DATE: June 10, 2016

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

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

The Department is adopting this final rule, Chapter 101, MaineCare Benefits Manual (MBM), Chapter II, Section 4, Ambulatory Surgical Center (ASC) Services.

This rulemaking more closely aligns ASC policy with the reimbursement methodology used by the Centers for Medicare and Medicaid Services (CMS). Specifically, MaineCare will no longer reimburse ASCs separately for prosthetic devices that are outside the all-inclusive rate for covered surgical procedures, as defined by CMS. 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 MaineCare Benefits Manual (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 Outpatient Prospective Payment System (OPPS). Section 4.05, Non-Covered Services, is amended to clarify that 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.

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, removes the disclaimer that the section is dependent upon approval from CMS because approval has been granted, further clarifies which services and supplies are Non-Covered Services under this section, and where else these services may be covered in the MBM, updates the MaineCare provider website URL, and makes minor formatting edits.

As part of this rulemaking, physicians delivering covered services in an ASC will be reimbursed for their professional services at the “facility rate” listed in the MaineCare Fee Schedule (https://mainecare.maine.gov/) under MBM, Section 90, Physician Services.

As a result of public comment, the adopted rulemaking improved language around physician reimbursement to clarify that physician and anesthetist professional services are still separately billable under MBM, Section 90, Physician Services. In addition, the Department added citations to the Code of Federal Regulations to assure that the Department’s interpretation of “implantable prosthetic devices” will be aligned with CMS.

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.

A concise summary of the adopted rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process.
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, Section 4, Ambulatory Surgical Center Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This rulemaking more closely aligns ASC policy with the reimbursement methodology of ASC facility and non-facility services, as defined by the Centers for Medicare and Medicaid Services (CMS). This includes a change that MaineCare will no longer reimburse ASCs separately for prosthetic devices that are outside the all-inclusive rate for covered surgical procedures, as defined by the CMS.

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, removes the disclaimer that the section is dependent upon approval from CMS because approval has been granted, further clarifies which services and supplies are Non-Covered Services under this Section, updates the MaineCare provider website URL, and makes minor formatting edits.

Also, as part of this rulemaking, physicians delivering covered services in an ASC will be reimbursed for their professional services at the “facility rate” listed in the MaineCare Fee Schedule (https://mainecare.maine.gov/) under MBM, Section 90, Physician Services.

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EFFECTIVE DATE: June 15, 2016

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4.01 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.

4.02 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.

4.03 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.

4.04 COVERED SERVICES

Covered services are those items and services, stated below, which are 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 Registrar for the annual ASC final rule 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/.
4.04 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:

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. Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

5. Medical and surgical supplies not on pass-through status under 42 CFR 419.66 Subpart G;

6. Equipment;

7. Surgical dressings;

8. Implanted prosthetic devices, including intraocular lenses (IOLs), (payment for presbyopia-correcting intraocular lens and astigmatism-correcting intraocular lens will be at the rate of a conventional intraocular lens) and related accessories and supplies not on pass-through status under 42 CFR 419.66 Subpart G;

9. Implanted DME and related accessories and supplies not on pass-through status under 42 CFR 419.66 Subpart G;

10. Splints and casts and related devices;

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;

12. Administrative, recordkeeping and housekeeping items and services;

13. Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

14. Supervision of the services of an anesthetist by the operating surgeon.
4.04 COVERED SERVICES (cont.)

B. Ancillary Services

Effective 6/15/16

Ancillary items and services that are integral to a covered surgical procedure (defined above) and for which separate payment is allowed, include the following:

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 ASC 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.

4.05 NON-COVERED SERVICES

Effective 6/15/16

Non-covered services are services that are not billable under this section of policy as ASC facility services. ASC facility services do not include physician or anesthetist services (Section 90; Section 14); laboratory (Section 55), radiology or diagnostic procedures (other than those directly related to the performance of the surgical procedure) (Section 101); ambulance services (Section 5); or non-implantable prosthetic devices and durable medical equipment (other than those that serve the function of a case or splint or are otherwise considered integral to the performance of a covered surgical procedure) (Section 60).

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.
4.06 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.
4.07 **REIMBURSEMENT**

Reimbursement for covered services shall be made as described below. The reimbursement rate is an all-inclusive rate and covers the facility costs described in 4.04(A).

4.07-1 **Reimbursement** is based on a fee schedule. The fee schedule reimburses at 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.

4.07-3 **Reimbursement of Physician Services for Covered Services in an ASC**

Physician services for covered surgical procedures will receive separate payment under MaineCare Benefits Manual, Section 90, Physician Services. The reimbursement rate for services delivered with ASC as the Place of Service (POS) will receive the facility rate set forth in the physician fee schedule located at: [https://mainecare.maine.gov/](https://mainecare.maine.gov/).

4.08 **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.