sec. 17b-262-728. Services covered and limitations

(a) Subject to the limitations and exclusions identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay for medically necessary [and medically appropriate] home health care services provided by home health care agencies that are directly related to the client's diagnosis, symptoms or medical history. These services include:

(1) [nursing] Nursing care services limited to the following:

(A) [physical] Physical nursing care or the teaching of nursing care, including, but not limited to, direct services such as enemas, irrigations, dressing changes, treatments and administration and supervision of medication;

(B) [admission] Admission of clients to agency services; development of the initial care plan; and subsequent reviews of the care plan, no more than one every 60 days;

(C) [diabetic] Diabetic teaching for thirty consecutive days per diabetic client;

(D) [pregnancy-related] Pregnancy -related preventive prenatal and postpartum nursing care services to women at high risk of negative pregnancy outcome that are performed during the prenatal or postpartum period of pregnancy for the purpose of, but not limited to:

(i) [evaluation] Evaluation of medical health status, obstetrical history, present and past pregnancy related problems and psychosocial factors such as emotional status, inadequate resources, supportive helping networks and parenting skills; and

(ii) [the] The provision of general health education and counseling, referral, instruction, suggestions, support or observation to monitor for any untoward changes in the condition of a prenatal or postpartum woman at high risk so that other medical or social services, if necessary, can be instituted during the prenatal or postpartum stage of childbearing;

(2) [hands] Hands on care provided by a home health aide;

(3) [home] Home health aide assistance with an IADL provided in conjunction with hands on care;

(4) [physical] Physical therapy services;

(5) [speech] Speech therapy or speech pathology services;

(6) [occupational] Occupational therapy services; and

(7) EPSDT.

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

(1) The department shall pay for home health care services only when these services are provided in the client's home. However, the department shall pay for medically necessary [and medically appropriate] nursing care services for clients who leave their place of residence to engage in normal life activities. The total number of hours of nursing care services shall be limited to those hours to which the client would be entitled if services were provided exclusively at the client's place of residence. Such services shall not be provided in hospitals, nursing facilities, chronic disease hospitals, intermediate care

facilities for the [mentally retarded] individuals with intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client.

Sec. 17b-262-729. Services not covered

The department shall not pay a home health care agency:

(1) [for] For services provided to a client who is receiving the same service concurrently from an individual therapist, clinic, hospital, practitioner, rehabilitation center or other health care provider;

(2) [for] For services provided by or through another agency or facility as part of its licensing requirements. For example, the department shall not pay for home health aide services if the client lives in a facility that provides home health aide services as part of its licensing requirements;

(3) [when] When the client is in a hospital, nursing facility, chronic disease hospital, ICF/MR or other facility that is paid an all-inclusive rate directly by Medicaid for the care of the client;

(4) [when] When the client is receiving the same home health care services concurrently from another home health care agency. This limitation does not preclude a home health care agency from contracting with another agency as described in section 19-13-D70 of the Regulations of Connecticut State Agencies;

(5) [for] For well child care or for prenatal or postpartum care that is not high risk;

(6) [for] For medical and surgical supplies or durable medical equipment used by the nurse, home health aide or therapist as part of the course of treatment for a client;

(7) [for] For cancelled visits, appointments not kept or services not provided;

(8) [for] For information or services provided to a client over the telephone; or

(9) [for] For anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.

Sec. 17b-262-731. Need for service

(a) The department shall pay for medically necessary [and medically appropriate] home health care services only under orders of a licensed practitioner as part of a care plan.

Sec. 17b-262-737. Definitions

As used in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Chronic disease hospital” means a “chronic disease hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;
- (2) “Client” means a person eligible for goods or services under the Medicaid program;
- (3) “Customized orthotic or prosthetic device” means a device prescribed by a licensed practitioner that is specifically manufactured to meet the special medical, physical or psychosocial needs of a client. A customized orthotic or prosthetic device requires special construction, the plans for which are taken from an exact model of a particular client's body part;
- (4) “Department” means the Department of Social Services or its agent;
- (5) “Documented in writing” means that the prescription has been handwritten, typed or computer printed;
- (6) “Home” means the client's place of residence and includes a boarding home, community living arrangement or residential care home. “Home” does not include a facility such as a hospital, chronic disease hospital, nursing facility, intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;
- (7) “Hospital” means a “short-term hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;
- (8) “Intermediate care facility for [the mentally retarded] or “ICF/MR”] individuals with intellectual disabilities” or “ICF/IID” means a residential facility for [the mentally retarded]individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;
- (9) “Licensed practitioner” means an individual who is either licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing an orthotic or prosthetic device;

[(10) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally-recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;]

[(11)] (10) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act, as amended from time to time;

[(12)] (11) "Medical necessity" or "medically necessary" [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness, to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(13)] (12) "Nursing facility" or "NF" [means an institution as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time;

[(14)] (13) "Orthotic or prosthetic device" or "device" means a corrective or supportive device prescribed by a licensed practitioner, within the scope of his or her practice as defined by federal and state law, to:

(A) [artificially] Artificially replace a missing portion of the body;

(B) [prevent] Prevent or correct physical deformity or malfunction; or

(C) [support] Support a weak or deformed portion of the body;

[(15)] (14) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

[(16)] (15) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(17)] (16) "Provider" means the vendor or supplier of an orthotic or prosthetic device who is enrolled with the department as a medical equipment, devices[,] and supplies supplier; and

[(18)] (17) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-740. Services covered and limitations

(a) Services Covered

(1) The department shall pay for the purchase or repair of a medically necessary [and medically appropriate] orthotic or prosthetic device, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies, provided such device is prescribed by a licensed practitioner in conformance with accepted methods of diagnosis and treatment.

Sec. 17b-262-748. Definitions

As used in sections 17b-262-747 [through] to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

- (1) “Billing provider” means the Connecticut Department of Children and Families.
- (2) “Child” means a person who is under twenty-one (21) years of age.
- (3) “Department” or “DSS” means the Department of Social Services or its agent.
- (4) “DCF” means the Department of Children and Families.
- (5) “Individual treatment plan” means a written plan developed by the performing provider in accordance with section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.
- (6) “Licensed clinical staff” means:
 - (A) [a] A doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;
 - (B) [a] A psychologist who is licensed under chapter 383 of the Connecticut General Statutes;
 - (C) [a] A marriage and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;
 - (D) [a] A clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;
 - (E) [an] An alcohol and drug counselor who is licensed under chapter 376b of the Connecticut General Statutes;

(F) [an] An advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes; or

(G) [a] A registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field.

(7) “Medicaid” means the program operated by the department pursuant to [Section] section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act.

(8) “Medically necessary” [or "medically appropriate" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring] or “medical necessity” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes.

(9) “Monthly rate” means the amount the department pays for each [PNMI] Private Non-Medical Institution client for [PNMI] Private Non-Medical Institution program services for each month of service.

(10) “Performing provider” means an entity that participates in the Medicaid program as a provider of [PNMI] Private Non-Medical Institution children's rehabilitative services and that is a state licensed or approved (A) residential treatment facility; group home; maternity home; or similar institution; or (B) child placing agency that offers a therapeutic foster care or professional parent program.

(11) “Private Non-Medical Institution client”, “PNMI client” or “client” means a client who is a child that (A) has been placed with a [PNMI] Private Non-Medical Institution performing provider by a state agency and (B) determined by the department to be eligible for Medicaid.

(12) “Private Non-Medical Institution” or “PNMI” means an entity that is not a health insuring organization, hospital, nursing home, or a community health care center, but which (A) provides residential services for children and is licensed or approved by the state of Connecticut as (i) a residential treatment facility, group home, maternity home, or similar institution or (ii) a child placing agency that offers a therapeutic foster care or a professional parent program; or (B) is an out-of-state facility determined by the Commissioner of the Department of Children and Families to meet comparable licensure standards or requirements.

(13) “Residential treatment facility” means a 24 hour mental health facility that is licensed or approved by the Department of Children and Families and that operates for the purpose of effecting positive change and normal growth and development for emotionally disturbed, behavior disordered and socially maladjusted children.

(14) “Group home” means a community based residential facility with a home-like environment that is licensed or approved by the Department of Children and Families; provides board and care, counseling, life-skill training and recreation; and arranges for or helps residents access educational, vocational and therapy services that are offered in the community.

(15) “Maternity home” means a maternity home that (A) is licensed by DCF as a group home; (B) is a 24 hour facility that provides board, care, treatment and the therapeutic environment required to promote positive change and growth in pregnant adolescents and young mothers; and (C) has neonatal and postnatal programs that are designed to assess client needs and develop skills in parenting, socialization and independent living.

(16) “Therapeutic foster care” means a program offered by a DCF approved or licensed child placing agency that recruits, trains and supports foster parents who provide family foster care to children with emotional and behavioral needs.

(17) “Professional parent program” means a program provided by a DCF approved or licensed child placing agency that (A) recruits, trains and supports foster parents who provide family foster care to children with multiple needs and (B) serves children who need a greater level of care than those children who are served in a therapeutic foster care agency program.

(18) “Provider agreement and contract” means the signed, written contractual agreement between the department and the performing provider and the billing provider of PNMI children's rehabilitative services.

(19) “Rehabilitative services” means those services described in 42 C.F.R. 440.130(d), as amended from time to time, and include those services identified in section 17b-262-752 of the Regulations of Connecticut State Agencies.

(20) “Title V Agency” means the Department of Public Health, which administers [Title] title V of the Social Security Act, known as the Maternal and Child Health Services Block Grant.

(21) “PNMI program” means the component part of the state's [Title] title V program, which is administered through agreement among the billing provider, the department and the [Title] title V Agency.

Sec. 17b-262-751. Need for services

Payment for PNMI rehabilitative services shall be made by the department only if all of the following conditions are met:

(1) The client shall be assessed by the billing provider or its agent to determine that the PNMI rehabilitative services are medically necessary [or medically appropriate].

Sec. 17b-262-759. Definitions

As used in sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Adult” means a person who is 18 years of age or older;
- (2) “Department” or “DSS” means the Department of Social Services or its agent;
- (3) “DMHAS” means the Department of Mental Health and Addiction Services;
- (4) “DPH” means the Department of Public Health;
- (5) “Group home” means a privately operated, community-based residential facility that serves sixteen or fewer adult clients, is licensed by the Department of Public Health as either a private freestanding mental health residential living center or a private freestanding community residence pursuant to sections 19a-495-551 or 19a-495-560 of the Regulations of Connecticut State Agencies, is certified by the Department of Mental Health and Addiction Services as a provider of mental health rehabilitation services pursuant to section 17a-485d of the Connecticut General Statutes, and meets the requirements of section 17b-262-760 of the Regulations of Connecticut State Agencies for participation in the Medicaid program as a provider of PNMI rehabilitative services;
- (6) “Licensed clinician” means:
 - (A) [a] A doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;
 - (B) [a] A psychologist who is licensed under chapter 383 of the Connecticut General Statutes;
 - (C) [a] A marriage and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;
 - (D) [a] A clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;
 - (E) [an] An advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;
 - (F) [a] A registered nurse who is licensed under chapter 378 of the Connecticut General

Statutes and who has a minimum of one year of experience in the mental health field; or

(G) [a] A professional counselor who is licensed under chapter 383c of the Connecticut General Statutes;

(7) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(8)] (8) “Medically appropriate” means medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting;]

[(9)] (8) “Medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring] or “medical necessity” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(10)] (9) “Monthly rate” means the amount the department pays for each PNMI client for PNMI program services for each month of service in which there is a qualifying billable unit of service provided;

[(11)] (10) “Provider” means an entity that participates in the Medicaid program as a qualified group home provider of PNMI adult rehabilitative services as evidenced by an executed provider agreement with DSS;

[(12)] (11) “Private Non-Medical Institution client”, “PNMI client” or “client” means a Medicaid-eligible adult who resides in a participating group home and who receives covered [PNMI] Private Non-Medical Institution rehabilitative services in accordance with sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies;

[(13)] (12) “Prior authorization” means approval for the provision of service from the department before the provider actually provides the service;

[(14)] (13) “Private Non-Medical Institution” or “PNMI” means an entity that is a qualified group home provider of adult rehabilitative services under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies and is not a health insuring organization, hospital, nursing home[,] or a community health care center;

[(15)] (14) “Provider agreement” means the signed, written contractual agreement between the department and the provider of PNMI rehabilitative services;

[(16)] (15) “Qualifying billable unit of service” means forty hours of rehabilitative services during a calendar month or the prorated equivalent based on the number of days

the client is in residence at the group home during that month. For purposes of calculation, the forty hours, or the prorated equivalent, may be made up of fifteen minute sub-units, using a rounding convention to be determined by the department;

[(17)] (16) “Rehabilitative services” means those services identified in section 17b-262-763 of the Regulations of Connecticut State Agencies when provided by a qualified provider on behalf of a PNMI client;

[(18)] (17) “Residential rehabilitation plan” means a written plan developed by the performing provider in accordance with section 17b-262-760(5) of the Regulations of Connecticut State Agencies; and

[(19)] (18) “Under the supervision” means that a licensed clinician provides periodic supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitative services performed by the unlicensed staff.

Sec. 17b-262-780. Definitions

As used in sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Applied income” means the amount of income that each client receiving chronic disease hospital services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual. section 5045.20;

(2) “Assessment” means a comprehensive written evaluation of an individual's functional performance in relation to a set of measurable medical or physical criteria;

(3) “Client” means a person eligible for goods or services under the department's Medicaid program;

(4) “Chronic disease” means a disease having one or more of the following characteristics:

(a) [is] Is permanent;

(b) [leaves] Leaves residual disability;

(c) [is] Is caused by non-reversible pathological alteration;

(d) [requires] Requires special training of the client for rehabilitation; or

(e) [is] Is expected to require a long period of supervision, observation or care;

(5) “Chronic disease hospital” means “chronic disease hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(6) “Commissioner” means the [commissioner of social services or his or her designee] Commissioner of Social Services or the Commissioner’s agent;

(7) “Department” means the [department of social services] Department of Social Services or its agent;

(8) “Durable medical equipment” means equipment that meets all of the following requirements:

(a) [can] Can withstand repeated use;

(b) [is] Is primarily and customarily used to serve a medical purpose;

(c) [is] Is generally not useful to a person in the absence of an illness or injury; and

(d) [is] Is non-disposable;

(9) “Institution for mental diseases” [means “institution for mental diseases” as defined] has the same meaning as provided in 42 CFR 435.1009, as amended from time to time;

(10) “Licensed practitioner” means any person licensed by the state of Connecticut, any other state, the District of Columbia or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(11) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(12)] (12) “Medical appropriateness” or “medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities];

[(13)] (12) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

[(14)] (13) “Preadmission assessment” means a clinical assessment of ongoing needs and prognosis as necessary to determine the chronic disease hospital's ability to provide for a client's expected needs;

[(15)] (14) “Provider” means a chronic disease hospital that is enrolled in Medicaid;

[(16)] (15) “Provider agreement” means the signed, written, contractual agreement between the department and the provider;

[(17)] (16) “Physician” means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes;

[(18)] (17) “Rehabilitation” means any medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental disability and restoration of an individual to his or her best possible functional level;

[(19)] (18) “Resident” means a client living in a chronic disease hospital;

[(20)] (19) “Team” means a group of individuals employed by or under contract to the chronic disease hospital and may include psychiatrists, specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, respiratory specialists, prosthetists, orthotists, psychiatrists or respiratory specialists. Other practitioners, including but not limited to, mental health practitioners, may be part of the team as appropriate;

[(21)] (20) “Team conference” means a meeting of the team to develop a treatment plan of care;

[(22)] (21) “Treatment plan of care” means the written description of services designed to meet a resident's medical, nursing and rehabilitation needs that are identified in the resident's assessment. The treatment plan of care shall include measurable objectives and a specific timetable; and

[(23)] (22) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-783. Need for service

In order for a client to be approved for admission to a chronic disease hospital, the client shall meet the criteria for admission as either a chronic disease client or a rehabilitation client. All care shall be medically necessary [and medically appropriate].

(a) The criteria for admission as a chronic disease client are as follows:

(1) Each chronic disease client shall require services that can be provided safely and effectively at a chronic disease hospital level, shall be ordered by a physician and documented in the client's medical record, and shall include at least a daily physician visit and assessment or the 24-hour availability of medical services and equipment available only in a hospital setting; and

(2) The client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client.

(b) The criteria for admission as a rehabilitation client are as follows:

(1) Each rehabilitation client shall require an intensive rehabilitation program at the level of a chronic disease hospital level of care that includes a multi-disciplinary approach to improve the client's ability to function to his or her maximum potential. Factors shall be present in the client's condition that indicate the potential for functional improvement or freedom from pain. A client who requires therapy solely to maintain function shall not be considered an appropriate rehabilitation candidate;

(2) Each client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client;

(3) A preadmission assessment shall be developed, prior to admission by specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, prosthetists or orthotists;

(4) The treatment plan of care shall be directed by a physician who is board certified or eligible for board certification in an appropriate specialty; and

(5) The treatment plan of care shall be designed to achieve specific goals within a specified timeframe.

(c) Team conferences shall be conducted for each client. The first team conference shall occur not later than seven calendar days after the client's admission.

(d) For rehabilitation clients, subsequent conferences shall occur at least once every fourteen calendar days. All team members, or a designee within the same specialty, shall be in attendance. The purpose of the conference shall be to conduct an assessment of the client's progress, make adjustments to the established goals as indicated or terminate the program when the expected goal has been reached or determined to be no longer attainable.

(e) For chronic disease clients, subsequent conferences shall occur at least once every 90 days. The depth of the periodic review shall be appropriate to the client's clinical status and prognosis.

(f) The department may use nationally recognized guidelines applicable to chronic

disease hospitals or inpatient rehabilitation hospitals in determining if the admission is medically necessary [and medically appropriate].

Sec. 17b-262-805. Definitions

As used in section 176-262-804 to section 176-262-816, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Active treatment” [means “active treatment” as defined in 42 CFR, Part 441, section] has the same meaning as provided in 42 CFR 441.154;

(2) “Acute” means having rapid onset, severe symptoms and a short course;

(3) “Allied Health Professional” or “AHP” means a licensed individual who is qualified by special training, education, skills and experience in behavioral health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, professional counselors and other qualified therapists as defined in [Title] title 20 of the Connecticut General Statutes;

(4) “Authorization” means the approval of payment for services or goods by the department based on a determination of medical necessity [and appropriateness]. For elective admissions, authorization also serves as the certification of need as defined in this section;

(5) “CMS” means the Centers for Medicare and Medicaid Services;

(6) “Certification of need” means an evaluation process for clients who are under consideration for admission to a [PRTF] Psychiatric Residential Treatment Facility;

(7) “Client” means a person eligible for goods or services under Medicaid who is under age twenty-one at the time services are received. If a client received services immediately before reaching age twenty-one, payment shall be available for services received before the earlier of the date that the client no longer requires the services or the date that the client reaches age twenty-two;

(8) “Department” means the Department of Social Services or its agent;

(9) “Elective admission” means any admission to a [PRTF] Psychiatric Residential Treatment Facility that is non-emergent, including, but not limited to, transfers from one [PRTF] Psychiatric Residential Treatment Facility to another;

(10) “Independent team” means a team that meets the requirements set forth in 42 CFR[, Part 441, section] 441.153(a). The independent team may not include anyone who is related, in any way, to the admitting facility, or who is directly responsible for the care of patients whose care is being reviewed or has a financial interest in the admitting facility.

The department performs the functions of the independent team;

(11) “Individual plan of care” or “plan of care” means a written plan that meets the criteria set forth in 42 CFR[, Part 441, Section] 441.155;

(12) “Inpatient” [means “inpatient” as defined in 42 CFR, Part 440, section 440.2] has the same meaning as provided in 42 CFE 440.2, as amended from time to time;

(13) “Interdisciplinary team” [means a team that meets the requirements set forth in section 42 CFR, Part 441, section 441.156] has the same meaning as provided in 42 CFR 441.156, as amended from time to time;

(14) “Medicaid” means the program operated by the department pursuant to section [176-260] 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act;

[(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;]

[(16)] (15) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or to prevent a medical condition from occurring] has the same meaning as is provided in section 17b-259b of the Connecticut General Statutes;

[(17)] (18) “Medical record” [means “medical record” as described in 42 CFR, Part 482, section 482.61] has the same meaning as provided in 42 CFR 482.61 and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies;

[(18)] (17) “Overnight pass” means a conditional release to the client's proposed residence on discharge of not more than two days duration, after admission and prior to the day of discharge, in which the client has been permitted by the attending physician to be absent from the facility premises and in accordance with the client's treatment needs and goals as specified in the plan of care;

[(19)] (18) “Provider” means a [PRTF] Psychiatric Residential Treatment Facility that is enrolled in Medicaid;

[(20)] (19) “Provider agreement” means the signed, written contractual agreement between the department and the provider;

[(21)] (20) “Psychiatric emergency” means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility

could reasonably be expected to result in serious dysfunction, disability or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a physician emergency certificate are not automatically deemed to qualify as a psychiatric emergency;

[(22)] (21) “Psychiatric Residential Treatment Facility” or “PRTF” means a facility that meets all the requirements in 42 CFR [Part] 441, Subpart D and 42 CFR [Part] 483, Subpart G;

[(23)] (22) “Quality of care” means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the condition and the client under treatment;

[(24)] (23) “Retrospective review” means the review conducted after services are provided to a client, to determine the medical necessity[, medical appropriateness] and quality of the services provided;

[(25)] (24) “Transfer” means that a client is discharged from a PRTF and directly admitted to another;

[(26)] (25) “Under the direction of a physician” means that health services may be provided by allied health professionals or paraprofessionals whether or not the physician is physically present at the time that the services are provided; and

[(27)] (26) “Utilization management” means the prospective, retrospective or concurrent assessment of the medical necessity [and appropriateness] of the allocation of health care resources and services given, or proposed to be given, to a client.

Sec. 17b-262-809. Services not covered

The department shall not pay for the following PRTF services that are not covered under Medicaid:

(a) [procedures] Procedures or services of an unproven, educational, social, research, experimental or cosmetic nature or for any diagnostic, therapeutic or treatment procedures in excess of those deemed medically necessary [and appropriate] by the department to treat the client's condition;

Sec. 17b-262-812. Utilization review program

(a) The department conducts utilization review activities for services delivered by the PRTF for clients where Medicaid has been determined to be the appropriate payer.

(b) To determine whether admission to a PRTF is medically necessary [and medically appropriate], the department or the Administrative Service Organization shall:

- (1) [authorize] Authorize each PRTF admission, unless the department notifies the providers that a specific admission or diagnosis does not require such authorization; and
- (2) [perform] Perform retrospective reviews, at the department's discretion, which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the [appropriateness,] necessity or quality of the health care services provided.

Sec. 17b-262-830. Definitions

As used in section 17b-262-829 to section 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) “Advanced practice registered nurse” or “APRN” means an advanced practice registered nurse as defined in section 20-87a of the Connecticut General Statutes;
- (2) “Applied income” means the amount of income that each client receiving hospice care is expected to pay each month toward the cost of care, calculated according to the department's Uniform Policy Manual, section 5045.20;
- (3) “Attending physician” means a physician who is identified by the client at the time he or she elected to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care;
- (4) “Bereavement counseling” means emotional, psychosocial[,] and spiritual support and services provided before and after the client's death to the client and the client's family to assist with issues related to grief, loss and adjustment;
- (5) “Client” means a person eligible for goods or services under the department's Medicaid program;
- (6) “Commissioner” means the Commissioner of Social Services or [his or her designee] the Commissioner's agent;
- (7) “Concurrent” means in the same time period covered by the care plan;
- (8) “Counseling” means services, including dietary counseling, provided for the purpose of helping the client and caregivers to adjust to the client's approaching death;
- (9) “Date of terminal diagnosis” means the date on which a physician first diagnoses the client as terminally ill;
- (10) “Department” means the Department of Social Services or its agent;
- (11) “Election period” means one of three or more periods of care a client may choose to receive the hospice benefit. The periods consist of an initial 90-day period, a subsequent

90 day period and an unlimited number of subsequent 60-day periods;

(12) “Home” means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. “Home” does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(13) “Home health aide” means an individual who has completed the homemaker-home health aide services training and competency evaluation program in accordance with [Sec.] section 19-13-D69 of the Regulations of Connecticut State Agencies;

(14) “Home health care agency” means “home health care agency” as defined in section 19a-490 of the Connecticut General Statutes and licensed pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(15) “Hospice” means an agency that is primarily engaged in providing care to terminally ill individuals and meets the requirements of section 19-13-D72(b)(2) of the Regulations of Connecticut State Agencies. The hospice model of care is based on a coordinated program of home and inpatient care, employing an interdisciplinary team to meet the special needs of terminally ill individuals;

(16) “Hospice aide and homemaker” [means a “hospice aide and homemaker” as defined] has the same meaning as provided in 42 CFR 418.76;

(17) “Hospital” means “general hospital” as defined in section 19-13-D1 (b)(1) of the Regulations of Connecticut State Agencies;

(18) “Interdisciplinary team” means a group of hospice personnel to include, but not be limited to, a physician, a registered nurse, a pharmacist, a social worker and a counselor that is responsible for providing services to meet the physical, psychosocial, spiritual and emotional needs of a terminally ill client or family members, as delineated in a specific plan of care. The interdisciplinary team is responsible for participating in the establishment of a plan of care for each client, supervising hospice services and reviewing and updating the plan of care as necessary;

(19) “Intermediate care facility for [the mentally retarded] or “ICF/MR”] individuals with intellectual disabilities” or “ICF/IID” means a residential facility for persons with [mental retardation] intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(20) “Legal representative” means an individual who has been authorized under Connecticut state law to direct medical care or to elect or revoke the election of hospice

care on behalf of a terminally ill individual who is mentally or physically incapacitated;

(21) “Licensed practical nurse” or “LPN” means “licensed practical nurse” as defined in section 20-87a of the Connecticut General Statutes;

(22) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by [Title] title XIX of the Social Security Act, as amended from time to time;

[(23) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;]

[(24)] (23) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; to prevent a medical condition from occurring;] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes [or to alleviate] and includes health care provided to alleviate suffering through the palliation of symptoms at the end of life;

[(25)] (24) “Medical record” [means “medical record” as defined] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;

[(26)] (25) “Nursing care” means the services provided by a registered nurse or a licensed practical nurse;

[(27)] (26) “Nursing facility” or “NF” [means “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a), as amended from time to time, and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies;

[(28)] (27) “Occupational therapy” means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

[(29)] (28) “Palliative care” means care that addresses physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice;

[(30)] (29) “Physical therapy” means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

[(31)] (30) “Physician” means a physician or surgeon licensed pursuant to section 20-10 or 20-12, inclusive, of the Connecticut General Statutes;

[(32)] (31) “Plan of care” means a comprehensive assessment of the client's needs that identifies the types and frequency of services necessary to manage the client's discomfort and relieve the symptoms of the terminal illness as well as to identify any services necessary to meet the needs of the family that meet the requirements of 42 CFR 418.54;

[(33)] (32) “Prior authorization” or “PA” means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(34)] (33) “Provider” means a hospice that is certified by Medicare as a hospice, is licensed by the Connecticut Department of Public Health as a hospice and is enrolled with Medicaid;

[(35)] (34) “Registered nurse” means “registered nurse” as defined in section 20-87a of the Connecticut General Statutes;

[(36)] (35) “Social worker” means an individual licensed pursuant to section 20-195n of the Connecticut General Statutes;

[(37)] (36) “Speech therapy” or “speech pathology” means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes; and

[(38)] (37) “Terminally ill” means a condition in which the patient has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

Sec. 17b-262-842. Services not covered

(a) When a client elects the hospice benefit, the client waives his or her right to receive the following services under Medicaid:

(1) [treatment] Treatment intended to cure the terminal illness;

(2) [treatment] Treatment related to the terminal illness except for the treatment provided by the designated hospice;

(3) [hospice] Hospice services provided by a provider other than the one designated by the client on the hospice form submitted to the department. However, the provider may subcontract with another hospice for services as described [is section.] in section 17b-262-838(f); and

(4) [any] Any services that are duplicative of any service provided by the hospice provider with the exception of services of the client's attending physician.

(b) In order for charges to be billed separately, the provider shall first demonstrate that the service is not related to the terminal illness.

(c) The department shall not pay for services that are not medically necessary [and medically appropriate].