State of Connecticut

REGULATION

of

NAME OF AGENCY
Department of Social Services

SUBJECT MATTER OF REGULATION
Requirements for Payment of Services Provided by Independent Licensed Audiologists, Physical Therapists, Occupational Therapists and Speech Pathologists

Section 1. Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies are amended to read as follows:

Sec. 17b-262-630. Scope

Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of services provided by independent licensed audiologists, physical therapists, occupational therapists and speech pathologists for clients who are determined eligible to receive services under Connecticut’s Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes [(CGS)]. Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies shall not apply to therapy services provided by home health agencies, clinics, rehabilitation centers, hospitals or other health care providers.

Sec. 17b-262-631. Definitions

For the purposes of sections 17b-262-630 to 17b-262-640, 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;]

(1) “Advanced practice registered nurse” or “APRN” means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;

(2) “Audiologist” means [one who is licensed to practice audiology pursuant to Chapter 399 of the Connecticut General Statutes, and who also meets the definition of audiologist as defined in Title 42 of the Code of Federal Regulations (CFR), Part 440, subsection (c) of section 440.110, as amended from time to time an individual] a person licensed to practice audiology pursuant to chapter 397a of the Connecticut General Statutes and who meets the definition of “qualified audiologist” in 42 CFR 440.110(c)(3);

(3) ["Audiological services] “Audiology” means evaluation and treatment provided by [a licensed] an audiologist [as defined in subdivision (3) of section 20-408 of the Connecticut General Statutes, and in Title 42 of the CFR, Part 440, subsection (c) of section 440.110, as}
amended from time to time];

(4) “Border [hospital] provider” [means an out-of-state general hospital which has a common medical delivery area within the State of Connecticut and is deemed a border hospital by the department on a hospital by hospital] has the same meaning as provided in section 17b-262-523 of the Regulations of Connecticut State Agencies;

(5) “Chronic disease hospital” [means a “chronic disease hospital” as defined] has the same meaning as provided in section 19-13-D1 of the Regulations of Connecticut State Agencies 19a-550 of the Connecticut General Statutes;

(6) “Client” means a person eligible for goods or services under [the department's] Medicaid [program];

(7) “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;

(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) "HealthTrack Services " means the services described in subsection (r) of section 1905 of the Social Security Act, as amended from time to time;]

[(11)[9] “Early and Periodic Screening, Diagnostic and Treatment Special Services” or “[HealthTrack] EPSDT 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, as amended from time to time, and are:

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

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation] services that are not otherwise covered under Medicaid but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider and the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;]
"Home" means the client’s place of residence, which includes a boarding home or residential care home. Home does not include a hospital or long-term care facility;

"Hospital" means a “short-term hospital” as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies. [This includes a children’s general hospital.] It shall also include [a] an out-of-state hospital or a hospital that is a border hospital provider;

"Independent therapist” means [a licensed] an audiologist, physical therapist, occupational therapist or speech pathologist [operating as an independent practitioner] practicing in the community independently and not associated with a hospital, long-term care facility, clinic, home health agency or any other health care provider;

"Independent therapy [services]” means those services provided by [a licensed audiologist, physical therapist or speech pathologist operating as an independent practitioner] an independent therapist, a physical therapy assistant or an occupational therapy assistant;

"Intermediate [care facility for the mentally retarded] Care Facility for the Mentally Retarded” or “ICF/MR” 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 pursuant to 42 CFR 442.101, as amended from time to time;

"International Classification of Diseases” or “ICD” means the most recent system of disease classification established by the World Health Organization or such other disease classification system that the department requires providers to use when submitting Medicaid claims;

"Interperiodic 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;

"Licensed practitioner” means a [professional person providing health care pursuant to a license issued by the Department of Public Health (DPH)] physician, a physician assistant, an advanced practice registered nurse or a podiatrist providing services within the licensed practitioner’s scope of practice under state law;

"Long-term care facility” means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities;

(B) inpatient chronic disease hospitals[--inpatient]; and

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

"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)] (18) “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 XIX of the Social Security Act, as amended from time to time;

[(22)] (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] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(20) “Nursing facility” has the same meaning as provided in 42 USC 1396r(a) and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or a rest home with nursing supervision;

(21) “Occupational therapist” has the same meaning as provided in section 20-74a(2) of the Connecticut General Statutes;

(22) “Occupational therapy” means services provided by an occupational therapist or an occupational therapy assistant and that meets the definition of occupational therapy in 42 CFR 440.110(b);

(23) “Occupational therapy assistant” has the same meaning as provided in section 20-74a(3) of the Connecticut General Statutes;

(24) “Physical therapist” [means “physical therapist” as defined] has the same meaning as provided in section 20-66 of the Connecticut General Statutes[, and who also meets the definition of physical therapist as defined in Title 42 of the CFR, Part 440, subsection (a) of section 440.110, as amended from time to time];

(25) “Physical therapy assistant” has the same meaning as provided in section 20-66 of the Connecticut General Statutes;

[(25)] (26) “Physical therapy services” means the evaluation and treatment provided by a physical therapist [as defined in subdivision (2) of section 20-66 of the Connecticut General Statutes and in Title 42 of the CFR, Part 440, subsection (a) of section 440.110, as amended from time to time] or physical therapy assistant in accordance with 42 CFR 440.110(a);

[(26)] (27) “Physician” means a [physician] person licensed pursuant to section [20-10] 20-13 of the Connecticut General Statutes [or a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes];

(28) “Physician assistant” has the same meaning as provided in section 20-12a(5) of the Connecticut General Statutes;

(29) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to chapter 375 of the Connecticut General Statutes;

[(27)] (30) “Prior authorization” 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;

[(28)] (31) “Provider” means an independent [licensed audiologist, speech pathologist, or physical therapist] therapist enrolled with [the department] Medicaid;

[(29)] (32) “Provider agreement” means the signed, written[, contractual] agreement between the department and the provider [of services or goods] for enrollment in Medicaid;

[(30)] (33) “Speech pathologist” means [one who is licensed to practice speech therapy or pathology pursuant to Chapter 399 of the Connecticut General Statutes, and who also meets the definition of speech pathologist as defined in Title 42 of the CFR, Part 440, subsection (c) of section 440.110, as amended from time to time] a “licensed speech and language pathologist” as defined in chapter 399 of the Connecticut General Statutes;

[(31)] (34) “Speech pathology services” means the evaluation and treatment provided by a speech pathologist [licensed pursuant to section 20-408 of the Connecticut General Statutes and in Title 42 of the CFR, Part 440, subsection (c) of section 440.110, as amended from time to time] in accordance with 42 CFR 440.110(c); and

[(32) "State Plan" means the document which contains the services covered by the Connecticut Medicaid program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations, as amended from time to time.]

(35) “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 shall be excluded when calculating the usual and customary charge.

Sec. 17b-262-632. Provider participation

In order to participate in [the] Medicaid [program] and receive payment from the department, providers shall:

(a) [meet and maintain] Comply with all applicable licensing, accreditation[,] and certification requirements;

(b) [meet and maintain] comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies; [and]

(c) comply with sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies; and

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

Sec. 17b-262-633. Eligibility

Payment for independent therapy services prescribed by a licensed practitioner, [functioning within
his or her scope of practice as defined under state law,] is available on behalf of all [persons eligible
for the Medicaid program] clients who have a need for such services and which are medically
necessary subject to the conditions and limitations which apply to [these] such services.

Sec. 17b-262-634. Services covered and limitations

Subject to the limitations and exclusions [listed below] in this section, the department shall pay for
[the professional evaluation or treatment services of a licensed independent audiologist, physical
therapist, or speech pathologist] independent therapy which conforms 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:

(1) [for services] Services provided in the provider’s office or the client’s home; and

(2) [for Health Track Services and Health Track] EPSDT Special Services.

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

[[1 services covered shall be limited to those listed in the department's applicable fee
schedule; ]

[[2 physical] (1) Physical therapy [evaluation], speech therapy [evaluation], occupational
therapy and audiology evaluation services shall be limited to one of each type per day,
per client regardless of the length of time it takes to complete the evaluation;

[[3] (2) for physical therapy[,] and occupational therapy services, the department shall pay
per modality as listed on the fee schedule;

[[4] (3) for speech therapy and audiology services, the department shall not pay for more
than one and one half hours of treatment per day;

[[5] (4) the fee for evaluation shall include all treatment when evaluation and treatment are
provided on the same day; and

[[6] (5) group speech therapy services shall [be limited in size to] include a maximum of
three persons per group, per session regardless of [the] each participant’s payment
source [of each participant].

(c) The department shall not pay for the following independent therapy [services]:

(1) [audiological, physical therapy, or speech pathology services provided by an
independent therapist] Independent therapy when the client is concurrently receiving the same therapy services [to treat the same diagnosis] from a hospital, chronic disease hospital, clinic, rehabilitation clinic, home health agency[,] or any other health care provider [and the department is paying for these services];

(2) services provided to clients who are [patients or] residents of a hospital, long-term care facility[,] or any other facility [which] that is required to include [audiology, physical, therapy, or speech pathology services] independent therapy in its rates;

(3) cancelled office visits or appointments not kept; and

(4) information or services provided to a client by a provider electronically or over the telephone.

**Sec. 17b-262-635. Need for service**

(a) The department shall pay for independent therapy [services which are provided by independent licensed audiologists, physical therapists, and speech pathologists and are] that is medically necessary [and medically appropriate] when [the client's need for service is prescribed by] a licensed practitioner[, functioning within his or her respective scope of practice as defined by state law] prescribes the client’s need for the service.

(b) [The need for service shall be reestablished by an evaluation performed by a] A [physician, or other] licensed practitioner [functioning within his or her respective scope of practice as defined by state law, at least every] shall reestablish the need for service by performing an evaluation not more than twelve months [from the date of the first] after the previous evaluation.

(c) The provider shall document the initial and subsequent need for service [shall be documented] in the client’s record.

**Sec. 17b-262-636. Prior authorization**

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

(1) [all] All audiology [evaluation], physical therapy [evaluation], occupational therapy and speech pathology evaluation services in excess of one evaluation per calendar year, per client, per provider;

(2) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of nine treatments per calendar year per provider per client, involving the following primary [diagnosis] diagnoses:

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

(B) cases involving musculoskeletal system disorders of the spine covered by ICD[, as amended from time to time]; and
(C) cases involving symptoms related to nutrition, metabolism[,] and development covered by the ICD; [as amended from time to time:]

(3) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of two services per calendar week[,] per client[,] per provider; and

(4) [Health Track] EPSDT Special Services[, as follows:

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

(B) the request for [Health Track] EPSDT Special Services shall include:

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

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

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

(5) any service that is not on the department’s fee schedule.

[(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.]

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

(b) The length of the initial authorization period is at the department’s discretion, but shall be for no longer than three months;

[(d)] (c) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request or longer if determined appropriate by the department on a case-by-case basis.

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

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

[(g) (e) 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-262-637. Billing procedures

[Claims from providers shall be submitted on the department's designated form or electronically submitted to the department's fiscal agent and shall include] Providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment.

Sec. 17b-262-638. Payment

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

(b) Payment shall be made at the lowest of:

(1) [the] The provider’s usual and customary charge [to the general public];

(2) the lowest Medicare rate;

(3) the amount in the [applicable] independent therapy fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(c) Notwithstanding the provisions of subsection (b)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

Sec. 17b-262-639. Payment rates

The commissioner [establishes] shall establish the fees contained in the department’s fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

Sec. 17b-262-640. Documentation

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

(b) [All] The provider shall maintain all required documentation [shall be maintained] in its original form, paper or electronic, for at least five years or longer, as required by applicable statutes and regulations in the provider’s file, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation [shall be maintained] until the end of the dispute or five years, whichever is greater.

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

(d) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.
**Statement of Purpose**

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

The purpose of the regulations is to add “independent occupational therapists” to the list of independent therapists that may bill for Medicaid payment under sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies.

(A) The problems, issues or circumstances that the regulation proposes to address: Effective January 1, 2012, the Department transitioned from a Managed Care Organization (“MCO”) model to an Administrative Services Organization (“ASO”) model. Under the ASO model, the Department’s existing regulations will determine the requirements for payment for medical services. Currently there are no regulations governing the payment of independent occupational therapists under Medicaid and, therefore, those services will not be reimbursed under an ASO model unless the regulation is amended as proposed. The proposed regulation will set forth the requirements for payment for independent occupational therapist under Medicaid. This amendment will also permit individuals receiving independent occupational therapy services under their MCOs prior to the transition to continue to receive those services after they are transitioned to the ASO.

(B) The main provisions of the regulation: Add “occupational therapist” to the regulation as necessary and add definitions for the terms “occupational therapist” and “occupational therapy.” The proposed regulation also makes several technical corrections.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws are: The proposed regulation will amend the current regulations to permit payment for services provided by independent occupational therapists. This will also ensure that individuals receiving services from an independent occupational therapist paid for by their MCO prior to January 1, 2012, to continue to receive those services and have them paid for by Medicaid after they are transitioned to the ASO.
CERTIFICATION

This certification statement must be completed in full, including items 3 and 4, if they are applicable.

1) I hereby certify that the above (check one) ☐ Regulations ☑ Emergency Regulations

2) are (check all that apply) ☐ adopted ☑ amended ☐ repealed by this agency pursuant to the following authority(ies): (complete all that apply)
   a. Connecticut General Statutes section(s) 17b-262.
   b. Public Act Number(s) _____.
      (Provide public act number(s) if the act has not yet been codified in the Connecticut General Statutes.)

3) And I further certify that notice of intent to adopt, amend or repeal said regulations was published in the Connecticut Law Journal on January 17, 2012; (Insert date of notice publication if publication was required by CGS Section 4-168.)

4) And that a public hearing regarding the proposed regulations was held on March 14, 2012; (Insert date(s) of public hearing(s) held pursuant to CGS Section 4-168(a)(7), if any, or pursuant to other applicable statute.)

5) And that said regulations are EFFECTIVE (check one, and complete as applicable)
   ☐ When filed with the Secretary of the State
   OR ☑ on (insert date) January 1, 2012

DATE
June 7, 2012
SIGNED (Head of Board, Agency or Commission)
OFFICIAL TITLE, DULY AUTHORIZED
Commissioner

APPROVED by the Attorney General as to legal sufficiency in accordance with CGS Section 4-169, as amended

DATE
SIGNED (Attorney General or AG’s designated representative)
OFFICIAL TITLE, DULY AUTHORIZED

Proposed regulations are DEEMED APPROVED by the Attorney General in accordance with CGS Section 4-169, as amended, if the attorney General fails to give notice to the agency of any legal insufficiency within thirty (30) days of the receipt of the proposed regulation. (For Regulation Review Committee Use ONLY)

☑ Approved ☐ Rejected without prejudice
☐ Approved with technical corrections ☐ Disapproved in part, (Indicate Section Numbers disapproved only)
☐ Deemed approved pursuant to CGS Section 4-170(c)

By the Legislative Regulation Review Committee in accordance with CGS Section 4-170, as amended
DATE
SIGNED (Administrator, Legislative Regulation Review Committee)

Two certified copies received and filed and one such copy forwarded to the Commission on Official Legal Publications in accordance with CGS Section 4-172, as amended.

DATE
SIGNED (Secretary of the State)
BY

(For Secretary of the State Use ONLY)
GENERAL INSTRUCTIONS

1. All regulations proposed for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his/her determination of legal sufficiency. (See CGS Section 4-169.)

2. After approval by the Attorney General, the original and one electronic copy (in Word format) of all regulations proposed for adoption, amendment or repeal must be presented to the Legislative Regulation Review Committee for its action. (See CGS Sections 4-168 and 4-170 as amended by Public Act 11-150, Sections 18 and 19.)

3. Each proposed regulation section must include the appropriate regulation section number and a section heading. (See CGS Section 4-172.)

4. New language added to an existing regulation must be in **underlining** or **CAPITAL LETTERS**, as determined by the Regulation Review Committee. (See CGS 4-170(b).)

5. Existing language to be deleted must be enclosed in brackets [ ]. (See CGS 4-170(b).)

6. A completely new regulation or a new section of an existing regulation must be preceded by the word "(NEW)" in capital letters. (See CGS Section 4-170(b).)

7. The proposed regulation must have a statement of its purpose following the final section of the regulation. (See CGS Section 4-170(b).)

8. The Certification Statement portion of the form must be completed, including all applicable information regarding Connecticut Law Journal notice publication date(s) and public hearing(s). (See more specific instructions below.)


CERTIFICATION STATEMENT INSTRUCTIONS
(Numbers below correspond to the numbered sections of the statement)

1. Indicate whether the regulation is a regular or an emergency regulation adopted under the provisions of CGS Section 4-168(f).

2. a) Indicate whether the regulation contains newly adopted sections, amendments to existing sections, and/or repeals existing sections. Check all cases that apply.
   
   b) Indicate the specific legal authority that authorizes or requires adoption, amendment or repeal of the regulation. If the relevant public act has been codified in the most current biennial edition of the Connecticut General Statutes, indicate the relevant statute number(s) instead of the public act number. If the public act has not yet been codified, indicate the relevant public act number.

3. Except for emergency regulations adopted under CGS 4-168(f), and technical amendments to an existing regulation adopted under CGS 4-168(g), an agency must publish notice of its intent to adopt a regulation in the Connecticut Law Journal. Enter the date of notice publication.

4. CGS Section 4-168(a)(7) prescribes requirements for the holding of an agency public hearing regarding proposed regulations. Enter the date(s) of the hearing(s) held under that section, if any; also enter the date(s) of any hearing(s) the agency was required to hold under the provisions of any other law.

5. As applicable, enter the effective date of the regulation here, or indicate that it is effective upon filing with the Secretary of the State. Please note the information below.

   Regulations are effective upon filing with the Secretary of the State or at a later specified date. See CGS Section 4-172(b) which provides that each regulation is effective upon filing, or, if a later date is required by statute or specified in the regulation, the later date is the effective date. An effective date may not precede the effective date of the public act requiring or permitting the regulation. Emergency regulations are effective immediately upon filing with the Secretary of the State, or at a stated date less than twenty days thereafter.