DATE: November 9, 2017

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Adopted Rule: Chapters II & III, Section 45, Hospital Services

This letter gives notice of an adopted rule: MaineCare Benefits Manual, Chapters II & III, Section 45, Hospital Services.

The Department is adopting changes in these rules, as set forth below. The Department is seeking and anticipates receiving approval from CMS for the rule changes. Pending CMS approval, the rule changes are effective November 14, 2017. The changes include the following:

Chapter II:

a) An amendment to Section 45.05-4, Restricted Services, clarifying that dental services which are medically necessary and done in a hospital setting are allowed.

b) A clarification in Section 45.05-6, Restricted Physician Services Associated with Hospital Services, stating that all hospital-based providers are subject to the limitations in Chapter II, Section 90, Physician Services.

c) An update to language in Section 45.13, Reporting Requirements for Acute Care Critical Access Hospitals and Private Psychiatric Hospitals, to reflect current reporting requirements; to provide additional guidance for updating 340B status changes when applicable; and include the requirement to have mechanisms in place to prevent duplicate discounts on drugs.

d) The addition in Section 45.04-4, Supplies, Appliances and Equipment, of separate reimbursement for Long Acting Reversible Contraceptives (LARC) when the device is inserted during the postpartum inpatient hospital stay. The LARC will be covered in addition to the hospital Diagnosis-Related Group (DRG) payment to provide adequate reimbursement to providers for the device.

e) An update to Section 45.04-8, Diabetes Self-Management Training Services, amending the language to accurately reflect the program’s current title and model.

f) Correction and/or deletion of outdated references and minor language editing for clarification purposes.

Chapter III:

a) Updates throughout the rule of the term “radiology” to “imaging” to reflect prevalent terminology usage.

b) Expansion of the definition of “Discharge” (Sec. 45.01-6) to include inpatient maintenance chemotherapy as an exception to the fourteen-day (14) readmission protocol due to the required planning for standards of care.

c) The addition to Section 45.02-5, Reporting and Payment Requirements, of requirements for providers to submit mapping documents as part of the required documentation when filing the AsFiled Medicare Cost Report with the Department to aid the Department in payment methodology calculations.
d) Amend 45.02-5(E), Payment Requirements in the Event of an Overpayment to the Hospital, to require payment of 100% (instead of 50%) of the hospital-discovered overpayment as determined by the As-filed Medicare Cost Report. This change is required by federal law. (42 U.S.C. §1320a-7k)

e) The addition of the Payment Window Rule (Sections 45.03-1(D)(1)(b) and 45.06-1(B)(2)) instructing hospitals, or entities wholly-owned or wholly-operated by a hospital, to bill the technical component of outpatient services provided within a 3-day (or 1-day) window preceding inpatient admission on the inpatient claim. The 1-day payment window applies to distinct rehabilitation, psychiatric, and substance abuse units. This provision is consistent with 42 C.F.R. §412.2(c)(5) and 42 C.F.R. §413.40(c)(2), and is currently in place by Medicare to treat certain technical components as operating costs of the inpatient hospital services.

f) Added a new provision, Section 45.03-1(D)(3), Hospital Outpatient Provider-Based Departments (PBDs). This provision adopts the Medicare Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) rule, which essentially requires that, with the exception of dedicated emergency department services, services furnished in off-campus provider-based hospital outpatient departments that began billing under the OPPS on or after November 2, 2015, no longer be paid under the OPPS. With the exception of these “excepted locations,” services provided in PBDs must use modifiers to identify non-excepted items and services. These non-excepted services are paid at a reduced MaineCare rate.

g) In Section 45.07, an increase in the amount of the supplemental pool is being made to comply with P.L. 2017, ch. 284, Sec. 2447.272. The Department is also adopting a restructuring of the supplemental pool methodology. The new methodology creates two supplemental pools; an inpatient supplemental pool and an outpatient supplemental pool. This change is to ensure that the annual supplemental payments can be issued to providers without exceeding the allowable upper payment limits as described in 42 C.F.R. §447.272 (upper payment limits for inpatient services) and §447.321 (upper payment limits for outpatient services). The new methodology is based on a calculation of a hospital’s relative share of inpatient or outpatient MaineCare payments (rather than a hospital’s relative share of inpatient MaineCare discharges) since the new methodology is utilizing both an inpatient and an outpatient supplemental pool. The data used to calculate the relative share of a hospital’s MaineCare payment is data from the state fiscal year 2014, which provides a consistent and more accurate basis with minimal risk of additional claim activity.

h) Updating the prospective interim payment (Section 45.04-2) methodology used to identify the estimated departmental annual obligation relating to both inpatient and outpatient services. This change provides for more accuracy in estimating prospective interim payments.

i) Addition of language in the Out-of-State Hospitals’ reimbursement, Section 45.10, clarifying that reimbursement for laboratory and imaging outpatient service shall not exceed the 100% of Medicare reimbursement rate for the Maine area ’99 locality, and that the hospitals are required to report and are subject to all applicable pricing modifiers. This change is to ensure payments do not exceed Medicare amounts.

j) Clarification of language in the Clinical Laboratory and Imaging Services, Section 45.11, to more succinctly explain how services are covered and reimbursed in accordance with applicable sections of the MaineCare Benefits Manual.

k) Revision of language in Section 45.13-2 to reflect that the Final, rather than Interim, Cost Report will be used by the Department when calculating a Disproportionate Share Hospital (DSH) settlement to more accurately reflect inpatient utilization rates. This is also consistent with the regulation which provides that hospitals within the category are assessed for DSH eligibility “after final settlement is complete for all hospitals in a category.”

l) Addition of ICD-10 code H65.01, Acute serous otitis media, right ear, to Appendix B, which had been inadvertently left out during the last amendment to this rule.

m) Minor corrections and editing of language and formatting for clarification and organizational purposes.

Rules and related rulemaking documents may be reviewed at, or printed from, the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or call Maine Relay at 711.
Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Chapter II & III, Section 45, Hospital Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department is adopting changes in these rules, as set forth below. The Department is seeking and anticipates receiving approval from CMS for the rule changes. Pending CMS approval, the rule changes are effective November 14, 2017. The changes include the following:

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d) Amend 45.02-5(E), Payment Requirements in the Event of an Overpayment to the Hospital, to require payment of 100% (instead of 50%) of the hospital-discovered overpayment as determined by the As-filed Medicare Cost Report. This change is required by federal law. (42 U.S.C. §1320a-7k)

e) The addition of the Payment Window Rule (Sections 45.03-1(D)(1)(b) and 45.06-1(B)(2)) instructing hospitals, or entities wholly-owned or wholly-operated by a hospital, to bill the technical component of outpatient services provided within a 3-day (or 1-day) window preceding inpatient admission on the inpatient claim. The 1-day payment window applies to distinct rehabilitation, psychiatric, and substance abuse units. This provision is consistent with 42 C.F.R. §412.2(c)(5) and 42 C.F.R. §413.40(c)(2), and is currently in place by Medicare to treat certain technical components as operating costs of the inpatient hospital services.

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m) Minor corrections and editing of language and formatting for clarification and organizational purposes.


**EFFECTIVE DATE:** November 14, 2017  
**AGENCY CONTACT PERSON:** Anne Labonte Perreault, Comprehensive Health Planner  
**AGENCY NAME:** Division of Policy  
**ADDRESS:**  
242 State Street  
11 State House Station  
Augusta, Maine 04333-0011  
[Anne.labonte-perreault@maine.gov](mailto:Anne.labonte-perreault@maine.gov)  
**TELEPHONE:** (207)-624-4082  
**FAX:** (207) 287-1864  
TTY users call Maine relay 711
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45.01 DEFINITIONS

45.01-1 340B Hospital means a hospital eligible to participate in the federal 340B Drug Pricing Program administered by the U.S. Department of Health and Human Services Health Resources and Services Administration. Currently, only hospitals that may also receive disproportionate share may participate in the 340 Drug Pricing Program. Information about 340B participation is at: http://www.hrsa.gov/opa/.

45.01-2 Authorized Agent means an organization authorized by the Department to perform functions pursuant to these rules under a valid contract or other approved, signed agreement.

45.01-3 Critical Access Hospital means a hospital licensed by the Department as a critical access hospital.

45.01-4 Day(s) Awaiting Nursing Facility (NF) Placement means any day on which a hospital provides services to an inpatient that would constitute post-hospital nursing facility services if provided by a nursing facility,

1. if that day falls after a quality assurance or utilization review process has determined that inpatient hospital services for the individual are not medically necessary;

2. if post-hospital nursing facility services are not otherwise available to the individual (as described in Section 45.07-2); and

3. that the Department or its Authorized Agent has determined is medically eligible for nursing facility services as described in Chapter II, Section 67, of this Manual.

45.01-5 Hospital means a hospital licensed by the Department of Health and Human Services in Maine, or appropriate licensing agencies in the state where the hospital is located, and qualified to participate in the Medicare Program.

45.01-6 Inpatient means a patient who has been admitted to the hospital and is receiving room, board and professional services in the hospital on a continuous twenty-four (24) hour-a-day basis.

45.01-7 Outpatient means a patient who is receiving professional services at a licensed hospital, or distinct part of such hospital, which is not providing the patient with room, board and professional services on a continuous twenty-four (24)-hour-a-day basis. An outpatient is an individual who has not been admitted to the hospital for an overnight stay.
45.01 DEFINITIONS (cont.)

45.01-8 Swing-Bed means a federally certified hospital bed that may be used interchangeably as an acute care bed or a skilled nursing facility (NF) bed as defined in Chapter II, Section 67 of this Manual.

45.01-9 Utilization Review/Management means the evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities by each participating hospital. It includes a review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices.

45.02 ELIGIBILITY FOR CARE

Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the provider’s responsibility to verify a member’s MaineCare eligibility as described in MBM, Chapter I, prior to providing services.

45.03 DURATION OF CARE

All hospital admissions and continued stays must be certified for medical necessity and length of stay through an appropriate utilization review plan.

45.04 COVERED SERVICES

45.04-1 Semi-Private Accommodations

Reimbursement will be made for eligible members for placement in semi-private accommodations (two (2) or more beds).

45.04-2 Intensive Care or Coronary Care

Accommodations in an intensive care unit or a coronary care unit are reimbursable if ordered by the patient's physician as medically necessary.

45.04-3 Drugs and Biologicals

A. Drugs and Biologicals

Drugs, vaccines, cultures, and other preparations made from living organisms and their products, used in diagnosing, immunizing, or treating members (biologicals) are covered. Drugs and biologicals furnished by a hospital for a patient's use outside of the hospital are not covered as inpatient services.
45.04 COVERED SERVICES (cont.)

B. Hospital Pharmacies Affiliated with a Nursing Facility

A hospital that is affiliated with a nursing facility through common ownership or control is allowed to dispense covered MaineCare prescription drugs through its pharmacy to members in that nursing home. The drugs must be dispensed by a registered pharmacist according to dispensing regulations.

Billing must be accomplished in accordance with MBM Section 80, Pharmacy Services, and Section 67, Nursing Facility Services.

45.04-4 Supplies, Appliances and Equipment

Supplies, appliances and equipment are covered if they are surgically implanted or are an integral part of a hospital procedure and it would be medically contraindicated to limit the patient's use of the item to his or her hospital stay (e.g.: cardiac valves, pacemakers, tracheotomy tubes, halovests, titanium rods, etc.).

A temporary or disposable item that is medically necessary to facilitate the patient's discharge from the hospital, and is required until the patient can obtain a continuing supply, is covered as an inpatient service for up to a ten (10) day supply.

*MaineCare will separately reimburse for Long Acting Reversible Contraceptives (LARC), in addition to the hospital DRG reimbursement, if the device is placed immediately postpartum in the inpatient setting. Billing for the LARC must be submitted on a separate claim using type of bill code 0121 (inpatient billed as outpatient) with the appropriate HCPC code.

Except as noted above, supplies, appliances, including prosthetic devices, and equipment furnished to an inpatient or outpatient for use outside of the hospital must have prior authorization in accordance with and meet criteria in Chapter II, Section 60, Supplies and Durable Medical Equipment, of this Manual, and reimbursement must be made to a supplier of durable medical equipment. MaineCare will not reimburse a hospital or supplier of durable medical equipment for the rental or purchase of a therapy bed (specialty air beds built into a hospital bed frame).

45.04-5 Ancillary, Diagnostic and Therapeutic Services

Ancillary, diagnostic and therapeutic services that are medically necessary are covered services subject to limitations in Section 45.05.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
45.04 COVERED SERVICES (cont.)

45.04-6 Swing-Bed and Days Awaiting Placement Services

The provision of acute care services to a member in a swing-bed must be consistent with requirements set forth in this Section of the Manual.

NF swing-bed and days awaiting placement services must meet all state and federal laws, including federal Medicaid laws and regulations and the “Nursing Facility Services” requirements set forth in Section 67 of this Manual, and members must be eligible for NF level of services as determined by an assessment conducted by the Department or its Authorized Agent. Members in swing-bed and days awaiting placement are exempt from both: i) pre-admission screening for mental illness and mental retardation; and ii) Minimum Data Set + (MDS+) resident assessment screening.

45.04-7 Asthma Self-Management Services

Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula or any other asthma management services that are approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America.

Each service must have:

A. a physician advisor;
B. a primary instructor (a licensed health professional or a health educator with a baccalaureate degree);
C. a pre and post assessment for each member that shall be kept as part of the member’s record;
D. an advisory committee that may be part of an overall patient education advisory committee; and
E. a physician referral for all participants.

*Outpatient Diabetes Self-Management Training Services

Diabetes Self-Management and Training (DSMT) services for members with diabetes (any form) can be rendered by qualified outpatient hospitals in Maine that have current National DSMT site recognition/accreditation, and have a current DSMT

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
45.04 COVERED SERVICES (cont.)

Letter of Understanding (LOU) with the DHHS, Maine CDC, Diabetes Unit. These outpatient hospitals will be reimbursed when the provider furnishes these services to a MaineCare member whose physician, primary care provider, or non-physician practitioner has prescribed these services for the management of the member’s diabetes. The services consist of:

1. Any/all diabetes education and support services outlined within the most current American Diabetes Association (ADA) - National Standards for Diabetes Self-Management Education and Support and Clinical/Medical Care Standards for people with diabetes (any form).

2. The order for education and support services is initiated with a physician referral, written or electronic, that provides the order for Diabetes Self-Management Training (DSMT) services for patients with a diabetes diagnosis.

When the MaineCare member is under age twenty-one (21), MaineCare will also reimburse for this service when provided to the people who provide the member’s daily care.

45.04-9 Hospital Based Physician Services

Effective July 1, 2006, only provider practices that qualify as “provider-based” entities under 42 C.F.R. § 413.65 are covered services.

45.05 RESTRICTED SERVICES

45.05-1 Whole Blood and Packed Red Blood Cells

Each eligible member may receive as many pints of whole blood and packed red blood cells as are medically necessary.

In the case of a MaineCare member who is also receiving Title XVIII benefits, MaineCare will pay for the first three pints of blood, not covered under Title XVIII.

Whole blood (provided the hospital cannot obtain a replacement donation) and packed red blood cells will be reimbursable only for each pint administered. Reimbursement will not be made on the basis of replacing two pints of blood for each pint received by the member regardless of whether the blood (either fully or partially) is provided from a blood bank or from a donor.

45.05-2 Newborn Infants

MaineCare reimburses for services provided to newborn infants of MaineCare mothers during the time the mother is hospitalized. MaineCare will pay for services
45.05  RESTRICTED SERVICES (cont.)

to the newborn after the mother is discharged, if these services are certified by the physician as being medically necessary and the infant is MaineCare eligible.

45.05-3  **Abortions, Sterilizations and Hysterectomies**
MaineCare will only reimburse hospitals for these services if documentation meets the requirements of Chapter II, Section 90, Physician Services.

45.05-4  **Dental Services**
Dental services provided in a hospital setting are only covered for emergency care or medically necessary to be done in a hospital setting.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.*

45.05-5  **Private Rooms for Patients with Infectious Diseases**
MaineCare will reimburse for private rooms for patients with infectious diseases when medically necessary to meet the patient's medical needs or to prevent the spread of disease.

The designee of the committee charged with infection control must document the medical necessity in the patient's medical record. The designee must formally inform the committee of his or her decisions regarding assigning private rooms to patients with infectious disease. The committee must record the designee’s actions in its minutes.

45.05-6  **Restricted Physician Services Associated with Hospital Services**
Unless prior authorization (PA) has been granted by the Department, DHHS will not reimburse hospitals for any costs associated with any restricted physician services performed in the hospital, which require PA pursuant to Chapter II, Section 90 (Physician Services) of this Manual. Additionally, all other Section 90 limitations and restrictions apply to Section 90 services provided in hospitals.

45.05-7  **Organ Transplant Procedures**
Please refer to Chapter II, Section 90, Appendix A, Physician Services, of this Manual for specific information related to MaineCare coverage of and criteria for transplant procedures.
45.05 **REstricted SERVICES** (cont.)

45.05-8 **Therapeutic Leave of Absence During Days Awaiting Nursing Facility Placement**

Effective March 25, 2013, all hospitals must inform patients who are in days awaiting NF placement, in writing, of their right to one (1) overnight leave of absence through March 31, 2013. If CMS approves, effective April 1, 2013 all hospitals must inform patients who are in days awaiting NF placement, in writing, of their right to twenty (20) therapeutic overnight leaves of absence through June 30, 2013; and twenty (20) overnight leaves of absence from July 1, 2013 through June 30, 2014 and subsequent state fiscal years.

MaineCare will reimburse a hospital to reserve a bed for a member on an overnight leave of absence if the following conditions are met:

A. The patient's plan of care provides for such an absence;

B. The member takes no more than a total of one (1) overnight leave of absence from March 25, 2013 through March 31, 2013;

C. If CMS approves, the member takes no more than a total of twenty (20) therapeutic overnight leaves of absence from April 1, 2013 through June 30, 2013;

D. If CMS approves, the member takes no more than a total of twenty (20) therapeutic overnight leaves of absence from July 1, 2013 through June 30, 2014 and subsequent state fiscal years;

E. The Department is called for prior authorization; and

F. The Department is notified if the member does not return to the facility within the prior authorized leave period.

45.05-9 **Outpatient Observation Services**

MaineCare only reimburses for observation or testing when ordered by a physician. Outpatient observation must not exceed forty-eight (48) hours.

45.05-10 **Physical, Occupational and Speech Therapy for Adults**

Physical, occupational and speech therapy for members age twenty-one (21) and over must be provided in accordance with Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; and Section 109, Speech and Hearing Services, respectively, including any limitations or requirements for rehabilitation detailed in those Sections of the MBM.
45.06 NON-COVERED SERVICES

45.06-1 Private Room

Accommodations in a private room will not be reimbursable unless they meet conditions spelled out in Section 45.05-5 above. Hospitals may not bill a MaineCare member for the difference between a private room rate and a semi-private room rate unless the member requests a private room and signs a written statement acknowledging that he or she is to be billed the difference.

45.06-2 Routine Physician Visits

Routine physician visits are not reimbursable for members awaiting placement in a NF or in swing beds.

45.06-3 Admission Not Certified By Utilization Review

MaineCare will not reimburse for a hospital admission that is not certified by a utilization review.

The only exception to this policy is when a member is admitted prior to utilization review for an acute condition that requires medically necessary treatment that is only available in a hospital and it is medically necessary for the treatment to be delivered prior to the time it feasible for the case to be reviewed. Services rendered prior to the review are not reimbursable unless the utilization review is conducted within one (1) business day of the admission. (For example, if a member is admitted on a Friday at 6:00 P.M., is first reviewed on Monday at 11:00 A.M. and denied at that time: three (3) days are reimbursable.) The member or responsible party must be notified in writing if these criteria will not be met and all or part of the admission will not be a MaineCare covered service; and must sign an acknowledgement of financial responsibility for this non-covered service.

45.06-4 Unauthorized Days Awaiting Placement or NF-level Swing Bed Services

MaineCare will not reimburse for any days awaiting placement or NF level services providing swing beds that have not been approved by the Department or its Authorized Agent.

45.07 POLICIES AND PROCEDURES

45.07-1 Discharge Planning

Medicaid patients denied continued hospitalization as a result of utilization review, or denied Medicare or other third party coverage on the basis of no longer having medical necessity for hospitalization, shall be denied Medicaid coverage unless approved for days awaiting NF placement, as described in Section 45.07-2. A copy of
45.07 POLICIES AND PROCEDURES (cont.)

the denial letter indicating the last day of third party coverage must be submitted to:
Program Integrity, SHS 11, Augusta, ME, 04333.

Each hospital shall maintain a written record of discharge planning procedures, setting forth at least the following:

A. The name of the staff member of the hospital who has operational responsibility for discharge planning.

B. The manner and methods by which such staff member will function, including his or her authority and relationship with the facility's staff.

C. The time period in which each eligible individual's need for discharge planning will be determined (which period may not be later than seven days after the day of admission).

D. The local agencies and individuals available to the facility as discharge planning resources, and a requirement that the attending physician assist a multidisciplinary team in developing discharge plans. Responsibilities for implementation shall be a team decision.

E. A provision for periodic review and re-evaluation of the facility's discharge planning program.

45.07-2 Medical Eligibility Determination for Nursing Facility (NF) Care

Prior to discharge, the hospital must notify members who will require nursing facility care services that a preadmission long-term care assessment is required for each applicant, regardless of source of payment, including private pay individuals. The Department or its Authorized Agent shall conduct the assessment using the approved eligibility assessment form. For a member transferring from a hospital to a NF under Medicare or any other private insurance coverage, the long-term care assessment may be delayed until the exhaustion of his or her insurance covered NF stay. To receive MaineCare coverage for days awaiting placement, or nursing facility level services, a member must meet the medical eligibility requirements as set forth in Chapter II, Section 67.

When it is expected that a patient will convert from Medicare, private pay or other third party coverage to MaineCare coverage, the hospital, on behalf of the member, must request, a nursing facility eligibility assessment prior to the exhaustion of the individual's current coverage. The Department or Authorized Agent must conduct this assessment when these third-party benefits are exhausted. In the cases of Medicare denials, a copy of the hospital's Medicare denial letter, indicating the last day of covered services, must be submitted to the Department or its Authorized Agent.
45.07 POLICIES AND PROCEDURES (cont.)

45.07-3 General Procedures for Medical Eligibility Determination

Eligible members who no longer require acute care and are to be transferred from a hospital to a NF, skilled NF level swing-bed, or days awaiting NF placement status must be determined medically eligible, pursuant to the criteria set forth in Chapter II, Section 67 of this Manual, by the Department or its Authorized Agent, prior to this transfer.

An individual may be admitted directly to a skilled NF level swing-bed without prior acute inpatient services, if determined medically eligible by the Department or its Authorized Agent.

1. The hospital shall request an assessment by submitting a complete referral form to the Authorized Agent. An incomplete form will be returned to the hospital and the assessment delayed until receipt of a complete form. Forms may be faxed. The Authorized Agent shall complete the medical eligibility assessment form within twenty-four (24) hours of the request for an assessment and the eligibility assessment shall not be conducted sooner than twenty-four (24) hours prior to the denial of acute level of care or discharge from a hospital.

2. If the patient is not a MaineCare member, the hospital's discharge planner or other designated person shall explore MaineCare eligibility and refer the patient, family member or guardian to the Office of Integrated Access and Support.

3. The hospital's discharge planner or other designated person must request that the Department or its Authorized Agent complete the eligibility assessment forms as specified in Chapter II, Section 67 of this Manual.

4. The Department or its Authorized Agent will inform the member and offer the choice of available, appropriate and cost-effective, home and community-based services and alternatives to NF placement. The relative costs to the member of each option must be explained.

5. If the member does not select community-based services, he/she must accept the first available, appropriate nursing facility placement within a sixty (60)-mile radius of his/her home, or MaineCare reimbursement will cease. If the member refuses to accept the placement, the hospital discharge planner must notify the Department. The Department will issue a ten (10) day notice of intent to terminate services. The member may accept a placement beyond the sixty (60) miles from home radius, however, this cannot be required of the member.
45.07 POLICIES AND PROCEDURES (cont.)

The discharge planner shall document in the medical record all efforts to obtain appropriate placement.

6. If the member is eligible for both MaineCare and Medicare and is eligible for Medicare nursing facility services, the member shall be admitted to a Medicare-certified NF bed, except in the following circumstances:

   a. The member has been a resident in a NF and desires to return to that NF and can receive appropriate care; or

   b. An appropriate Medicare-certified NF bed is not available within a sixty (60)-mile radius of the member's home.

   Once a NF bed is secured, the hospital must notify the Department or its Authorized Agent, on the approved form, of the member's placement.

7. Prior to a member's return to a NF, following a hospital stay that exceeds bed hold limitations in Chapter II, Section 67, the member must be assessed by the Department or its Authorized Agent using the medical eligibility determination form to determine whether he/she continues to meet the medical eligibility criteria set forth in Chapter II, Section 67 for NF services, and whether or not community-based services are an appropriate option.

8. When a member is found financially eligible retroactively, MaineCare will reimburse for covered services that the hospital provides only during the period for which the member has been found to be both medically and financially eligible.

45.07-4 Program Integrity

Program Integrity monitors the services provided and determines the appropriateness and necessity of services. See Chapter I for further information.

45.08 ELIGIBILITY FOR HOME CARE FOR CHILDREN ELIGIBLE THROUGH THE KATIE BECKETT BENEFIT

The following criteria must be met for children to be eligible for home care through the Katie Beckett benefit:

A. Age and Disability

   The child must be eighteen (18) years of age or younger and be determined disabled under SSI rules. The Medical Review Team (MRT) at the Office of Integrated Access and Support makes the disability determination as part of the application process.
45.08 **ELIGIBILITY FOR HOME CARE FOR CHILDREN ELIGIBLE THROUGH THE KATIE BEECKT BENEFIT** (cont.)

B. **Level of Care**

The child must require a level of care that is typically provided in a hospital, although the child does not have to be admitted, relocated nor have a history of admissions to a hospital. If the child requires a level of care that can be provided in a nursing facility, eligibility for the Katie Beckett benefit must be assessed under Chapter II, Section 67 of this Manual.

C. **Appropriateness of Community-Based Care**

The child must be able to receive or currently be receiving appropriate care outside a hospital setting that provides that level of care.

D. **Limits of Cost of Community-Based Care**

The total annual cost to MaineCare for home care must be no greater than the amount MaineCare would pay for the child’s care in an institution.

45.09 **ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA FOR PSYCHIATRIC UNIT AND DETOXIFICATION SERVICES**

Members must be determined eligible for admission and continued stay. Providers must maintain a member record for each member documenting the medical necessity for psychiatric unit services. Documentation must be available to the Department and its Authorized Agent. There must be daily documentation that the admission criteria continues to be met for the member to remain eligible for services.

45.09-1 **Psychiatric Criteria**

Members must meet all four (4) of the following criteria to be eligible for psychiatric unit services, and must continue to meet all four (4) of the following criteria in order to continue to be eligible for psychiatric services:

1. The member has a substantiated diagnosis found in the most current version of the American Psychiatric Association’s *Diagnostic and Statistical Manual* (DSM).

2. Treatment is medically necessary. Medical necessity must include one (1) or more of the following:

   a. The member exhibits an immediate or direct threat of serious harm to self or there is a clear and reasonable inference of serious harm to self, where suicidal precautions or observations on a 24-hour/day
b. The member is exhibiting an immediate or direct threat of serious harm to others or there is evidence for clear and reasonable inference of serious harm to others. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour/day basis.

c. The member is exhibiting an extreme disabling condition such that one cannot take care of self in a developmentally appropriate level or requires assistance beyond the home or residential setting. The member’s symptoms must be of such severity that they require 24-hour/day intensive medical, psychiatric, and nursing services. Outpatient treatment would be clearly unsafe or is unavailable. A lower level of care is not available or would not be adequate to successfully treat those symptoms.

3. **Age specific criteria**

   a. For members under the age of twenty-one (21) or adults with a legal guardian:

      i. The member’s family / guardian(s), where applicable and clinically indicated, are willing to actively participate throughout the duration of treatment.

      ii. The services can reasonably be expected to improve the member’s condition or prevent further regression so that inpatient services will no longer be needed.

   b. For members age sixty-five (65) or older, services are the only alternative available to maintain or restore the member to the greatest possible degree of health and independent functioning.

4. A clear indication that the inpatient psychiatric services offered provide the member with active treatment.

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45.09-2 **Detoxification Criteria**

Members must meet the following criteria to be eligible for detoxification services.
45.09 ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA FOR PSYCHIATRIC UNIT AND DETOXIFICATION SERVICES (cont.)

The member’s symptoms must meet American Society of Addiction Medicine (ASAM) Level 4 criteria as defined in the most recent edition of The ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-Occurring Conditions:

a. Member must have Substance – Use or Substance-Induced Disorder based upon DSM-5; and

b. Member must meet ASAM Level 4 Dimensions 1, 2, or 3.

45.10 REIMBURSEMENT

See Chapter III, Section 45, “Principles of Reimbursement for Hospital Services”.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing the MaineCare Program, including billing Medicare, as described under Title XVIII.

45.11 CO-PAYMENT FOR INPATIENT SERVICES, OUTPATIENT HOSPITAL CLINIC SERVICES

A. A co-payment will be charged to each MaineCare member receiving either inpatient or outpatient hospital services. Two separate co-payments will be charged if the member receives both inpatient and outpatient services. The amount of the co-payment shall not exceed three dollars ($3.00) per day for either category of hospital services provided, according to the following schedule:

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<td>$10.00 or less</td>
<td>$.50</td>
</tr>
<tr>
<td>$10.01 - 25.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>$25.01 - 50.00</td>
<td>$2.00</td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>$3.00</td>
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</tbody>
</table>

B. The member shall be liable for co-payments up to a maximum of thirty dollars ($30.00) per calendar month for each category: inpatient or outpatient service, and regardless of whether there are multiple hospital service providers within the same month. After the maximum thirty dollar ($30.00) monthly cap(s) has been charged to the member, the member shall not be liable for additional co-payments and the provider(s) shall receive full MaineCare reimbursement.

C. No provider may deny services to a member for failure to pay a co-payment. Providers must rely upon the member's representation that he or she does not have
45.11 CO-PAYMENT FOR INPATIENT SERVICES, OUTPATIENT HOSPITAL CLINIC SERVICES (cont.)

the cash available to pay the co-payment. A member's inability to pay a co-payment does not, however, relieve him/her of liability for a co-payment.

D. Providers are responsible for documenting the amount of co-payments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous co-payments.

Co-payment exemptions and dispute resolution procedures are contained in Chapter I.

45.12 BILLING INSTRUCTIONS

A. Only providers that qualify as “provider based” entities under 42 CFR 413.65 may bill under this Section of the MaineCare Benefits Manual.

B. Copies of MaineCare billing instructions may be downloaded at http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html

45.13 *REPORTING REQUIREMENTS

Acute Care Critical Access Hospitals and Private Psychiatric Hospitals must submit National Drug Codes (NDC) for all outpatient claims for all single source drugs (as defined in 42 CFR 447.502) and all multiple source drugs (as defined in 42 CFR 447.502).

Drugs purchased through Section 340B of the Public Health Service Act (referred to as 340 B hospitals) are exempt from this requirement.

Hospitals are responsible for updating their enrollment applications, and submitting an updated Memorandum of Understanding document to reflect 340B status when it changes. Hospitals participating in 340B shall comply with 42 USC § 256b(a)(5)(A)(i), which prohibits duplicate discounts or rebates (manufacturers are protected from giving a 340B discount and a Medicaid rebate on the same drug). In accordance with 42 USC § 256b(a)(5)(A)(ii), hospitals participating in 340B shall comply with a CMS-established mechanism, or establish their own mechanism, to ensure that they are in compliance with the duplicate discount prohibition. For more information on duplicate discounts refer to the following website https://www.hrsa.gov/opa/programrequirements/medicaidexclusion/index.html.

MaineCare will not pay for drugs that do not have a CMS rebate agreement unless they are medically necessary and a PA has been approved.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
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*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
**SECTION 45**

**HOSPITAL SERVICES**

**ESTABLISHED 1/1/85**

**LAST UPDATED 11/14/2017**

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INTRODUCTION

MaineCare recognizes seven different types of hospitals for the purpose of reimbursement, all of which are detailed below. MaineCare uses a different payment methodology for each type of facility. MaineCare reimburses hospitals in the following ways:

1) **Private Acute Care Non-Critical Access Hospitals** will be reimbursed using a Diagnosis Related Group (DRG) based methodology for inpatient services effective July 1, 2012, using Ambulatory Patient Classification system payments for outpatient services;

2) **Public Acute Care Non-Critical Access Hospitals** will be reimbursed using a Diagnosis Related Group (DRG) based methodology for inpatient services and at a percentage of cost basis for outpatient services;

3) **Acute Care Critical Access Hospitals** will be reimbursed at a percentage of cost basis for inpatient and outpatient services;

4) **State Owned Psychiatric Hospitals** will be reimbursed on a cost basis for inpatient and outpatient services;

5) **Private Psychiatric Hospitals** will be reimbursed at a percentage of charge basis for inpatient services and at a percentage of cost basis for outpatient services; and

6) **Hospitals Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board** will be reimbursed at a percentage of cost basis for inpatient and outpatient services.

7) **Rehabilitation Hospitals** will be reimbursed using a discharge rate effective July 1, 2012, Ambulatory Patient Classification system payments for outpatient services.

45.01 DEFINITIONS

45.01-1 **Acute Care Critical Access Hospital** is a hospital licensed by the Department of Health and Human Services (DHHS or “the Department”) as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.

45.01-2 **Acute Care Non-Critical Access Hospital** is a hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.

45.01-3 **Ambulatory Payment Classifications (APC)** means the classification of hospital-based outpatient services for use in determining facility reimbursement as defined in the Medicare APC system.
45.01 DEFINITIONS (cont.)

45.01-4 **As-Filed Medicare Cost Report** means the cost report that the hospital files with the Medicare fiscal intermediary and with MaineCare, utilizing the CMS Medicare Cost Report form. In order for an As-Filed Medicare Cost Report to be accepted by MaineCare, hospitals must complete all information in the sections relevant to Title XIX, whether or not required by CMS.

45.01-5 **Diagnosis-Related Group** (DRG) means the classification of medical diagnoses for use in determining reimbursement as defined in the Medicare DRG system or as otherwise specified by the Department.

45.01-6 **Discharge** is when a member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section for all hospitals except critical access hospitals, a member is not considered discharged if he or she is transferred to any different location or different unit, such as a rehab unit, in the same hospital, or effective July 7, 2015, is readmitted to the same hospital on the same day or is readmitted to the same hospital within fourteen (14) days of an inpatient discharge for a diagnosis within the same DRG, regardless of complications or co-morbidity.

*There are exceptions to the fourteen (14) day readmission protocol. The exceptions are as follows:

a) Readmissions for individuals who are diagnosed with a mental health diagnosis described in the most current version of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM);

b) Readmissions for individual whose symptoms meet the American Society of Addiction Medicine (ASAM) Level 4 Criteria, as defined in the most recent edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-Occurring Conditions; and

c) Readmissions for individual receiving inpatient maintenance chemotherapy treatment.

Effective July 1, 2011, for hospitals billing under DRG based methodology, transferring a member to a distinct rehabilitation unit within the same hospital for the same diagnosis will be considered a discharge.

45.01-7 **Distinct Rehabilitation Unit** is a unit within an acute care non-critical access hospital that specializes in the delivery of inpatient rehabilitation services. The unit must be reimbursed as a distinct rehabilitation unit as a sub provider on the Medicare cost report.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.*
45.01-8 **Distinct Psychiatric Unit** is a unit within an acute care non-critical access hospital that specializes in the delivery of inpatient psychiatric services. The unit must be reimbursed as a distinct psychiatric unit as a sub provider on the Medicare cost report or must be comprised of beds reserved for use for involuntary commitments under the terms of a contract with the Department of Health and Human Services. The claim must also be distinguishable as representing a discharge from a distinct psychiatric unit in the MaineCare claims processing system.

45.01-9 **Distinct Substance Abuse Unit** is a unit that combines the medical management of withdrawal with a structured inpatient rehabilitation program. Services include coordinated group education and psychotherapy, and individual psychotherapy and family counseling as needed. Licensed Alcohol and Drug Abuse Counselors (LADCs) assist medical staff in developing an interdisciplinary plan of care.

Evidence-based best practices such as motivational interviewing are used by staff who are trained in substance abuse treatment. The claim must also be distinguishable as representing a discharge from a distinct substance abuse unit in the MaineCare claims processing system. This label is not a Medicare designation.

45.01-10 **Final Cost Settlement Report** is the report issued by the DHHS Office of Audit that contains the final settlement calculation and settlement amount due to or due from the hospital. This Report utilizes the hospital cost data from the Medicare Final Cost Report.

45.01-11 **Hospital Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board (MGCRB)** is a hospital that has been reclassified by the MGCRB. The MGCRB decides on requests of hospitals that are reimbursed under the Prospective Payment System (PPS) for the purposes of Medicare for reclassification to another area (urban or in some cases rural) for the purposes of receiving a higher wage index. (See section 1886 of the Social Security Act, 42 U.S.C. § 1395ww). Further information can be found at http://www.cms.hhs.gov/MGCRB/.

45.01-12 **Institution for Mental Disease** (IMD) means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. This includes medical attention, nursing care, and related services.

45.01-13 **Interim Cost Settlement Report** is the report issued by the DHHS Office of Audit that contains the settlement calculation and amount due to or due from the hospital. This report utilizes the hospital cost data from the As-Filed Medicare Cost Report.
45.01 Definitions (cont.)

45.01-14 **Low Income Utilization Rate** for a hospital means the sum of:

1) the fraction (expressed as a percentage)
   a) the numerator of which is the sum (for a period) of (i) the total revenues paid the hospital for patient services under a State plan, and (ii) the amount of the cash subsidies for patient services received directly from State and local governments, and
   b) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

2) the fraction (expressed as a percentage)
   a) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause a) (ii) of subparagraph 1) above in the period reasonably attributable to inpatient hospital services, this numerator shall not include contractual allowances and discounts (other than for indigent patients not eligible for MaineCare), and
   b) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

45.01-15 **MaineCare Supplemental Data Form**, also known as the As-Filed MaineCare Report, is a form submitted by hospitals on a template provided by the department which contains information supplemental to the Medicare Cost Report necessary for computing the Prospective Interim Payment, including, but not limited to, data pertaining to hospital-based physicians, lab and radiology claims and third party payments.

45.01-16 **MaineCare Paid Claims History** is a summary of all claims billed by the hospital to MaineCare for MaineCare eligible members that have been processed and accepted for payment by MaineCare.

45.01-17 **MaineCare Utilization Rate** (MUR) means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital’s number of inpatient days attributable to patients who (for such days) were eligible for MaineCare and the denominator of which is the total number of the hospital’s inpatient days in that period.
45.01 DEFINITIONS (cont.)

In this paragraph, the term “inpatient days” includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The period used to determine the MUR is the Payment Year, as defined below.

45.01-18 Medicare Final Cost Report means the Report issued by the Medicare fiscal intermediary and issued to the hospital and to MaineCare.

45.01-19 Payment Year, for purposes of Disproportionate Share (DSH) eligibility calculations, means a year commencing on or after October 1st. However, if a hospital has a fiscal year that commences between September 20 and September 30, then its fiscal year shall be deemed to be a fiscal year commencing October 1st of the same calendar year. For example, if a hospital’s fiscal year ends September 25, its fiscal year shall be deemed to be a fiscal year commencing October 1 of that calendar year.

45.01-20 Private Psychiatric Hospital is a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment, and care of persons with mental illness and is privately owned. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.

45.01-21 Prospective Interim Payment (PIP) is the prospective periodic payment made to hospitals. State owned hospitals receive quarterly prospective interim payments. All other hospitals that receive PIP payments will receive them on a weekly basis. These payments may represent only a portion of the amount due the hospital; other lump sum payments made to hospitals throughout the year are not Prospective Interim Payment unless designated.

45.01-22 Provider’s Fiscal Year is the twelve (12) month period used by a hospital as an accounting period.

45.01-23 Rehabilitation Hospital is a hospital that provides an intensive rehabilitation program and is recognized as an Inpatient Rehabilitation Facility by Medicare.

45.01-24 State Fiscal Year is the twelve (12) month period used by the State of Maine as an accounting period which begins July 1 and ends June 30 (e.g., SFY 2001 begins July 1, 2000, and ends June 30, 2001).

45.01-25 State Owned Psychiatric Hospital is a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment, and care of persons with mental illness and is owned and operated by the State of Maine. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.
45.01 **DEFINITIONS** (cont.)

45.01-26 **Transfer** means a member is moved from one hospital to the care of another hospital. MaineCare will not reimburse for more than two discharges for each episode of care for a member transferring between multiple hospitals.

45.02 **GENERAL PROVISIONS**

45.02-1 **Inflation**

For purposes of determining inflation, unless otherwise specified, the economic trend factor from the most recent edition of the “Health Care Cost Review” from Global Insight is used.

45.02-2 **Third Party Liability (TPL)**

When a member is admitted to a hospital, it is the hospital’s responsibility to identify all coverage available and perform all procedural requirements of identified coverage to assure proper reimbursement. The Department will remove claims data from the MaineCare paid claims history when the TPL reimbursement for that claim is equal to or exceeds MaineCare reimbursement. Please see Chapter I Section 1.07 of the MaineCare Benefits Manual for detailed definitions applicable to Third Party Liability. Providers must adhere to the procedures outlined in that Section. Any MaineCare claims data submitted by a hospital may only be withdrawn within one hundred twenty (120) days of the date of the remittance statement.

45.02-3 **Interim and Final Cost Settlements**

At interim and final settlements, the hospital will reimburse the Department for any overpayments within thirty (30) days of receipt of the settlement report, or the Department will reimburse the amount of any underpayment to the hospital. Each Interim and Final Cost Settlement Report must be treated separately for purposes of remitting checks for overpayment and underpayment. If no payment is received within thirty (30) days, the Department may offset prospective interim payments, if permitted by federal and state law. Any caps imposed on Prospective Interim Payments (PIPs) are not applicable to the determination of settlement amounts.

The final settlement will not be performed until the Department receives the Medicare Final Cost Report. If the Medicare Final Cost Report has been received by the Department prior to the issuance of the Interim Cost Settlement Report, the Department will issue only a Final Cost Settlement Report.

Pursuant to PL 2007, P & S Law, Chapter 19, when carrying out final and interim settlements of payments, the Department shall pay all final settlements for hospital fiscal years 2003 and earlier prior to paying interim settlements for services for hospital fiscal years 2005 and later. This does not limit the Department’s authority to:
45.02 GENERAL PROVISIONS (cont.)

1. Make ongoing MaineCare payments for services being rendered during the current fiscal year; or

2. Provide partial settlements for hospital fiscal years 2004 and later to certain hospitals in need of such relief in order to relieve financial hardship. Financial hardship is determined by the Department and includes consideration of such factors as a high settlement amount due as a percent of total patient revenue, significant negative operating margins and/or negative cash flow as reflected on audited financial statements.

The provider must submit a written request for a hardship waiver to the DHHS Commissioner 60 days from the due date for the hospital’s MaineCare cost report. All supporting documentation must be submitted with the request.

The Department will not make a determination of financial hardship until resources are available to issue interim or final hospital audit settlements. The Department may request additional information to support the provider’s claim of financial hardship before making a determination.

45.02-4 Crossover Payments

MaineCare does not reimburse for Medicare crossover payments, except to the extent required by CMS (See 42 U.S.C. 1396a(a)(10)(E)(i) and 42 U.S.C. 1396d(p)(3)).

45.02-5 Reporting and Payment Requirements

All Maine hospitals are required to submit an As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and additional documents as described below, within five (5) months of the end of the provider’s fiscal year, as defined above, to the State of Maine Department of Health and Human Services, Office of Audit, 11 State House Station, Augusta, ME, 04333. Non-Maine (out-of-state) hospitals are not required to submit any cost reports.

A. As-Filed Medicare Cost Report and MaineCare Supplemental Data Forms

Maine hospitals are required to utilize the Medicare Cost Report forms including both Title XVIII and Title XIX work sheets for their As-Filed Medicare Cost Reports. Title XIX worksheets must include all MaineCare charge data available at the time of filing. The MaineCare Supplemental Data Form must also be provided on a template provided by the Department. All sections relevant to Title XIX must be completed, whether or not required by CMS.
45.02  GENERAL PROVISIONS (cont.)

B.  Required Certifications and Signatures

All documents must bear original signatures. The administrator of the hospital must certify the As-Filed Medicare Cost Report by signing it. If someone other than facility staff prepares the return, the preparer must also sign the report.

The hospital shall also submit a copy of the MaineCare Supplemental Data Form electronically.

C.  As-Filed Medicare Cost Report and MaineCare Supplemental Data Form Time Period

The As-Filed Medicare Cost Report and the MaineCare Supplemental Data Form shall cover the twelve (12) month period of each provider's fiscal year unless:

1.  a change in licensing category has become effective during a provider’s fiscal year, (e.g., a hospital becomes designated as a critical access hospital) in which case the hospital must file two (2) versions of As-Filed Medicare Cost Report and the MaineCare Supplemental Data Form, one (1) for the part of the fiscal year under one licensing category and another for the part of the fiscal year under the second licensing category; or

2.  advance authorization to submit an As-Filed Medicare Cost Report and a MaineCare Supplemental Data Form for a lesser period has been granted in writing by the Director of the Office of Audit.

D.  Documentation Required to Be Filed With the As-Filed Medicare Cost Report

The Department requires that the following supporting documentation be submitted with the As-Filed Medicare Cost Report:

Note:  [Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.]

(1)  Audited financial statements;
(2)  Worksheet reconciling financial statement revenue to the Worksheet C charges on the As-Filed Medicare Cost Report;
(3)  MaineCare Supplemental Data Form;
(4)  UB Mapping – mapping revenue codes to appropriate cost center; and
(5)  1500 Mapping – mapping of 1500 claims to clinic/cost centers by service area, specialty, or physician.

Effective 11/14/2017
**GENERAL PROVISIONS (cont.)**

**E. Payment Requirements in the Event of an Overpayment to the Hospital**

If a hospital determines from the As-Filed Medicare Cost Report that the hospital owes monies to the Department of Health and Human Services, a check equal to one hundred percent (100%) of the amount owed to the Department must accompany the As-Filed Medicare Cost Report.

If the Department does not receive a check with the As-Filed Medicare Cost Report, the Department may elect to suspend prospective payments, pursuant to State regulations and statutes.

**F. Consequences of Failing to File Complete and Adequate As-Filed Medicare Cost Report and MaineCare Supplemental Data Form**

The Department has determined that failing to file an adequate, complete As-Filed Medicare Cost Report and MaineCare Supplemental Data Form, as determined by the Department, in a timely manner as required above is grounds for the Department to impose sanctions pursuant to the MaineCare Benefits Manual Chapter I, Section I.

The Office of Audit may reject any reports that do not comply with these regulations. In such cases, the Department shall deem the report incomplete until re-filed and in compliance.

**G. Extensions**

Hospitals must file all requests for extension of time to file an As-Filed Medicare Cost Report and/or MaineCare Supplemental Data Form in writing, and the Office of Audit must receive the request no less than fifteen (15) days prior to the due date. The hospital must clearly explain the reason for the request and specify the date by which the Office of Audit will receive the report.

The Office of Audit will not grant automatic extensions. The Director of the Office of Audit has the sole discretion to determine whether the request is for good cause based on the merits of each request. A "good cause" is one that supplies a substantial basis for the delay or an intervening action beyond the provider’s control. Ignorance of the rule, inconvenience, or a Cost Report preparer engaged in other work will not be considered “good cause.”

**Data for PIP Calculation**

To calculate the PIP for a given state fiscal year the Department will use the most recent data.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.*
45.02  **GENERAL PROVISIONS** (cont.)

AsFiled Medicare Cost Report, and the MaineCare Supplemental data form filed by the hospital, to the extent these reports contain complete information, including but not limited to, the Title XIX section of the Medicare Cost Report and the MaineCare paid claims history to the extent that it is available. If they are not complete, the Department will use the most recent Cost Settlement Report. The Department will also review any additional data submitted by the deadline regarding significant differences in costs that occurred after the year of the cost report. The Department’s estimates of PIP will also reflect operational and/or policy revisions expected to result in substantive changes to services provided by hospitals.

The deadline for receipt of data related to the calculation of prospective interim payments, including estimated discharges, will be May 31 of the calendar year in which the state calculates the PIP.

45.02-7  **Cap on PIP Payments**

If CMS approves, the Department caps PIP payments so that the total payment to all hospitals receiving a PIP is not less than 70% of the calculated amount of the total PIP for the state fiscal year.

45.03  **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS**

45.03-1  **Department’s Total Obligation to the Hospital**

The Department of Health and Human Services’ total annual obligation to a hospital will be the sum of MaineCare’s obligation for the following: inpatient services + outpatient services + inpatient capital costs + hospital based physician costs + graduate medical education costs + Disproportionate Share Payments (for eligible hospitals) + supplemental pool reimbursements – third party liability payments.

A.  **Inpatient Services** (not including distinct psychiatric or, if CMS approves, substance abuse unit discharges)

Effective for reimbursement for admissions on or after July 1, 2011, the Department will pay using DRG-based discharge rates, which include estimated capital and medical education costs (see Appendix for full description). The Department will reimburse hospitals based on required billing forms, as described in the Department’s billing instructions. As explained in Appendix, the payment is comprised of three components: the capital expense and graduate medical education components will be subject to interim and final cost settlement, and the DRG direct rate component will not be cost settled.
45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

B. Distinct Psychiatric Unit

Effective October 1, 2011, MaineCare will pay a distinct psychiatric unit discharge rate equal to $6,438.72, except for: (1) Northern Maine Medical Center, for which the distinct psychiatric discharge unit rate will be $15,679.94, and (2) effective July 1, 2013, $9,128.31 per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area. MaineCare will only reimburse at the distinct unit psychiatric rate when the member has spent the majority of his or her stay in the distinct unit.

MaineCare will only reimburse for one (1) discharge for a single hospital for one (1) episode of care.

Distinct psychiatric unit discharge rates will not be adjusted annually for inflation.

C. Distinct Substance Abuse Unit

Effective April 1, 2013, MaineCare will pay a distinct substance abuse unit discharge rate equal to $4,898. MaineCare will only reimburse at the distinct unit substance abuse rate when the member has spent the majority of his or her stay in the distinct unit. For each patient’s separate hospital admission, even if the patient was admitted to the distinct substance abuse unit and any other unit in the hospital, MaineCare will only reimburse for one (1) discharge.

D. Outpatient Services, Including Laboratory and Imaging

1. Private Hospitals

   a. APC Payment

Effective July 1, 2013, the Department will reimburse hospitals 83.7% of the adjusted Medicare APC rates, where the APC is applicable, unless otherwise specified in this rule.

The APC payment does not include hospital-based physician services. The APC payment may include ancillary services such as imaging and laboratory test costs.

APC payments are made when the member receives services in an emergency room, clinic, or other outpatient setting, or if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital where the patient received the outpatient services.
If the outpatient is admitted from a hospital’s clinic or emergency department, to the same hospital as an inpatient, the hospital shall be paid only a DRG-based discharge rate and will not receive an APC payment.

An outlier payment adjustment is made to the rate when an unusually high level of resources has been used for a case. Effective July 1, 2013, calculations for outlier payments will follow Medicare rules and be paid at 83.7% of the Medicare payment.

b. *Payment Window Rule*

This rule institutes billing and payment procedures for outpatient services provided on either the date of a member’s inpatient hospital admission or during the three calendar days immediately preceding the date of a member’s inpatient hospital admission. Hospitals (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a member’s inpatient stay, the diagnoses, procedures and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the member during the 3 days immediately preceding the date of inpatient hospital admission. Distinct rehabilitation, psychiatric, and substance abuse units of a hospital are subject to only a 1-day payment window (the 1 calendar day immediately preceding the date of inpatient hospital admission.)

An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity’s routine operations, regardless of whether the hospital also has policymaking authority over the entity.

The technical component of all outpatient diagnostic and clinically related non-diagnostic services that are provided by the hospital, or by an entity wholly owned or wholly operated by the hospital, are to be billed with the claim for inpatient services when the outpatient services are provided in the three (3) calendar days (or 1 calendar day if applicable) preceding an inpatient admission.

All non-clinically related, non-diagnostic services provided before admission are not to be included on the inpatient claim. These outpatient services should be identified with the appropriate condition code. All non-diagnostic services, clinically related or not, provided on the date of

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
inpatient admission are always deemed to be related to the admission and are to be included on the inpatient claim.

MaineCare will reimburse the technical portion of the outpatient services on the inpatient claim.

For physician services provided during the payment window and billed on the CMS 1500, the entity must append the appropriate modifier to all claim lines identified as connected to the inpatient stay. MaineCare will reimburse the professional component with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split.

It is the responsibility of the admitting hospital to notify wholly-owned or wholly-operated entities of an inpatient admission which may impact the entities eligibility for payment.

The payment window rule does not apply to outpatient services included in the rural health clinic or federally qualified health center all-inclusive rate, nor does it apply to ambulance and maintenance renal dialysis services.

c. Fee Schedule Payments

A limited number of Current Procedural Terminology (CPT) codes do not have associated Medicare APC rates, as listed in Addendum B (see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html). MaineCare covers certain services listed in Addendum B and pays for these services based on a fee schedule (see: https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx).

d. Payment for Non-emergency use of the Emergency Department

Effective October 1, 2015, hospital payment for an emergency department visit (CPT codes 99281-99285 billed with revenue codes 0450-0459), with a primary diagnosis code included in Appendix B will be paid the outpatient physician’s professional evaluation and management service fee schedule rate. This will be determined by using the current physician’s payment rate listed in the MaineCare Fee Schedule associated with the emergency department CPT code reported on the UB04 claim. The MaineCare Fee schedule can be found at: https://mainecare.maine.gov.
45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

2. Public Hospitals

a. APC Payment

Effective July 1, 2009, the Department’s total annual obligation to a hospital for outpatient services equals the lower of 83.8% of MaineCare outpatient costs or charges.

MaineCare’s share of clinical laboratory and imaging costs are added to this amount. The procedure codes and terminology of the Healthcare Common Procedure Coding System (HCPCS) (available at www.cms.hhs.gov) are used to establish MaineCare allowances for clinical laboratory and imaging services.

Hospitals must use APC billing for all outpatient services. The APC billing does not include hospital-based physician services. The APC billing may include ancillary services such as imaging and laboratory test costs.

APC billing is required when the member receives services in an emergency room, clinic, or other outpatient setting, or if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital where the patient received the outpatient services.

If the outpatient is admitted from a hospital’s clinic or emergency department, to the same hospital as an inpatient, the hospital shall not report this under APC billing requirements.

b. Payment for Non-emergency use of the Emergency Department

Effective October 1, 2015, hospital payment for an emergency department visit (CPT codes 99281-99285 billed with revenue codes 0450-0459), with a primary diagnosis code included in Appendix B will be the outpatient physician’s professional evaluation and management service fee schedule rate. This will be determined by using the current physician’s payment rate listed in the MaineCare Fee Schedule associated with the emergency department CPT code reported on the UB04 claim. The MaineCare Fee schedule can be found at: https://mainecare.maine.gov.

3. *Hospital Outpatient Provided-Based Departments (PBDs)

Effective November 14, 2017, items and/or services that are furnished by an off-campus hospital outpatient provider based department (PBDs) will be

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

reimbursed as follows: MaineCare requires hospitals to use a modifier to identify non-exceptioned items and services provided by PBDs. These services are paid at a reduced MaineCare rate, proportionate to the reimbursement described in the annual CMS OPPS/ASC final rule. PBDs are required to bill non-exceptioned items and services on an institution claim (UB04) and report the modifier on each claim line for non-exceptioned items and services. Physicians will be paid the professional claim and will be paid at the facility rate consistent with current policies for physicians practicing in an institutional setting for the technical component of all non-exceptioned items and services.

The non-exceptioned items and services modifier requirement does not apply to items and services furnished by:

- A dedicated emergency department;
- Remote locations of a hospital (where inpatient services are furnished) and locations that are within 250 yards of a remote location of a hospital; and
- A location that was billing as an outpatient department of a hospital prior to November 2, 2015 (known as “exceptioned” locations).

Relocation of an off-campus PBD from the hospital’s recorded address of November 1, 2015, will be considered “new” and ineligible for continued exceptioned status. Any expansion of an exceptioned PBD (to include new or additional services) will be considered “new” and ineligible for exceptioned status for those new or additional services.

E. Capital and Graduate Medical Education Costs

MaineCare will reimburse its share of inpatient capital costs and all graduate medical education costs.

Estimates of these costs will be included in the DRG-based discharge rate as described in the Appendix. This reimbursement is subject to cost settlement.

F. Hospital based Physician

MaineCare will reimburse

- 93.3% of its share of inpatient hospital based physician,
45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

- 93.4% of its share of outpatient emergency room hospital based physician costs, and
- 83.8% of non-emergency room outpatient hospital based physician costs.

Hospitals will be reimbursed based on claim forms filed with the Department. The billing procedure is described in Chapter II, Section 45. These payments are subject to cost settlement.

45.03-2 Prospective Interim Payment (PIP) for Outpatient Services (Public Hospitals Only)

The estimated Departmental outpatient annual obligation will be calculated to determine the PIP payment using data as described in 45.02-6. This sum will be reduced by the anticipated amount of reimbursement for Medicare approved provider based primary care physician services required to be billed on the CMS 1500 under Chapter II, Section 45 and those outpatient services the hospital has elected to bill on the CMS 1500. The PIP payment does not include DSH payments or the hospital’s share of the supplemental pool as described below.

45.03-3 Interim Cost Settlement

All calculations are based on the hospital’s As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which interim settlement is being performed. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. Interim Settlement for years up to and including SFY ‘11

To the extent applicable, MaineCare’s interim cost settlement with a hospital will include settlement of:

- Prospective interim payments; and
- Payments made for hospital based physician services provided on or after the date MIHMS went live.

2. DRG Based System/Outpatient Prospective Payment – SFY 2012 Only for Private Hospitals, SFY 2012 and Forward for Public Hospitals

MaineCare’s interim cost settlement with a hospital operating under the DRG-based system will include settlement of:

- The DRG-based discharge rate as further described in the Appendix;
- Payments made for hospital based physician services; and
- Outpatient prospective interim payments.
3. **DRG and APC Based System – SFY 2013 and Forward for Private Hospitals**

MaineCare’s interim cost settlement with a hospital operating under the DRG and APC based system will include settlement of:

- The DRG-based discharge rate as further described in the Appendix; and
- Payments made for hospital based physician services.

APC payments will not be cost settled.

45.03-4 **Final Cost Settlement**

All settlement processes use charges included in MaineCare paid claims history for the relevant year, MaineCare supplemental data form and the hospital’s Medicare Final Cost Report. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. **Final Settlement for years up to and including SFY ‘11**

MaineCare’s final cost settlement with a hospital will include settlement of:

- Prospective interim payments, and
- Payments made for hospital based physician services provided on or after the date MIHMS went live.

2. **DRG Based System/Outpatient Prospective Payment – SFY 2012 Only for Private Hospitals, SFY 2012 and Subsequent for Public Hospitals**

MaineCare’s final cost settlement with a hospital operating under the DRG-based system will include settlement of:

- The DRG-based discharge rate as described in Appendix A;
- Payments made for hospital based physician services; and
- Outpatient prospective interim payments.

3. **DRG and APC Based System – SFY 2013 and Forward – Private Hospitals**

MaineCare’s final cost settlement with a hospital operating under the DRG and APC based system will include settlement of:

- The DRG-based discharge rate as further described in Appendix A; and
- Payments made for hospital based physician services

APC payments will not be cost settled.
45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS

All calculations made in relation to acute care critical access hospitals (CAH) must be made in accordance with the requirements for completion of the Medicare Cost Report and Generally Accepted Accounting Principles, except as stated below.

45.04-1 Department’s Total Obligation to the Hospital

The Department of Health and Human Services’ total annual obligation to the hospitals will be the sum of MaineCare’s obligation of the following: inpatient services + outpatient services + days awaiting placement and in swing beds + hospital based physician + Disproportionate Share Hospital (for eligible hospitals) + supplemental pool reimbursements (for eligible hospitals) – third party liability payments.

A. Inpatient Services

MaineCare will reimburse one hundred and nine percent (109%) of allowable costs.

B. Outpatient Services

MaineCare will reimburse one hundred and nine percent (109%) of allowable costs.

C. Supplemental Pool

Effective November 1, 2011, the Department will allocate the supplemental amount of four million dollars ($4,000,000) each state fiscal year among the privately owned and operated acute care critical access hospitals based on their relative share of total MaineCare payment as compared to other critical access hospitals. Each privately owned and operated hospital will receive its relative share of this supplemental payment.

The relative share is defined as the critical access hospital’s MaineCare payment in the applicable state fiscal year divided by MaineCare payments made to all CAH hospitals in that year; multiplied by the total supplemental pool. This amount will not be adjusted at the time of audit.

Data used to determine the relative share will relate to the latest state fiscal year for which there exists an As-Filed Medicare Cost Report or a Final Cost Settlement Report for all critical access hospitals at the time the pool allocation is done.

D. MaineCare Member Days Awaiting Placement at a Nursing Facility

The Department will reimburse prospectively at the estimated statewide average rate per member day for NF services. The Department will reimburse at the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The Department shall compute the average statewide rate per member day based on
45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS (cont.)

the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital’s fiscal year.

E. Other Components

MaineCare will reimburse its share of inpatient hospital based physician, outpatient emergency room hospital based physicians and all graduate medical education costs. MaineCare’s share of emergency room hospital based physician costs is reimbursed at 100% of cost.

Effective July 1, 2009, MaineCare will reimburse 93.3% of its share of inpatient hospital based physician, 93.4% of its share of outpatient emergency room hospital based physician, and 83.8% of outpatient non-emergency room hospital based physician costs.

45.04-2 *Prospective Interim Payment

The estimated departmental annual inpatient/outpatient obligation, described above, will be calculated using the most recent MaineCare Supplemental Data Form increased by the rate of inflation to the beginning of the current state fiscal year. Third party liability payments are subtracted from the PIP obligation.

PIPs will be reduced by the anticipated amount of reimbursement for Medicare approved provider based primary care physician services as required to be billed on the CMS 1500 under Chapter II, Section 45, all inpatient hospital based physician payments and those outpatient services the hospital has elected to bill on the CMS 1500. The PIP payment does not include DSH payments or the hospital’s share of the supplemental pool payments.

45.04-3 Interim PIP Adjustment

The Department initiates an interim PIP adjustment under very limited circumstances, including but not limited to, restructuring payment methodology as reflected in a state plan amendment; when a hospital “changes” categories (e.g., becomes designated critical access); or a hospital opens or closes resulting in a redistribution of patients among facilities.

45.04-4 Interim Cost Settlement

The Department calculates the Interim Cost Settlement with a hospital using the same methodology as is used when calculating the PIP, except that the data sources used are the

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS (cont.)

hospital's As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which interim settlement is being performed.

45.04-5 Final Cost Settlement

The Department of Health and Human Services’ calculates the final settlement with a hospital using the same methodology as is used when calculating the PIP, except that the data sources used are the Medicare Final Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which settlement is being performed.

45.05 HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE BY THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD (MGCRB) PRIOR TO OCTOBER 1, 2008.

The reimbursement methodology for these hospitals is identical to that used for critical access hospitals, except that these hospitals are not eligible for payments from the supplemental pool described in Section 45.04.

45.06 REHABILITATION HOSPITALS

45.06-1 Department’s Total Obligation to the Hospital

The Department of Health and Human Services’ total annual obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + outpatient services + inpatient capital costs + days awaiting placement in swing beds + Disproportionate Share Payments (for eligible hospitals) + supplemental pool reimbursements – third party liability payments.

A. Inpatient Services

The Department will reimburse $12,440.44 per discharge.

B. Outpatient Services, including Laboratory and Imaging

1. APC Payments

Effective 11/14/2017

Effective July 1, 2013, the Department will reimburse rehabilitation hospitals 83.7% of the adjusted Medicare APC rate where the APC applies.
45.06 REHABILITATION HOSPITALS (cont.)

The APC payment does not include hospital-based physician services. The APC payment may include ancillary services such as imaging and laboratory test costs. If multiple procedures are performed, the Department will pay the hospital 83.7% of Medicare’s single bundled APC rate.

APC payments will be made for services received in an emergency room, clinic or other outpatient setting, or, if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital, where the member received the outpatient services. If the outpatient is admitted from a hospital’s clinic or emergency department to the same hospital as an inpatient, the hospital will be paid only a discharge rate and will not receive an APC payment.

An outlier payment adjustment will be made to the rate when an unusually high level of resources has been used for a case. Effective July 1, 2013, calculations for outlier payments will follow Medicare rules and be paid at 83.7% of the Medicare payment.

2. *Payment Window Rule

This rule institutes billing and payment procedures for outpatient services provided on either the date of a member’s inpatient hospital admission or during the one calendar day immediately preceding the date of a member’s inpatient hospital admission. Hospitals (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a member’s inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the member during the 1 day immediately preceding the date of inpatient hospital admission.

An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity’s routine operations, regardless of whether the hospital also has policymaking authority over the entity.

The technical component of all outpatient diagnostic and clinically related non-diagnostic services that are provided by the hospital, or by an entity wholly owned or wholly operated by the hospital, are to be billed with the claim for inpatient services when the outpatient services are provided in the one (1) calendar day preceding an inpatient admission.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.
All non-clinically related, non-diagnostic services provided before admission are not to be included on the inpatient claim. These outpatient services should be identified with the appropriate condition code. All non-diagnostic services, clinically related or not, provided on the date of inpatient admission are always deemed to be related to the admission and are to be included on the inpatient claim.

MaineCare will reimburse the technical portion of the outpatient services on the inpatient claim.

For physician services provided during the payment window and billed on the CMS 1500, the entity must append the appropriate modifier to all claim lines identified as connected to the inpatient stay. MaineCare will reimburse the professional component with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split.

It is the responsibility of the admitting hospital to notify wholly-owned or wholly-operated entities of an inpatient admission which may impact the entities eligibility for payment.

The payment window rule does not apply to outpatient services included in the rural health clinic or federally qualified health center all-inclusive rate, nor does it apply to ambulance and maintenance renal dialysis services.

3. Fee Schedule Payments

A limited number of Current Procedural Terminology (CPT) codes do not have associated Medicare APC rates, as listed in Addendum B (see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html). MaineCare covers certain services listed in Addendum B and pays for these services based on a fee schedule (see: https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx).

C. Capital and Graduate Medical Education Costs

MaineCare will reimburse its share of inpatient capital costs and all graduate medical education costs during the interim and final settlement processes.

D. Hospital based Physicians

MaineCare will reimburse

- 93.3% of its share of inpatient hospital based physician,
- 83.8% of outpatient hospital based physician costs.
45.06  **REHABILITATION HOSPITALS** (cont.)

Hospitals will be reimbursed based on claim forms filed with the Department. The billing procedure is described in Chapter II, Section 45. These payments are subject to cost settlement.

### 45.06-2  *Interim Cost Settlement*

All calculations will be based on the hospital's As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which interim settlement is being performed. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. **Interim Settlement for years up to and including SFY 2011**

   To the extent applicable, MaineCare’s interim cost settlement with a hospital will include settlement of:

   - Prospective interim payments; and
   - Payments made for hospital based physician services provided on or after the date MIHMS went live.

2. **Discharge Rate/Outpatient Prospective Payment – SFY 2012 Only**

   MaineCare’s interim cost settlement with a hospital operating under the discharge rate based system will include settlement of:

   - Capital and medical education costs based on Medicare and GAAP principles
   - Payments made for hospital based physician services
   - Outpatient prospective interim payments

3. **Discharge Rate and APC Based System – SFY ’13 and Forward**

   MaineCare’s interim cost settlement with a rehabilitation hospital operating under the discharge rate and APC based system will include settlement of:

   - Capital and medical education costs based on Medicare and GAAP principles
   - Payments made for hospital based physician services

   APC payments will not be cost settled

### 45.06-3  *Final Cost Settlement*

All calculations are based on the hospital's Final Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which interim settlement is being performed. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.
45.06  **REHABILITATION HOSPITALS** (cont.)

1. **Final Settlement for years up to and including SFY 2011**

To the extent applicable, MaineCare’s final cost settlement with a hospital will include settlement of:

- Prospective interim payments; and
- Payments made for hospital based physician services provided on or after the date MIHMS went live.

2. **Discharge Rate/Outpatient Prospective Payment – SFY 2012 Only**

MaineCare’s final cost settlement with a hospital operating under the discharge rate based system will include settlement of:

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital based physician services

3. **Discharge Rate and APC Based System – SFY 2013 and Forward**

MaineCare’s final cost settlement with a rehabilitation hospital operating under the discharge rate and APC based system will include settlement of:

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital based physician services

APC payments will not be cost settled.

45.07  **SUPPLEMENTAL POOL FOR NON-CRITICAL ACCESS HOSPITALS, HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE AND REHABILITATION HOSPITALS**

The Department will allocate a supplemental pool for each state fiscal year among the privately owned and operated Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board and rehabilitation hospitals. Effective July 1, 2017, the total pool shall equal seventy-one million, seven hundred eighty thousand, seventy-two dollars ($71,780,072). Effective November 14, 2017, up to $60,000,000 will be allocated to outpatient services and up to $60,000,000 will be allocated to inpatient services, not to exceed the total supplemental pool amount and not to exceed allowable aggregate upper payment limits.

45.07-1  **Inpatient Pool.** Effective November 14, 2017, the allocated inpatient pool amount will be distributed based on each hospital’s relative share of inpatient MaineCare payments,

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.*
45.07 *SUPPLEMENTAL POOL FOR NON-CRITICAL ACCESS HOSPITALS, HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE AND REHABILITATION HOSPITALS (cont.)

defined as the hospital’s inpatient MaineCare payment in state fiscal year 2014 divided by inpatient MaineCare payments made to all privately owned and operated Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board, and rehabilitation hospitals; multiplied by the supplemental pool.

Effective 11/14/2017

45.07-2 Outpatient Pool. Effective November 14, 2017, the allocated outpatient pool amount will be distributed based on each hospital’s relative share of outpatient MaineCare payments, defined as the hospital’s outpatient MaineCare payment in state fiscal year 2014 divided by outpatient MaineCare payments made to all privately owned and operated Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board, and rehabilitation hospitals; multiplied by the supplemental pool.

Each hospital in the pool will receive its relative share of this supplemental payment. Supplemental payments will be distributed semiannually, in even distributions in November and May.

This pool will be decreased by the amount a hospital would have received if that hospital was in the pool when the total pool amount was set and subsequently becomes an approved critical access hospital.

This supplemental pool payment is not subject to cost settlement.

45.08 PRIVATE PSYCHIATRIC HOSPITALS

45.08-1 Department’s Total Annual Obligation to the Hospital

The Department of Health and Human Services’ total annual obligation to the hospitals is the sum of MaineCare’s obligation of the following: inpatient services + outpatient services + Disproportionate Share Hospital (for eligible hospitals) – third party liability payments.

A. Inpatient Services

The rate will be negotiated and becomes effective at the beginning of a hospital’s fiscal year. The Department’s total annual obligation shall be computed based on the hospital’s negotiated rate.

The negotiated rate shall be between eighty-five percent (85%) and one hundred percent (100%) of the hospital’s estimated inpatient charges, less third party liability. The hospital must notify the Department sixty (60) days prior to any increase in its charges.
45.08  **PRIVATE PSYCHIATRIC HOSPITALS** (cont.)

If the hospital increases charges subsequent to the annual adjustment, the hospital and the Department will meet to consider the extent that the increase in charges will affect the amount paid by MaineCare and to negotiate the amount by which the previously negotiated percentage of charges must be adjusted to account for the impact. If the hospital commences any new MaineCare inpatient covered service, whether or not subject to Certificate of Need review, the parties will separately negotiate the percentage of charges to be paid by MaineCare for that service.

Special circumstances may arise during the course of a year that may warrant reconsideration and adjustment of the negotiated rate. These circumstances could include changes in psychiatric bed capacity or patient populations within the State that materially impact MaineCare or uncompensated care volume, extraordinary increases in charges, legislative deappropriation, MaineCare deficits that may result in decreased State funding, as well as other special circumstances that the parties cannot now foresee.

B. **Outpatient Services**

The Department’s total annual obligation to the hospital will be one hundred and seventeen percent (117%) of allowable outpatient costs, determined from the most recent Interim Cost Settlement Report, inflated forward to the current State fiscal year.

45.08-2  **Prospective Interim Payment**

Private psychiatric hospitals will be paid weekly prospective interim payments based on the Department’s estimate of the total annual obligation to the hospital.

45.08-3  **Interim Cost Settlement**

The Interim Cost Settlement with a hospital is calculated using the same methodology and negotiated percentage rate as is used when calculating the PIP, except that the data source used is the hospital’s MaineCare paid claims history for the year for which Interim Cost Settlement is being performed. The hospital is required to submit its Medicare As-Filed Cost Report to the Department.

45.08-4  **Final Cost Settlement**

The Department’s total annual obligation to a hospital will be computed using the same methodology as is used when calculating the PIP, except that the data sources used are the hospital’s Medicare Final Cost Report submitted to DHHS, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which settlement is being performed.
45.08 **PRIVATE PSYCHIATRIC HOSPITALS** (cont.)

**Note:** The Department retains the right to reopen and modify cost settlement(s) affecting the timeframe from October 1, 2001 forward to assure consistency with the State Plan in effect for the time period covered by the settlement.

45.09 **STATE OWNED PSYCHIATRIC HOSPITALS**

State owned psychiatric hospitals will be reimbursed as follows:

45.09-1 **Total Obligation to the Hospital**

The MaineCare total annual obligation to the hospitals will be the sum of: MaineCare’s obligation of the following: inpatient services + outpatient services + days awaiting placement + hospital based physician + direct graduate medical education costs + estimated DSH obligation – third party liability payments. Amounts are calculated as described below:

A. **Inpatient Services**

The total MaineCare inpatient operating costs from the most recent Interim Cost Settlement Report inflated forward as described in Section 45.02-1 to the current State fiscal year.

B. **Outpatient Services**

*MaineCare outpatient costs inflated to the current State fiscal year using the most recent Interim Cost Settlement Report.*

C. **MaineCare Member Days Awaiting Placement at a Nursing Facility**

The Department will reimburse prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The Department will compute the average statewide rate per member day based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital’s fiscal year.

D. **Other Components**

MaineCare’s share of hospital based physician + graduate medical education costs are taken from the most recent hospital Interim Cost Settlement Report inflated to the current year.
45.09 STATE OWNED PSYCHIATRIC HOSPITALS (cont.)

45.09-2 Estimated Claims Payments

The Department will reimburse claims submitted for inpatient and outpatient services, subject to final cost settlement.

45.09-3 Final Cost Settlement

The Department will calculate MaineCare’s Final Cost Settlement with a hospital using the Medicare Final Cost Report and MaineCare paid claims history for the year for which settlement is being performed. A final DSH adjustment will be made for eligible hospitals.

45.10 OUT-OF-STATE HOSPITALS

The Department will reimburse out-of-state hospitals for inpatient and outpatient services based on

1. The MaineCare rate if applicable;
2. The lowest negotiated rate with a payor whose rate the hospital provider currently accepts;
3. The hospital provider’s in-State Medicaid rate;
4. A percentage of charges; or
5. A rate specified in MaineCare’s contract with the hospital provider.

Except as otherwise specifically provided in the agreement between MaineCare and the out-of-state hospital providers, out-of-state hospital providers must accept MaineCare reimbursement for inpatient services as payment in full for all services necessary to address the illness, injury or condition that led to the admission. *Reimbursement for out-of-state hospital outpatient laboratory and imaging services shall not exceed the one-hundred percent (100%) of the Medicare reimbursement rate for the Maine area (“99 locality”). Out-of-state hospitals are required to report and are subject to all applicable pricing modifiers.

Out-of-State hospital providers must meet all requirements outlined in Chapter I of the MaineCare Benefits Manual (MBM) including signing a provider/supplier agreement and obtaining prior authorization.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.

45.11 CLINICAL LABORATORY AND IMAGING SERVICES

Hospital laboratory, imaging, and physician services provided to a member not currently a patient of the hospital are considered outpatient hospital services. These services are covered in accordance with requirements, and utilization limitations (including prior authorizations) described in the following sections of the MaineCare Benefits Manual and are reimbursable in accordance with MBM Chapter II, Section 55, Laboratory Services, Chapter II, Section 90, Physician Services, or Chapter II, Section 101, Medical Imaging Services. Rates for those services are posted on https://mainecare.maine.gov/.
45.11 CLINICAL LABORATORY AND IMAGING SERVICES (cont.)

In the case of tissues, blood samples or specimens taken by personnel that are not employed by the hospital but are sent to a hospital for performance of tests, the tests are not considered outpatient hospital services since the member does not receive services directly from the hospital.

Effective 11/14/2017

Certain clinical diagnostic laboratory tests must be performed by a physician and are, therefore, exempt from the fee schedule. Medicare periodically sends updated lists of exempted tests to hospitals. Laboratory services must comply with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA 88) and any applicable amendments.

45.12 PROVIDER PREVENTABLE CONDITIONS

In accordance with the Affordable Care Act, MaineCare will not reimburse providers for Provider Preventable Conditions (PPCs) as defined in the federal Medicaid regulation, 42 CFR 447.26.

All hospitals must identify and report to the Department all PPCs, but Hospital providers are prohibited from submitting claims for payment of these conditions except as permitted in 42 CFR 447.26, when the PPC for a particular patient existed prior to the initiation of treatment for that patient by that hospital provider.

The DRG payment calculations automatically ensure that providers will not be compensated for these conditions. Hospital providers who are not reimbursed using DRGs must report all PPCs on claims and bill zero charges for these PPCs, except as provided above.

45.13 DISPROPORTIONATE SHARE (DSH) PAYMENTS

45.13-1 General Eligibility Requirements for DSH Payments

To be eligible for DSH payments a hospital must have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Plan. In the case of a hospital located in a rural area that is an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. However, the obstetric criteria above do not apply to hospitals in which the inpatients are predominantly individuals under eighteen (18) years of age or to hospitals that did not offer non-emergency obstetric services as of December 21, 1987.

The hospital must also have a MaineCare utilization rate of at least one percent (1%). Acute care hospitals must also meet additional requirements as described below.

45.13-2 Additional Eligibility Requirements for Acute Care Hospitals

The hospital must also either a) have a MaineCare inpatient utilization rate at least one (1) standard deviation above the mean MaineCare inpatient utilization rate for hospitals
45.13 DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

receiving MaineCare payments in the state), or b) have a low income inpatient utilization rate exceeding twenty-five percent (25%).

For purposes of determining whether a hospital is a disproportionate share hospital in a Payment Year the Department will use data from the hospital’s Medicare Final Cost Report for the same period to apply the standard deviation test. *Final Cost Settlement Reports for the specified payment year must be issued by the Department for all acute care hospitals in order for DSH to be calculated by the Department.

*The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.

45.13-3 Disproportionate Share Payments

A. DSH Adjustment for Institutions for Mental Disease (IMD)

Subject to the CMS IMD Cap described below and to the extent allowed by the Centers for Medicare and Medicaid Services (CMS), the DSH adjustment will be one hundred percent (100%) of the actual uncompensated cost, as calculated using Medicare Cost Report and GAAP principles, of:

1. services furnished to MaineCare members plus,

2. charity care as reported on the hospital’s audited financial statement for the relevant payment year, MINUS

3. payments made by the State for services furnished to MaineCare member

CMS places a limit on the amount of DSH payment that may be made to IMDS (IMD cap). If the Department determines that aggregate payments to IMDS, as calculated above, would exceed the CMS IMD cap, payments will be made to State-owned facilities first. Remaining IMD DSH payments will be allocated among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the federal or state cap.

CMS places a limit on the amount of DSH payment that may be made to a single hospital. If approved by CMS, if the Department or CMS determine that payments to a hospital would exceed that cap, the overage shall be redistributed as follows:

- If any state-owned hospital has not reached its DSH cap it will receive DSH payments to the extent funds are available up to the limit of its hospital-specific cap.
45.13 DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

- Remaining IMD DSH funds will be allocated among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the federal or state cap.

The “relative share” is calculated as follows: calculate the fraction, the numerator of which is 100% of actual uncompensated cost of a non-state owned IMD, the denominator of which is the total of 100% of actual uncompensated cost for all non-state owned IMDS. That fraction is then multiplied by the remaining available for IMD DSH payments, as described above, to give the relative share for each non-state-owned IMD.

B. For Acute Care Hospitals

1. The pool of available funds for DSH adjustments for all acute care hospitals equals two hundred thousand dollars ($200,000) for each State fiscal year.

2. Fifty percent (50%) of this pool will be distributed among eligible hospitals in proportion to their relative share of MaineCare days of all eligible acute care hospitals. Relative share will be calculated as follows: the MaineCare days for each DSH eligible hospital will be divided by the sum of the MaineCare days for all DSH eligible hospitals to determine the DSH allocation percentage. This DSH allocation percentage for each eligible hospital will be multiplied by one hundred thousand dollars ($100,000) to determine each eligible hospital’s share.

For example:

Hospitals X, Y and Z are all eligible for DSH. MaineCare days for X equals five thousand (5,000); Y equals ten thousand (10,000) and Z equals fifteen thousand (15,000). The resulting total MaineCare days for DSH eligible hospitals would be thirty thousand (30,000)

(5,000+10,000+15,000). Hospital X’s DSH allocation percentage would be sixteen and seven tenths percent (16.7%) (5,000/30,000). Hospital X would get sixteen thousand seven hundred dollars ($16,700) ($100,000 times 16.7%) in DSH payments related to utilization.

3. Fifty percent (50%) of this pool will be distributed among eligible hospitals in proportion to the percentage by which the hospital’s MaineCare utilization rate as defined above, exceeds one standard deviation above the mean. The percentage points above the first standard deviation for each DSH eligible hospital will be divided by
45.13 DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

the sum of the percentage points above the standard deviation for all acute care eligible hospitals to determine the DSH allocation percentage.

This standard deviation related DSH allocation percentage for each eligible acute care hospital will be multiplied by one hundred thousand dollars ($100,000) to determine each hospital’s share of the DSH payments.

For example:

Assume the same three hospitals, X, Y and Z, are all eligible for DSH. Respectively, their utilization rates are 6, 7 and 8 percentage points above the mean MUR plus one standard deviation. The resulting total percentage points above the mean for all hospitals would be 21 (6+7+8). Hospital X's DSH allocation percentage would be twenty-eight and fifty-seven hundredths (28.57%) (6/21). If fifty percent (50%) of the available DSH pool is one hundred thousand dollars ($100,000), then Hospital X would get twenty eight thousand five hundred and seventy dollars ($28,570) ($100,000 times 28.57%) in DSH payments related to distance above one standard deviation above the mean.

After final settlement is complete for all hospitals in a category (i.e., acute care or psychiatric) hospitals within the category are assessed for eligibility for DSH payments. However, state psychiatric hospitals only may be paid estimated DSH prospectively if they are expected to be found eligible.
**APPENDIX A**

**DRG-BASED PAYMENT METHODOLOGY**

Effective July 1, 2011 (SFY 2012):

I. The Department has adopted the Medicare Severity Diagnosis Related Groups as described at www.cms.gov/AcuteInpatientPPS/.

II. The Department will calculate reimbursement for a covered inpatient service using the following formula:

   \[
   \text{(The hospital specific base rate multiplied by the DRG relative weight)} \\
   \text{plus an outlier payment (if applicable)}
   \]

III. **Hospital Specific Base Rate Calculation**

   Each hospital specific base rate is the total of 3 components:
   - statewide DRG direct care rate
   - hospital-specific capital rate
   - hospital-specific medical education rate

IV. **DRG Direct Care Rate Calculations**

   The statewide DRG direct care rate for all hospitals being paid under the DRG system is as follows:
   - Multiplies each hospital-specific base DRG rate by the number of discharges of each hospital, resulting in a total direct care payment for each hospital
   - Sums the total direct care payment for each hospital
   - Divides this sum by the total number of discharges

   The hospital-specific DRG direct care rate used in the calculation of the statewide DRG direct care rate for July 1, 2011 is calculated as follows:

   - divides the hospital’s SFY 10 discharge rate by the hospital’s case mix index (the average relative weight of a hospital’s base year claims, which equals the sum of the relative weights for all applicable discharges divided by the total number of discharges calculated using calendar year 2007 discharges)
   - inflates this figure to SFY 11

   The DRG direct care rate component of the DRG-based rate payment is not settled during the cost settlement process.
V. Hospital Specific Capital Rate Calculation

The hospital specific capital rate is calculated by allocating estimated capital costs over estimated discharges. Using data from hospital fiscal year 2008 cost reports, estimated capital costs are derived by applying capital cost to charge ratios to total charges, and trending that amount to state fiscal year 2011 using a 5.5% annual trend rate. These rates will be hospital specific for all years.

The capital rate component of the DRG-based rate payment is settled during the cost settlement process.

VI. Hospital Specific Medical Education Rate Calculation

The hospital specific medical education rate (including direct and indirect medical education) is calculated by allocating estimated education costs over estimated discharges. Using data from hospital fiscal year 2008 as filed Medicare cost reports, estimated costs are derived by trending medical education costs to state fiscal year 2011 using a 2.5% annual trend rate. These rates will be hospital specific for all years.

The medical education rate component of the DRG-based rate payment is settled during the cost settlement process.

VII. DRG Relative Weight Calculation

The relative weighting factor is assigned by the Department to represent the time and resources associated with providing services for that diagnosis related group. As described below, the Department calculated preliminary weights for each DRG, and then normalizes each weight to ensure that the statewide case mix index for applicable claims equals 1.0. The Department calculates relative weights using claims from critical access hospitals, non-critical access acute care hospitals and hospitals reclassified to a different Medicare geographic access area. The calculation does not include data from rehabilitation hospitals. Days awaiting placement in swing beds were taken into account when calculating relative weights.

a. DRGs with at least 10 admissions

The Department calculates preliminary weights for DRGs with at least 10 admissions by:

- Grouping base year claims for all hospitals described above by DRG
- For each DRG, the Department
  - Sums base year charges per claim
  - Divides this sum by the number of claims in the DRG to obtain an average charge per claim for this DRG
  - Divides this DRG-specific average by the average base year charge per claim for all applicable claims
b. **DRGs with fewer than 10 admissions**

If there are fewer than 10 cases for a DRG, the Department adjusts the MS-DRG relative weight by multiplying the relative MS-DRG weight by an “adjustment factor.” This adjustment factor is developed by:

- Calculating the case mix index for all DRGs with at least 10 admissions using MaineCare charges as described above (for example 1.5)
- Calculating the case mix index for all DRGs with at least 10 admissions using MS-DRG (for example 1.2)
- Calculating the ratio of the MS-DRG derived weight to the charged-based rate (in this example this factor would equal 1.5/1.2 or 1.25)

c. **Normalization**

The resulting weights for all DRGs are then normalized to result in a weighted average case mix of 1.0. This is done by calculating the preliminary case mix index (CMI) for all applicable claims (for example 1.25) and then multiplying each individual case weight by the inverse of this global CMI (in this example equal to 0.8).

VIII. **Transfer to a Distinct Rehabilitation Unit in the Same Hospital**

Notwithstanding the definition of a discharge in 45.01 above, a hospital may bill for two distinct episodes of care for a patient who is transferred from an acute care unit to a distinct rehabilitation unit in the same hospital. The Department will reimburse the hospital one DRG-based discharge rate for the episode of acute care and one DRG based discharge rate for the rehabilitation episode of care.

IX. **Outlier Adjustment Calculation**

An outlier payment adjustment is made to the rate when an unusually high level of resources has been used for a case. An outlier payment is triggered when the result of the following equation is greater than zero:

\[
\text{(charges multiplied by the hospital-specific cost to charge ratio)} - \text{outlier threshold} - \text{DRG-based discharge rate}
\]

The payment is equal to 80% of the resulting value.

The outlier threshold is equal to the value that ensures that 5% of payments related to DRG-based discharge rates are outlier adjustment payments.

In no instance is a reduction made to the rates for cases with unusually low costs or charges.
The following shall apply to non-emergent use of the emergency department (see Sec. 45.03-1(D)(1)(c) and 45.03-1(D)(2)(b))

ICD-10 codes will be used to identify non-emergent use of the emergency department for services delivered beginning October 1, 2015.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-10 Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J02.0</td>
<td>Streptococcal pharyngitis</td>
</tr>
<tr>
<td>J03.00</td>
<td>Acute streptococcal tonsillitis, unspecified</td>
</tr>
<tr>
<td>J03.01</td>
<td>Acute recurrent streptococcal tonsillitis</td>
</tr>
<tr>
<td>B97.10</td>
<td>Unspecified enterovirus as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td>B97.89</td>
<td>Other viral agents as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td>F41.9</td>
<td>Anxiety disorder, unspecified</td>
</tr>
<tr>
<td>F41.1</td>
<td>Generalized anxiety disorder</td>
</tr>
<tr>
<td>H10.30</td>
<td>Unspecified acute conjunctivitis, unspecified eye</td>
</tr>
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### SECTION 45: HOSPITAL SERVICES

**MAINECARE BENEFITS MANUAL**

**CHAPTER III, PRINCIPLES OF REIMBURSEMENT**

**ESTABLISHED 1/1/85**

**LAST UPDATED 11/14/2017**

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