

**Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION**

**Chapter 03 Types and Classes of Charges Which Cannot Be  
Changed Without Prior Approval.**

**Authority: Health-General Article, §§ 19-207, 19-210, 19-212, 19-215,  
19-217, 19-219, and 19-220**

**Annotated Code of Maryland**

**.01 Changes in Rates.**

A hospital may not increase any existing rate or charge of any class or type or impose any new rate or charge of any class or type without the approval of the Commission, except for those changes specifically excepted by regulation or order of the Commission.

**.02 Changes in Unit Rates.**

A. A hospital may vary its unit rates within any 100 percent inpatient patient care center without prior Commission approval, if the variation does not change the average charge per unit of service as prescribed in the Commission's Rate Review System.

B. A hospital may not vary its unit rates within any ancillary or ambulatory center without prior Commission approval if the Commission's Rate Review System prescribes a unit of service for that center.

**.03 Rates for Auxiliary Enterprises or Other Institutional Program.**

Any hospital may change without prior approval of the Commission its unit rate or rates in any auxiliary enterprise or other institutional program as these centers are defined in the Commission's Uniform Accounting and Reporting System and the Commission's Rate Review System.

**.04 Rates for New Services.**

Any hospital may institute a rate for a new patient care service if the rate is less than \$100 and does not change the average charge per unit of service for the patient care area in which the new patient care service is being provided.

**.05 Overcharges and Undercharges by Hospitals.**

A. For purposes of this regulation, the following definitions apply:

## 10.37.03.05G

(1) “Overcharge” means any charge for a hospital service under the jurisdiction of the Commission that is in excess of its approved rate.

(2) “Undercharge” means any charge for a hospital service under the jurisdiction of the Commission that is less than its approved rate.

B. When any hospital overcharges by more than the allowed corridors, as defined in §G of this regulation, that overcharge shall be recovered in prospective rates at 140 percent plus appropriate interest factors.

C. When any hospital overcharges less than the allowed corridor, as defined in §G of this regulation, that overcharge shall be reduced from prospectively approved rates at the actual amount of overcharge plus appropriate interest.

D. When any hospital undercharges more than 2 percent in obstetrics, nursery, labor and delivery, clinic, emergency rooms, pediatrics, or intensive care units, that undercharge may not be recovered in prospective periods.

E. When any hospital undercharges less than 2 percent in the patient service centers listed in §D of this regulation, that undercharge shall be added to prospectively approved rates at the actual amount of undercharges.

F. When a hospital undercharges beyond the allowed corridors, as defined in this section, the amount of undercharge in excess of the corridors less 40 percent shall be added to prospectively approved rates. These allowed undercharge corridors are defined as follows:

- |     |  |           |
|-----|--|-----------|
| (1) | Patient care areas, when the unit of service is a Patient day, not listed in §D of this regulation | 3 percent |
| (2) | Admissions center  | 3 percent |
| (3) | Ancillary service areas and ambulatory service Areas not listed in §D of this regulation           | 5 percent |

G. Overcharge Corridors and Pricing for Medical/Surgical Supplies and Drugs.

- (1) The allowed overcharge corridors are defined as follows:

## 10.37.03.06

(a) Daily patient care areas, ambulatory service Areas, and admissions center	2 percent
(b) Labor and delivery room	3 percent
(c) Renal Dialysis	5 percent
(d) Ancillary service areas other than labor And delivery room and renal dialysis	3 percent

10. There are no price corridors for medical/surgical supplies and drugs.

H. Notwithstanding the above, if any hospital's net overcharges are more than 1 percent of the hospital's total approved revenue, that overcharge shall be recovered in prospective rates at 140 percent plus appropriate interest factors.

10. In cases when a flagrant disregard of approved rates is found, the Commission may require direct repayment of overcharges and penalties to those patients who were overcharged.

J. The Commission may assess penalties as described above for rates approved effective July 1, 1978.

**.06 Change in Hospital-Based Physician Compensation Source.**

10. Each hospital shall promptly submit a rate application to the Commission for a change in rates whenever the source of a hospital-based physician's or physician support personnel's compensation has been modified (for example, a hospital-based physician previously compensated by the hospital commences billing for service or CRNA's previously compensated by the hospital are replaced by physicians billing fee for service).

B. Any rate application submitted under the requirements of §A, above, shall relate only to those changes in rates resulting from a modification in the source of a hospital-based physician's or physician support personnel's compensation.

C. Failure to submit a rate application as required under §A, above, shall subject the hospital to overcharge/undercharge penalties, as specified in Regulation .05, above, as if those funds presently provided for in rates and obtaining to the source of a hospital-based physician's compensation had not originally been approved.

## 10.37.03.09

**.07 Change in Education Programs.**

10. Each hospital shall promptly submit a rate application to the Commission for a change in rates whenever an educational program conducted by the hospital has been modified (for example, the loss a school of nursing program, the loss of resident/intern program, or a decrease in the number of students enrolled in the program).

B. Any rate application submitted under the requirements of §A, above, shall relate only to those changes in rates form a modification in an educational program conducted by a hospital.

C. Failure to submit a rate application as required under §A, above, shall subject the hospital to the overcharge/undercharge penalties as specified in Regulation .05, above, as if those funds presently provided for in rates and obtaining to the hospital's educational program had not originally been approved.

**.08 Rates for Identified Physician Cost.**

10. Any hospital which incurs or accrues costs as a result of professional medical services which are personally rendered for an individual patient by a physician, and which contribute to the diagnosis or treatment of an individual patient, shall account for those costs as an Identified Physician Cost in accordance with the "Accounting and Reporting System for Hospitals" manual which is incorporated by reference in COMAR 10.37.01.02A(2).

B. All those identified physician costs shall be charged to the individual patient as a separate charge and any bill rendered to a patient for those costs shall clearly and separately itemize those services and charges which are attributable to an identified physician cost.

C. Any hospital may change without prior approval of the Commission its unit or rates for any identified physician cost as that center is defined in the Commission's "Accounting and Reporting System for Hospitals" and the Commission's "Rate Review System" which is incorporated by reference in COMAR 10.37.10.02B.

D. The provisions of this regulation shall apply to all General Acute Care hospitals from October 1, 1983 and after that.

## 10.37.10.10A

**.09 Rates for Non-Physician Services Provided to Hospital Inpatients by Third-Party Contractors.**

A. A non-physician inpatient service is defined as a hospital service under the jurisdiction of the Commission provided by a third-party contractor to a hospital inpatient off-site of the hospital. The charge for this service shall be billed by the hospital.

B. The allowable rate shall be equal to or less than the Statewide median or price standard as developed by staff.

C. The same rate on average shall be charged to all inpatients, regardless of payor.

D. The sum of the rate charged to a hospital inpatient and the professional component, if any, on average, shall be not greater than that charged on average by the third-party contractor to its other patients for the sum of both components of the same service.

E. The hospital shall provide an audit by an independent CPA that the contractor is in compliance with §D of this regulation.

F. The hospital shall be at risk for any payment made to a contractor in excess of the allowable charge determined in accordance with §B of this regulation.

G. The Commission shall waive COMAR 10.37.10.07A, which requires a rate application be filed at least 60 days before the opening of a new service, for rate applications approved under this regulation.

H. The sections of this regulation are non-severable and the entire regulation shall be null and void 60 days after a Court of competent jurisdiction rules that any portion or section of this regulation is beyond the jurisdiction of the Commission.

**.10 Rates for Services with Revenues Exempt from Commission Jurisdiction**

A. Generally. The Commission may, on its own or upon application from a hospital, permit charges for services to be changed without its prior approval in those cases when  $66 \frac{2}{3}$  percent or more of the annual gross patient revenue attributable to the services is derived from either Medicaid or Medicare patients, or both, who are not required by State law or by the terms of the Medicare Waiver to pay Commission-approved rates for those services. The Commission shall consider this action only in those instances when the annual gross revenue for nonphysician services is not more than \$20 million (in 1996 dollars), adjusted by an appropriate index of inflation, or when the annual gross revenue subject to Commission rate setting is not more than \$5 million (in 1996 dollars) adjusted by an appropriate index of inflation.

## 10.37.03.10G

B. Filing of Application. A hospital seeking a rate-setting exemption under this regulation shall file a written application with the Commission identifying the service or services for which the exemption is requested. The application shall contain accurate and supporting documentation that the conditions set forth in §A of this regulation have been met for a minimum period of 12 months immediately before the application. The filing of an application for a rate-setting exemption does not constitute a contested case within the meaning of that term as defined in the Administrative Procedure Act.

C. Review of Application. The Commission staff shall review the application within a reasonable period of time and prepare a written recommendation on the request to the Commission. The decision to grant or deny the application rests within the sound discretion of the Commission.

D. Required Reports. A hospital granted an exemption under this regulation is required to file quarterly reports, in a manner to be prescribed by the Commission, in order to verify that the conditions set forth in §A of this regulation still obtain. The hospital shall continue to file all other required reports in conformity with the Commission's Accounting and Budget Manual for Fiscal and Operating Management (the Manual), which is incorporated by reference under COMAR 10.37.01.02.

E. Attestation. Responsible officials of an applicant hospital are required to attest that, to the best of their knowledge and belief, the reports filed, as required under §D of this regulation, have been prepared in conformity with the Commission's uniform accounting and financial reporting system as set forth in the Manual.

F. Further Investigation. If the Commission considers a further investigation necessary or desirable to authenticate information reported by a hospital seeking rate-setting exemption, the Commission may take further examination of the records or accounts of the hospital in accordance with the rules or regulations of the Commission.

G. Termination of Exemption. The Commission may terminate an exemption granted under this regulation at any time for cause.