PT 28-99

State of Maryland
Department of Health and Mental Hygiene

Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Hospital Transmittal No. 169
Managed Care Organization Transmittal No. 13
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Hospital Administrators
Managed Care Organizations

FROM: Joseph M. Millstone, Director
Medical Care Policy Administration

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

Hospital Administrative Days

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The Medical Assistance Program pays Administrative day rates to hospitals for Medicaid recipients who have received a determination from the Department or the Department's designee that the recipient no longer needs the level of care for which the hospital is licensed to provide, but is awaiting discharge to nursing facilities or other placement as described in COMAR 10.09.06.10.

The Department of Health and Mental Hygiene has included Administrative Day payments in the capitation rates paid to Managed Care Organizations beginning July 1, 1997, the start date of the HealthChoice Program. Managed Care Organizations were responsible for payment of administrative days to hospitals in conformance with regulations at COMAR 10.09.06.10. A. Hospitals can and should bill MCO's for administrative days.

Please direct any questions on this transmittal to the Medical Care Policy Administration, Division of Medical Services at (410) 767-1455.

E. A hospital is not eligible for administrative day reimbursement if the:

(1) Hospital bills the Program for days of care for which the hospital is licensed to provide; and

(2) Program or the Program's designee determines that the recipient no longer required that level of care for those days.

F. The Program pays room and board charges for the day of admission, and does not pay room and board charges for the day of discharge from the hospital.

G. Recipient's Resource.

(1) The local department of social services shall determine the amount of a recipient's resource available to pay toward the cost of medical or remedial care for inpatient services, and so inform the provider.

(2) The provider shall collect from the recipient the resources as shown on the designated form.

(3) The provider may not collect a total payment, including the recipient's resource and the Department's payment, which exceeds the provider's rate established by the Department or its designee.

(4) The provider shall show sums collected from a recipient's available resource as patient collections.

H. The provider shall submit request for payment on the form designated by the Department.

I. The provider shall submit with invoices, properly completed attachments as requested by the Department.

J. A provider may not bill the Program a charge exceeding that charged the general public for similar services.

K. Payments on Medicare claims are authorized if:

(1) The provider accepts Medicare assignment;

(2) Medicare makes direct payment to the provider;

(3) Medicare has determined that services were medically justified;

(4) The services are covered by the Program; and

(5) Initial billing is made directly to Medicare according to Medicare guidelines.

L. Payment on Medicare claims is made subject to the following provisions:

(1) Deductible and co-insurance, according to the limits of §H of this regulation, shall be paid subject to the HSCRC discounts, except in the case of a recipient receiving hospital services in an out-of-State facility, in which case deductible and co-insurance shall be paid in full; or

(2) Services not covered by Medicare, but by the Program, if medically justified according to §H of this regulation.

M. The provider may not bill the Department for:

(1) Completion of forms and reports;

(2) Broken or missed appointments;

(3) Professional services rendered by mail or telephone; or

(4) Services which are provided at no charge to the general public.

N. The Department will make no direct payment to the recipient.

O. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.06. The term "date of service" in COMAR 10.09.36.06 means the date of discharge or outpatient service.

P. The Department reserves the right to return to the provider, before payment, all invoices not properly completed.

Q. The provider shall submit claims for services rendered to Health Maintenance Organization—Medical Assistance (HMO-MA) enrollees to the HMO within 6 months of the date of discharge or outpatient services.

.11 Recovery and Reimbursement.

A. If the recipient has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for services covered by this chapter, the provider shall seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by the Medical Assistance Program, the provider may submit a claim to the Program. The provider shall submit a copy of the insurance carrier's notice or remittance advice with the provider's invoice. If payment is made by both the Program and the insurance or other source for the same service, the provider shall report, within 15 days after the close

described in 42 CFR 413, or on the basis of charges if less than reasonable cost. There shall be year-end cost settlement.

.10 Billing and Reimbursement Principles.

A. Administrative Days. To be paid for administrative days, the provider shall document on forms designated by the Department information which satisfies the conditions listed below:

(1) The recipient no longer needs acute general, special psychiatric, or other special hospital care, and the following conditions are met:

(a) The provider has:

(i) Implemented a predischarge plan and initiated placement activities for the recipient, and

(ii) In effect a plan for discharge during the period of administrative days, is actively pursuing placement at an appropriate level of care for the recipient, and has documented this activity in the recipient's record;

(b) If a hospital other than a special psychiatric hospital, the provider has:

(i) Received a determination from the Department or the Department's designee that the recipient no longer needs the level of care for which the hospital is licensed to provide,

(ii) Received a determination from the Department or its designee that the recipient requires the level of care provided by a special hospital, nursing facility, intermediate care facility, intermediate care facility-mental retardation, or a mental hospital, and a bed in an appropriate facility is not available,

(iii) Notified the Department's utilization control agent of predischarge planning before the termination of the need for inpatient hospitalization at the level the facility is licensed and certified to provide, and obtained a level of care determination from the agent,

(iv) Except for hospitals in noncontiguous states, submitted documentation to the utilization control agent that placement activity was conducted on each workday for which payment is requested for administrative days;

(c) If a special psychiatric hospital, the provider has:

(i) Determined that the recipient no longer needs the level of care for which the hospital is licensed to provide,

(ii) Immediately upon admission of a recipient who is at risk of a residential treatment center placement after discharge, notified the local agency responsible for development of the discharge treatment and education plan of the potential placement,

(iii) Determined that the recipient requires the level of care provided by a residential treatment center, and a bed in a residential treatment center is not available,

(iv) Notified, before the termination of the need for inpatient psychiatric hospitalization, local coordinating councils and any other local agency, as appropriate, of the necessity to continue inpatient psychiatric service at a residential treatment center.

(2) The recipient is at an inappropriate level of care but cannot be moved, and the following conditions are met:

(a) The attending physician has declared that, because of physical or emotional problems, the recipient is unable to be moved,

(b) The reason the recipient cannot be moved is adequately documented by the attending physician in the recipient's medical record, and

(c) Reevaluation by the attending physician of the recipient's inability to be moved and appropriate documentation of this in the recipient's record have been made at least every 3 days in acute general hospitals and every 14 days in chronic and special psychiatric hospitals.

B. During the period of administrative days, the utilization control agent shall review the documentation in increments of not more than 14 days for administrative stays in special hospitals other than psychiatric hospitals or not more than 3 days in acute general hospitals.

C. Payment for approved administrative days shall be the lesser of:

(1) An estimated State-wide average Medicaid nursing home payment rate as determined by the Department; or

(2) If the hospital has a unit which is a skilled nursing facility, the allowable costs in effect under Medicare for extended services provided to patients of the unit.

D. Payment for approved administrative days for a special psychiatric hospital seeking placement of a recipient to a residential treatment center shall be the average residential treatment center rate issued pursuant to COMAR 10.09.29.13B.