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45.01 **DEFINITIONS**

* + 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 340 B participation is at: <http://www.hrsa.gov/opa/>.
    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.
    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.

45.01-10 **Certified Intentional Peer Support Specialist (CIPSS)** means an individual who has completed the DHHS Office of Behavioral Health (OBH) curriculum for CIPSS and receives and maintains certification.

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

45.04 **COVERED SERVICES** (cont.)

(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.

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.

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

1. a physician referral for all participants.

45.04-8 **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

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.

45.04-10 **Outpatient Partial Hospitalization Services**

**Provider Requirements**: Outpatient Partial Hospitalization services can be offered only in Acute Care Non-Critical Access Hospitals or in an Acute Care Non-Critical Access hospital-based clinic or in a distinct part of the Acute Care Non-Critical Access Hospital, if listed in the Hospital’s license. This service is not covered in free standing clinics.

Outpatient Partial Hospitalization Programs (OPHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a OPHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

Outpatient Partial Hospitalization is active treatment that incorporates an individualized treatment plan which describes the coordination of services wrapped around the particular needs of the member. Services include a multidisciplinary team

45.04 **COVERED SERVICES** (cont.)

approach to patient care under the direction of a physician. Partial hospitalization services include:

1. Individual or group therapy;
2. Occupational therapy;
3. Care management/care coordination;
4. Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;
5. Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 C.F.R. 410.29);
6. Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the Member’s diagnosed condition and for progress toward treatment goals;
7. Family and/or natural support counseling services for which the primary purpose is the treatment of the Member’s condition;
8. Member training and education, to the extent the training and educational activities are closely and clearly related to the Member’s care and treatment of his/her/their diagnosed psychiatric condition; and
9. Medically necessary diagnostic services related to mental health treatment.

Covered services delivered by the multi-disciplinary team must be provided by practitioners acting within the scope of their licensing or certification. Practitioners include, but are not limited to:

1. Physician, Psychiatrist;
2. Physician Assistant;
3. Nurse Practitioner;
4. Registered nurse, Licensed Practical Nurse, Certified Nursing Aide;
5. Psychologist;
6. Licensed Master of Social Work and Conditionally Licensed Master of Social Work;
7. Licensed Clinical Professional Counselor and Conditionally Licensed Clinical Professional Counselors;
8. Licensed Marriage and Family Therapists and Conditionally Licensed Marriage and Family Therapists;
9. Certified Intentional Peer Support Specialist;
10. Occupational Therapists;
11. Speech Therapists;
12. Other staff qualified to treat mental health conditions.

To be eligible for partial hospitalization services, the member must need more active and inclusive treatment than is provided in an outpatient service, but not need full-time hospitalization or institutionalization. Upon admission, a physician must certify that the member admitted to Partial Hospitalization Services would require inpatient

45.04 **COVERED SERVICES** (cont.)

services if partial hospitalization services were not provided. The certification must identify the diagnosis and psychiatric need for partial hospitalization. Services must be delivered according to an individualized plan of care and must be reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

The individualized treatment plan must:

1. Be prescribed and signed by a physician;
2. Identify treatment goals, describes coordination of services, and designed to address the member’s identified needs;
3. Directly address the presenting symptoms;
4. Be used to evaluate the member’s response to treatment;
5. Describe ongoing efforts to restore the member to a higher level of functioning which will allow them to discharge to a lower level of care or remain in this level of care in order to prevent relapse or future hospitalization;
6. Identify any needed resources and supports upon discharge.

Outpatient Partial Hospitalization Services must be documented on a progress note that must include:

1. Date of service and duration of service (including time in/time out);
2. A description of the nature of the treatment service provided;
3. The member’s response to the therapeutic intervention and its relation to goals indicated on the treatment plan;
4. Signature of the practitioners delivering services.

Members in OPHP may be discharged by either stepping up to an inpatient level of care, which would be required for Members needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the Member’s clinical condition improves or stabilizes and they no longer require structured, intensive, multimodal treatment.

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.

45.05 **RESTRICTED SERVICES** (cont.)

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 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.

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 **RESTRICTED SERVICES** (cont.)

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.

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

Effective April 1, 2013, all hospitals must inform patients who are in days awaiting NF placement, in writing, of their right to twenty (20) overnight leaves of absence per state fiscal year (July 1st through June 30th).

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

1. The patient's plan of care provides for such an absence;
2. The member takes no more than a total of twenty (20) therapeutic overnight leaves of absence per state fiscal year;
3. 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

45.06 **NON-COVERED SERVICES** (cont.)

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 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:

45.07 **POLICIES AND PROCEDURES** (cont.)

1. 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.

**Hospital Discharge Instructions**. Hospital Emergency Departments are required to provide discharge instructions that include contact information for appropriate Health Home providers (including Opioid Health Home, Behavioral Health Home, and Health Home Services – Community Care Team providers) to eligible individuals with chronic conditions, including opioid use disorder, serious and persistent mental illness, and serious emotional disturbance.

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

45.07 **POLICIES AND PROCEDURES** (cont.)

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.

45.07-3 **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 for Family Independence.

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.

1. 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:

1. The member has been a resident in a NF and desires to return to that NF and can receive appropriate care; or
2. 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.

* 1. **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 Supplemental Security Income rules. The Medical Review Team (MRT) at the Office of Family Independence makes the disability determination as part of the application process.

* 1. **ELIGIBILITY FOR HOME CARE FOR CHILDREN ELIGIBLE THROUGH THE KATIE BECKETT 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:

1. 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

45.09 **ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA FOR PSYCHIATRIC UNIT AND DETOXIFICATION SERVICES** (cont.)

basis are required. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour day basis.

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.

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:

* 1. Member must have Substance – Use or Substance-Induced Disorder based upon DSM-5; and
  2. 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**

1. 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:

**MaineCare Payment for Service Maximum Member**

**Co-payment Per Day**

$10.00 or less $ .50

$10.01 - 25.00 $1.00

$25.01 - 50.00 $2.00

$50.01 or more $3.00

1. 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.
2. 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.

1. 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 340B hospitals) are exempt from this requirement.

Hospitals are responsible for updating their enrollment applications, and submitting an updated 340B Provider Agreement 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 any PA that is required under Section 90 of the *MaineCare Benefits Manual* has been approved in accordance with that Section.