DATE: January 12, 2016

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual (MBM), Chapter II, Section 4, Ambulatory Surgical Center Services

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Chapter II, Section 4, Ambulatory Surgical Center (ASC) Services.

The Department proposes to align Section 4, ASC Services with the current ASC reimbursement methodology as defined by the outpatient prospective payment system (OPPS) by the Centers for Medicare and Medicaid Services (CMS). The following changes to policy are included in this alignment:

- MaineCare will no longer reimburse ASCs separately for prosthetic devices that are outside of the all-inclusive rate for covered surgical procedures. CMS-defined all-inclusive rates include prosthetic devices that are considered integral to covered surgical services. Members may procure any additional medically necessary prosthetics that are not included in the all-inclusive rate through a durable medical equipment provider, physician, or other appropriately licensed provider in accordance with the applicable section of the MBM.

- Language is added to Section 4.04 (B), Ancillary Services, to reflect that certain radiology services are eligible for separate payment under the OPPS.

- Language is added to Section 4.05, Non-covered Services, which describes in more detail which services and supplies are non-covered and where else these services may be covered in the MBM.

- Clarification that per CMS determination, surgeries performed in ASCs are not expected to result in extensive blood loss; when there is a need for blood products, MaineCare considers this a facility service and no separate charge is permitted.

The Department also proposes to reimburse physicians or other qualified providers at the facility rate listed in the MaineCare Fee Schedule (https://mainecare.maine.gov/) for services delivered in ASCs. This is in recognition that ASCs are facilities and that the facility portion of the service is reimbursed through the all-inclusive rate described above.

This rulemaking also adds a general description of which surgical procedures are approved for delivery in an ASC, deletes components of the all-inclusive rate that were listed twice, more closely aligns reimbursement language with the CMS approved State Plan Amendment, removes the disclaimer that the section is dependent upon approval from CMS because
approval has been granted, updates the MaineCare provider website URL, and makes minor formatting edits.

Rules and related rulemaking documents may be reviewed at, or printed from, the 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. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual (MBM), Chapter II, Section 4, Ambulatory Surgical Center Services

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The Department proposes to align MBM, Section 4, Ambulatory Surgical Center (ASC) Services with the current ASC reimbursement methodology as defined by the outpatient prospective payment system (OPPS) by the Centers for Medicare and Medicaid Services (CMS). The Department also proposes to reimburse physicians or other qualified providers at the facility rate listed in the MaineCare Fee for services delivered in ASCs.

CMS-defined all-inclusive rates include prosthetic devices that are considered integral to covered surgical services; MaineCare will no longer reimburse ASCs separately for prosthetic devices that are outside of the all-inclusive rate for covered surgical procedures. Members may procure medically necessary prosthetics through a durable medical equipment provider, physician, or other appropriately licensed provider in accordance with the applicable section of the MBM.

Language is also added to Section 4.04 (B), Ancillary Services, to reflect that certain radiology services are eligible for separate payment under the OPPS. Section 4.05, Non-Covered Services, is amended to clarify that per CMS determination, surgeries performed in ASCs are not expected to result in extensive blood loss; when there is a need for blood products, MaineCare considers this a facility service and no separate charge is permitted. Language is also added to describe in more detail which services and supplies are non-covered and where else these services may be covered in the MBM.

This rulemaking also adds a general description of which surgical procedures are approved for delivery in an ASC, deletes components of the all-inclusive rate that were listed twice, more closely aligns reimbursement language with the CMS approved State Plan Amendment, removes the disclaimer that the section is dependent upon approval from CMS because approval has been granted, updates the MaineCare provider website URL, and makes minor formatting edits.


PUBLIC HEARING:
Date: February 9, 2016
Time: 1:00 pm
Location: Room 401, Cross Office Building, 111 Sewall Street, Augusta, ME 04330

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before 5:00 PM, on Tuesday, February 2, 2016.

DEADLINE FOR COMMENTS: Comments must be received by midnight Friday, February 19, 2016.

AGENCY CONTACT PERSON: Olivia Alford, Comprehensive Health Planner II
AGENCY NAME: MaineCare Services
ADDRESS: 242 State Street, 11 State House Station
Augusta, Maine 04333-0011
TELEPHONE: 207-624-4059 FAX: (207) 287-1864
TTY: 711 (Deaf or Hard of Hearing)
This Section is Dependent Upon Approval by the Centers for Medicare and Medicaid Services (CMS)

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SECTION 4  AMBULATORY SURGICAL CENTER SERVICES

This Section is Dependent Upon Approval by the Centers for Medicare and Medicaid Services (CMS)

4.1 DEFINITIONS

4.01-1 Ambulatory Surgical Center (ASC) means a freestanding facility that operates exclusively for the purpose of providing surgical services to persons not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission. The ASC must be certified by Medicare and comply with applicable licensure requirements, if any, in the State or Province in which it operates.

Ambulatory Surgical Centers reimbursed as part of an acute care hospital are excluded as providers under this Section of the MaineCare Benefits Manual.

4.01-2 Facility Services means items and services furnished by an ASC in connection with a covered surgical procedure.

4.2 MEMBER ELIGIBILITY

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

The provider is responsible for verifying a member’s eligibility for MaineCare prior to providing services on each occasion that services are provided. See Chapter I of the MaineCare Benefits Manual for more information on verifying eligibility.

4.3 DURATION OF CARE

Each MaineCare member is eligible for as many covered services as are medically necessary. The Department reserves the right to request additional information to determine medical necessity.

4.4 COVERED SERVICES

Covered services are those items and services, stated below, which are include all items and services furnished by an ASC in connection with a covered surgical procedure. Unless otherwise stated below, only covered surgical procedures currently on the Medicare-approved list of ASC covered procedures are allowed. See the Federal Register or http://www.cms.hhs.gov/ASCPayment/ for the current listing. Covered surgical procedures are those that would not be expected to pose a significant safety risk to a member when performed in an ASC, and for which standard medical practice dictates that the Member would not typically be expected to require active medical monitoring and care at midnight following the procedure.

Coding for covered services is based on the latest version of the American Medical Association’s standard Current Procedural Terminology (CPT) codes and can be accessed through the Department’s website at: https://mainecare.maine.gov/ProviderHomePage.aspx.
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4.4 COVERED SERVICES (cont.)

A. The following items and services are covered services and are included in the all-inclusive rates for reimbursement in this Section of the MaineCare Benefits Manual:

A. The following are part of the all-inclusive rate:

1. Nursing, technical personnel and other related services;

These include all services in connection with covered procedures furnished by nurses, technical personnel and other support staff involved in patient care who are employees of the ASC.

2. Use of surgical center facilities;

3. Drugs and biologicals for which separate payments are not allowed under the hospital outpatient prospective payment system (OPPS);

4. Diagnostic or therapeutic items and services: Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

These are items and services furnished by the ASC staff in connection with covered surgical procedures. Diagnostic tests, primarily urinalysis, blood hemoglobin, or hematocrit, performed just before surgery are included in the facility fee. The laboratory may perform diagnostic tests that may be required prior to surgery. Generally, these tests will have been performed prior to scheduling surgery under a CLIA certificate of waiver.

5. Administrative, record-keeping, and housekeeping items;

6. Blood, blood plasma, platelets:

Covered procedures are limited to those not expected to result in extensive loss of blood, but in some cases, blood and blood products may be required. When there is a need for blood and blood products, they are considered facility services and no separate charge is permitted.

7. Medical and surgical supplies not on pass-through status;
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4.04 COVERED SERVICES (cont.)

(8)(6) Equipment;

(7) Surgical dressings;

(9)(8) Implanted prosthetic devices, including intraocular lenses (IOLs), (payment for presbyopia-correcting intraocular lens and astigmatism-correcting intraocular lens will be the rate of a conventional intraocular lens) and related accessories and supplies not on pass-through status;

(10)(9) Implanted DME and related accessories and supplies not on pass-through status;

(11)(10) Splints and casts and related devices;

(12)(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(13)(12) Administrative, recordkeeping and housekeeping items and services;

(14)(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(15)(14) Supervision of the services of an anesthetist by the operating surgeon.

B. Prosthetic devices:

Prostheses such as joint and breast implants, artificial eyes and limbs, etc., may be billed in addition to the surgical procedure. Reimbursement will be made for the acquisition cost of the prosthetic device. Providers must maintain documentation of cost, including a copy of the original invoice, and make such documentation available to the Department upon request.

B. Ancillary Services:

The following ancillary services may be billed separately from the facility fee, using procedure codes listed in the most current version of the Healthcare Common Procedure Coding System (HCPCS), as maintained by the Center for Medicaid and Medicare Services (CMS). Ancillary items and services that are integral to a covered surgical procedure (defined, above) and for which separate payment is allowed include:
4.4 COVERED SERVICES (cont.)

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced, including but not limited to, the procurement of corneal tissue;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS.

(5) Certain radiology services for which separate payment is allowed under the OPPS.

When an Ambulatory Surgical Center bills for services covered under this Section of the MaineCare Benefits Manual for a given operative procedure, the physician(s) involved in performing the operative procedure is to bill for his or her professional services only under Chapter II, Section 90, and not for related ancillary services such as anesthesia supplies, which are covered services under this Section.

4.5 NON-COVERED SERVICES

Facility services do not include physician or anesthetists services (Section 90; Section 14); laboratory (Section 55), x-ray/radiology (other than those integral to performance of a covered surgical procedure) or diagnostic procedures (other than those integral to performance of a covered surgical procedure) (other than those directly related to the performance of the surgical procedure) (Section 101); ambulance services (Section 5); leg, arm and back braces (Section ___); or durable medical equipment (other than those that serve the function of a cast or splint or are otherwise considered integral to the performance of a covered surgical procedure) for use in the member’s home (Section 60); artificial limbs; non-implantable prosthetic devices and DMS; anesthesists’ services.

Covered procedures are limited to those not expected to result in extensive loss of blood, but in some cases, blood and blood products may be required. When there is a need for blood and blood products, they are considered facility services and no separate charge is permitted.

Other non-covered services include those services that cannot be safely performed in an outpatient setting or without support of a full array of hospital diagnostic and treatment services and equipment; and procedures that are not covered by MaineCare (e.g., cosmetic surgery).

Services are not separately billable unless specifically allowed under Medicare.
4.6 POLICIES AND PROCEDURES

4.06-1 Professional Staff

A physician is a doctor of medicine or osteopathy who possesses a current license to practice medicine or osteopathy in the State or Province in which the services are provided.

4.06-2 Member Records

There shall be a specific record for each member that shall include, but not necessarily be limited to:

A. The member’s name, address, and birth date;
B. The member’s social and medical history, as appropriate;
C. Operative reports or procedure/treatment descriptions, as appropriate;
D. A description of any tests ordered and performed and their results;
E. A description of treatment or follow-up care and dates scheduled for revisits;
F. Any medications and/or supplies dispensed or prescribed;
G. Any recommendations for and referral to other sources of care;
H. The dates on which all services were provided;
I. Written progress notes, which shall identify the services provided, pathology specimens obtained, and where sent, as applicable;
J. Informed consents; and
K. Assessment appropriate to the nature and scope of the procedure performed and the specific medical condition of the individual patient.

4.06-3 Program Integrity

See Chapter I of the MaineCare Benefits Manual, for Program Integrity procedures.
This Section is Dependent Upon Approval by the Centers for Medicare and Medicaid Services (CMS)

4.7 REIMBURSEMENT

Reimbursement for covered services shall be made as described below. The reimbursement rate is an all-inclusive rate. Providers cannot bill for facility services separately. The rendering provider will receive the facility rate for procedures performed in an Ambulatory Surgical Center.

4.07-1 Reimbursement is based on a fee schedule. The fee schedule reimburses at shall be the lower of:

A. 100% of the lowest amount allowed by the Maine Medicare Part B carrier based on current Medicare rates; or

B. the provider’s usual and customary facility charge.

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 prior to billing the MaineCare Program.

4.07-2 Reimbursement for Multiple Procedures

When multiple procedures are performed in the same operative session, MaineCare will pay for the procedure that has the highest payment amount as final payment for all procedures performed. For purposes of this Section, an operative session is an ambulatory surgical visit in which one or more of the covered surgical procedures are performed.

4.8 BILLING INSTRUCTIONS

Billing must be accomplished in accordance with the Department's billing instructions for the CMS 1500 that providers receive in their enrollment packages.