Report of the

State Level Provider and CDS Site Director

Workgroup

To the Joint Committee on Education

and Cultural Affairs

January 15, 2001

I. Purpose

In a letter to the Commissioner of Education dated March 21, 2000 the Joint Committee on Education and Cultural Affairs requested the department implement several related tasks and report back. The actions the committee requested that the department take are as follows:

- "To establish a joint State Level Provider and CDS Site Director Committee to:

    1. Develop recommendations for improved quality and consistency of service;
    2. Examine professional development to promote effective practices in serving eligible children;
    3. Review and refine adequacy and consistency of documentation for justification and continuation of direct service hires; and
    4. Implement time studies of CDS in-house staff and of a sample of independent contractors.

- To monitor the implementation of the Chapter 181, Regional Provider Advisory Board rule, which states that:

    1. The regional provider advisory boards will meet on a regular basis; and
    2. The regional provider advisory board will meet with the regional Boards of Directors of the CDS sites on a regular basis."

A written report to the committee is due by January 16, 2001 which includes a response to the requests contained in the letter of March 21, 2000 to Commissioner Albanese, and update on the implementation of the statutory changes resulting from the original resolve and an accounting of the number of direct hires by site for 2000.

II. Committee Convened

Letters of appointment were sent to workgroup members on June 5, 2000. The workgroup is composed of six regional CDS site directors, six providers (three nominated by the Department and three by the Early Intervention Coalition) and two Department staff. The workgroup had its first meeting June 21, and has had five additional meetings to date (July 27, September 28, October 26, November 16, 2000 and January 12, 2001).

At the initial meeting the workgroup reviewed its charge and agreed to keep the focus on systemic issues, to approach discussions with the primary goal being to offer the best services to children with disabilities 0-5 years of age, to keep a future focus with the department to make the committee a productive forum, and to operate by consensus. At that time each workgroup member shared his/her 2-3 critical issues. At the second meeting of the group in July, the workgroup agreed to focus on the four primary areas of the charge and incorporated the prioritized issues from the June meeting within each of the four topics. Subcommittees were established as follows:

- **Review and refine adequacy and consistency of documentation for justification and continuation of direct service hires**

A Subcommittee has refined the direct service hire form and developed a uniform document to record consultation with providers. It has been suggested that data, regular periodic information, be provided to local service provider advisory boards regarding trends in timeline compliance for evaluations, and number of children with unmet service needs to assist the service provider community in being aware of the needs and changes in the CDS System, which may help to eliminate some of the "surprise" that occurs in the direct hiring process. The subcommittee discussed the need to focus collaborative development of capacity-contracted capacity, if feasible, in house capacity, if necessary-to ensure timely services to children.

- **Implement time studies of CDS in house staff and of a sample of independent contractors.**

The State Office of CDS implements at least two time studies a year of the direct hires in the system

Independent contractors have not completed time studies to date.

IV. Update on Statutory Changes

A comprehensive audit of all regional CDS sites by a single auditor was completed in December 2000.

V. Accounting of the Number of Direct Hires by site for FY 2000

Charts in Appendix

VI. Next Steps

The committee has scheduled a meeting for February 23, 2001 at which time the group will review outstanding issues and will develop a workplan for the remainder of this fiscal year.

Letter

to

Commissioner

Stratford - C

STATE OF MAINE

ONE HUNDRED AND NINETEENTH LEGISLATURE

COMMITTEE ON EDUCATION AND CULTURAL AFFAIRS

March 21, 2000

MAR 23 2000

J. Duke Albanese
Commissioner
Department of Education
#23 State House Station
Augusta, ME 04333

Dear Commissioner Albanese:

As you know, LD 2304, Resolve, to Evaluate Accountability of the Child Development Services Delivery System, proposed that the Department of Education contract for an independent audit of the practice of CDS sites hiring professional staff therapists under certain circumstances. While the committee will not be reporting the resolve out favorably, we are proposing some statutory changes in the process for hiring site therapists.

One of the areas that the committee will address in its legislation is our belief that a regional site board of directors or its designee should consult with the provider advisory board in its region before seeking approval of the department to hire professional therapists as site staff. We understand that, used in this context, the term "consult" may be interpreted in different ways. The committee has purposefully employed only the broad term, rather than attempt to micromanage how the consultation must occur. We have done that in order to provide the greatest amount of flexibility for both the regional CDS sites and provider advisory boards and to encourage the maximum degree of communication between them.

If our proposed statutory language is enacted, we anticipate that the regional site boards of directors will communicate with their respective provider advisory boards as they consider the employment of professional staff. We hope that the provider advisory board members are able to provide information about the current capacity of independent contract providers in the affected discipline to serve the number of children in need of service and to provide constructive comments in a timely manner, so that the regional board can assure that the needed services are provided

In addition to our legislative recommendations, the committee also requests that the department implement several related tasks and report back next year. The actions the committee requests that the department take are as follows:

- To establish a joint State Level Provider and CDS Site Director Committee to:

    1. Develop recommendations for improved quality and consistency of service;
    2. Examine professional development to promote effective practices in serving eligible children;
    3. Review and refine adequacy and consistency of documentation for justification and continuation of direct service hires; and
    4. Implement time studies of CDS in-house staff and of a sample of independent contractors.

- To monitor the implementation of the Chapter 181, Regional Provider Advisory Board rule, which states that:

    1. The regional provider advisory boards will meet on a regular basis; and
    2. The regional provider advisory board will meet with the regional Boards of Directors of the CDS sites on a regular basis.

Please submit a written report to this committee by January 16, 2001 that includes a response to the requests contained in this letter, and update on the implementation of the statutory changes resulting from the original resolve and an accounting of the number of direct hires by site for 2000. Thank you for your attention in this matter. If you have any questions, please contact us.

Sincerely,

Sen. Georgette Berube

Sincerely,

Rep. Michael Brennan

Committee Membership

State Level Provider CDS Director Committee

name	add1	add2	add3	csz	phone (w)	fax	email
Bette Woodbury	Headstart Com. Conc	P.O. Box 278		South Paris, ME 042	(207) 743-1520		bwoodbury@community-concepts.org
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Kathy Burgess	Pine Tree Society	149 Front Stre		Bath, ME 04530	(207) 443-3341		
Kathy Seitel, Dir.	CDS Penobscot Cty.	In Town Plaz	376 Harlow St.	Bangor, ME 04401	(207) 947-8493	(207) 990-4819	
Lori Whittemore, Dir.	CDS Cumberlande Ct	999 Forest Av		Portland, ME 04103	(207) 878-8611	(207) 878-6980	
Mr. Michael Towey	Waldo County Gener	P.O. Box 287		Belfast, ME 04915	(207) 649-2536		speech@wchi.com
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Pam Edgecomb	12 High Street	Suite 102		Lewiston, ME 04240	(207) 777-1010	(207) 753-0477	
Pam Libby, Director	CDS Opportunities	PO Box 272,		Norway, ME 04268	(207) 743-9701	(207) 743-7063	cdshopp@gwi.net
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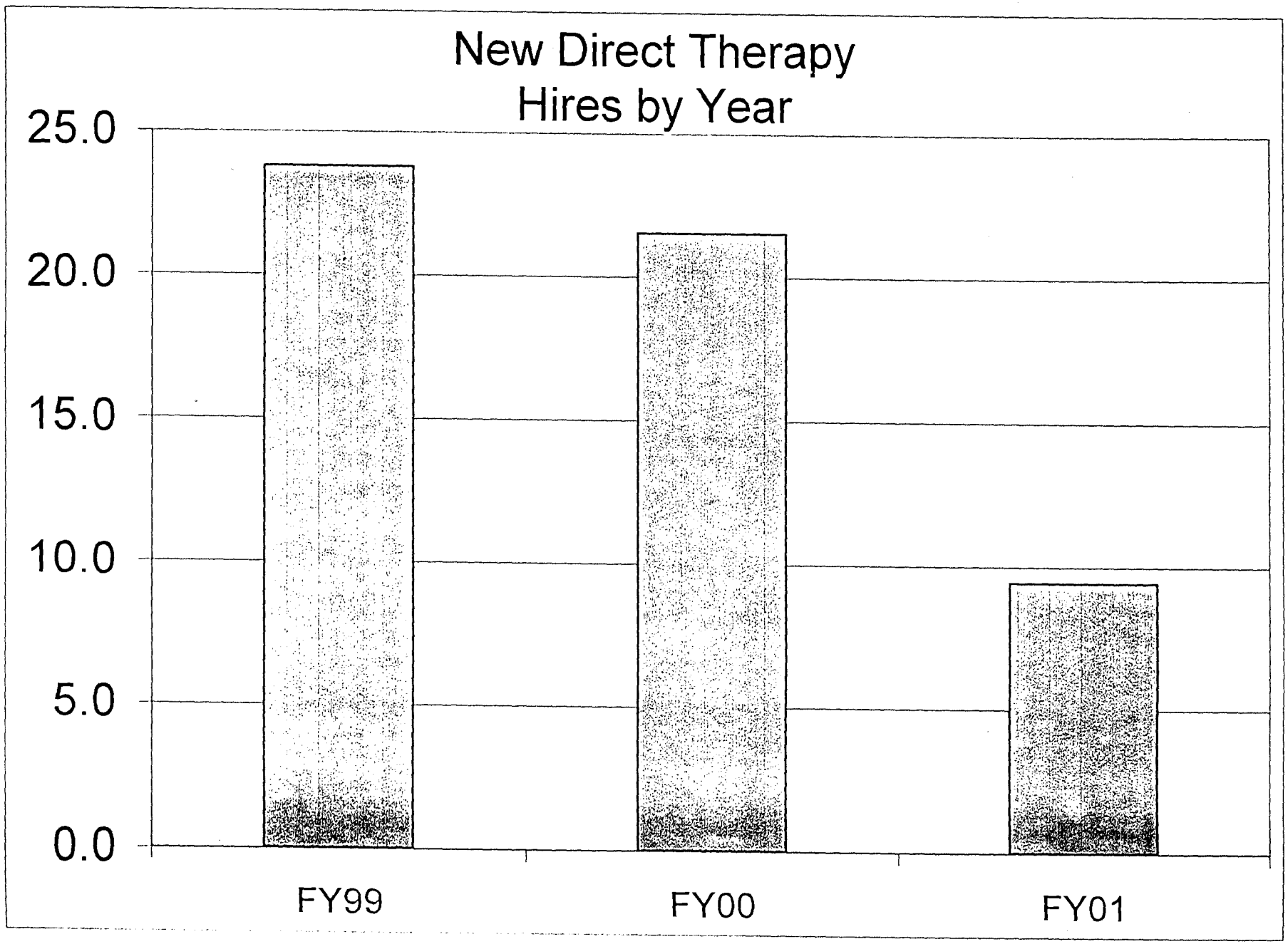
Yellow Light Breen	Dept. of Education	23 State Hous		Augusta, ME 04333	(207) 624-6620	(207) 624-6601	

Direct Hire

Data


New Direct Therapy
Hires by Year
25.0
20.0
15.0
10.0
5.0
0.0
FY99
FY00
FY01

Child Development Services
FY01
Direct Hires

A. State Staff Therapist is needed to perform evaluations to insure compliance with Chapter 180

	# of FTE's	Average # of Children Per Month waiting for evaluations	Average # of Days per Month over timelines	Site
ST	0.5	5	28	Penobscot
PT	1.0	2	50	Search
OT	1.0	5	31	York
PT	1.0	2	45	York
	3.5			

B. Therapists who service children on a contractual basis are unable to provide required reports or services within timelines.

	# of FTE's	Average # of Children Per Month waiting for evaluations	Average # of Days per Month over timelines	Site
DT	3.00	8	Unmet	Cumberland
DT	0.20	1	75	Knox
COT	0.20	2.25	19	Knox
OT	0.05	--	--	Knox
ST	0.50	5.6	57	Penobscot
DT	1.00	15	ould be Unserve	SoKennebec
	4.95			

C. Site Staff Therapist is able to provide services comparable to those provided by contract at an identifiable savings to the CDS System.

	# of FTE's	Cost of Employment	Cost to Contract	Identified Savings	Site
OT	1.0	19,100	25,626	6,526	Opportunities

FTE 9.45 Total Hires

Note: So.Kennebec changed several part time aides to 2 FTE's.
Note: York County has a need for OT services for 11.4 children who are over timeline by an average of 53.5 days. In addition, York County has a need for physical therapy services for 10children who are overtimelines by 25 days.

Direct Hire and Consultation Documentation Forms

irect Hire Justifications Site:_____ Date:_____

☐ A. Site Staff Therapist is needed to perform evaluations to insure compliance with Chapter 180.

☐ B. Therapists who service children on a contractual basis are unable to provide required reports or services within timelines mandated by IDEA.

☐ C. Site Staff Therapist is able to provide services comparable to those provided by contract at an identifiable savings to the CDS System.

A	B	C	D	E	F	G
Provider Type OT, PT, ST, DT	Yearly Cost if Employed (Sal & Benefits)	Add 12% for Administrative Costs	Anticipated Med & Ins Reimb Amount	Net Cost for Employee (B+C-D)	Yearly Cost If Contracted	Identified Savings or (Cost Difference) (E - F)
			Anticipated wkly caseload: _____ Medicaid %:_____ Med Rate:$_____ Insurance%:_____Ins. Rate:$_____ Med. Rev. (wkly caseload x MM% x Med Rate) = $_____ Ins Rev (wkly caseload x Ins.% x Ins Rate) = $_____ Total Weekly Revenue $_____ Number of wks per year _____ Total Yearly Revenue $_____		Contract Rate $_____ Caseload ____ x (100 - Med%___ - Ins%) x Contract Rate = Weekly Cost: $_____ x number of wks per year _____ Total Yearly Cost: $_____	

NOTE: Please attach the appropriate timeline compliance reports and unmet need reports, minimally three months.

Documentation of Consultation
Child Development Services

Who Was Contacted?	Date	Agency Therapist	Capacity (Openings)	Capacity to Build # additional slots	Length of time to Build	Notes:

Note: Please attach minutes of the Regional Provider Advisory Board meeting at which discussion occurred.

Billing Manual

CDS OT/ST/PT "Getting ready to bill!" Resource Guide

January 2001

INTRODUCTION:

The goal of our subcommittee has been to develop billing policies that will lead to consistent practices. This billing resource is designed for CDS sites and the therapists to whom they refer children and their families.

By expediting the reimbursement process, we believe that provider/site relations will be improved. The billing resource manual, in this way, will support the improvemer of the early intervention system.

Respectfully submitted:

Cathleen Burgess
Pamela Libby
Pamela Edgecomb

DEFINITION OF TERMS

Acceptable Denial: 1. Clients services are maximized
2. Identified Services are not covered by client's insurance.
3. Developmental Delay Diagnosis is not covered by the client's insurance.
4. Deductible not met

CDS Fiscal Year: July 1st to June 30th.

Credentialing: The application process that a site and/or a provider goes through to be able to participate with third party billing; process of becoming enrolled with insurances

Cycle: Cycles may vary by payor. Generally defined as the time period between the bill submission and receipt of payment for provided services. .

Deductible: The dollar amount that individual families are responsible for before insurances begin to pay for services.

DT - Developmental Therapy

Enrolled Provider: Any provider who is contracted with CDS

Lifetime Cap: Maximum amount of payout that an insurance will pay over the client's life time.

Medicaid: State and federally funded insurance.

Minimal Insurance Participation the willingness to enrolling with Anthem/ Bx; HealthSource/Cigna; Aetna; Medicaid

OT: Occupational Therapy

Other payers: All other insurances

PT: Physical Therapy

Referral: Request insurance or Maine Prime Care referral from the Primary Care Physician

Respective Services: OT, PT, ST

Service Providers Direct site hires as well as community service providers.

Service Coordinators The CDS employees who provide case management.

Script: Order from Physician for services

ST: Speech Therapy

Third party billing Accessing funding for O.T., PT, ST, DT from insurances including Medicaid

Year Cap: Maximum amount an insurance will pay for over the course of a year.

CPT-4 Codes: Current Procedural Terminology Codes

ECT: Early Childhood Team

EOB: Explanation of Benefits (What the insurance companies usually attach to denial with reasc for denial.)

HCFA: Healthcare Finance Administration Form

HMO: Health Maintenance Organization

ICD-9: International Classification of Diseases - 9th Revision (Diagnosis Codes)

IEP: Individual Education Plan

IFSP: Individualized Family Service Plan

PCP: Primary Care Physician

PPO: Preferred Provider Organization

Insurance Contact Information:

1. **Aetna U.S. Healthcare**
   HMO: 1-800-624-0756
   PPO: 1-800-818-2386

2. **Anthem Blue Cross** See page 3B for Additional Network numbers 1-800-832-6011
   Blue Shield
   Central Maine Partners Health Plan
   Maine Partner Health Plan
   Federal Blue Cross Employees 1-800-722-0203

4. **Cigna (Healthsource) Healthcare of Maine:**
   Cigna Only: 1-800-636-8459 or 1-800-280-7651
   Healthsource 1-800-909-2227 or 1-800-585-9435

5. **Medicaid - See page 3A**
   NYLCARE: 1-800-695-8717
   Health works (Primecare) 1-800-977-6740
   (SEE INSERT).

ADDITIONAL THIRD PARTY PAYERS SPECIFIC TO REGIONAL AREAS WILL HAVE TO BE ADD

Regional Payers:

6. **Martin's Point** -
   1-800-3122-0280

7. **TriCare**
   1-800-578-1294 (South Carolina)
   373-7603 (Paul Saucier- Brunswick)

INFORMATION EXCHANGES

I. Evaluation information exchange:

Placed in the appropriate/optimum order of events:

ACTION	RESPONSIBLE PARTY(ies)
1. Child is identified as needing evaluation	**Service Coordinator**
2. A. Initial referral is made for evaluation to service provider	**Service Coordinator**
B. All insurance (for all insurances) and demographic information for all insurances is forwarded with the referral **to service provider .**	**Service Coordinator**
Insurance information to include: a) Name of insurance b) Policy numbers c) Insurance contact phone numbers and addresses d) Expiration Date e) Who the insurance is through f) "Bill to" information	
3. Contact PCP to obtain an insurance or Maine Primecare referral and a script for service. Information to have ready for PCP office a. Patient name b. Patient date of birth c. Patient's insurance company d. Reason for the request	**Service Provider/Parent**
4. Within 5 business days from receipt of referral, insurance is contacted todetermine eligibility of funding Information to have ready for the third party request: a) Member enrollee number b) Plan number c) Certificate number d). Benefit riders e) Referral request f) Primary care physician name	**Service Provider**
5. Within 5 business days from receipt of referral the family is contacted and the evaluation is scheduled.	**Service Provider**
6. Evaluation is completed, report written and forwarded to CDS Service Coordinator within 20 calendar days from date of referral	**Service Provider**
7. ECT is held to determine eligibility for services	**All appropriate team members**
8. If the child is identified as needing services see page 5 Service Information Exchange Page	

II. Service Information Exchange

1. A. Referral is made to service provider for services — **Service Coordinator**
   B. All available insurance (for all insurances) and demographic information is forwarded with the referral to service provider
   Information to include — **Service Coordinator**
   a) Name of insurance
   b) Policy numbers
   c) Insurance contact phone numbers and addresses
   d) Expiration Date
   e) Who the insurance is through
   f) "Bill to" information
   g) Diagnosis code
   h) Frequency, duration and intensity of service

2. Contact with PCP occurs to obtain insurance referral for services and a script. Information to have ready for the PCP's office — **Service Provide/Parent**
   a. Patient name
   b. Patient date of birth
   c. Patient's insurance company
   d. Reason for the request
   e. Diagnosis with ICD-9
   f. Duration, frequency and intensity of services
   (Evaluation should have been forwarded to the PCP)
   g. Indicate the date the service is to commence

3. Within 5 business days from when the PCP has been contacted, insurance is contacted to determine eligibility of funding information to have ready to tell the third party may include: — **Service Provider**
   a) Member enrollee number
   b) Plan number
   c) Certificate number
   d). Benefit riders
   e) Referral request
   f) Primary care physician name
   g) Diagnosis with ICD-9 Codes
   h) CPT-4 codes for services
   i) location of services (i.e, some insurances will only pay for home services from a homehealth agency)
   (Note: Written confirmation of approval should be requested from insurance)

4. If insurance approves coverage of services, information is obtained — **Service Provider**
   a) How many visits are approved?
   b) What is the time frame for use of the approved visits?
   c) Are there specific limitation of the policy?
      1) Is there a lifetime cap? Per family, per person. If yes, notify the CDS site.
      2) Is this an event coverage or an annual coverage cap?
      3) Is there a deductible? (if so, CDS pays the deductible.)
      4) Is there a co-pay? (if so, CDS pays the co-pay only if the received insurance rate is lower than the CDS contracted

rate. In that case, CDS will pay the difference between the contracted rate and the insurance rate.)

d) What is the appeal process if we feel we need more services?

5. If insurance does not approve coverage of services — **Service Provider**
   a) request a written denial from the Insurance company in the form of an EOB.
   b) If the child has Medicaid, a copy of an EOB is forwarded with completed HCFA form with dates of service to Medicaid — **Service Providers**
   c) If child does not have Medicaid, EOB is enclosed with bill for services to CDS for payment — **Service Provider**
   d) When providers are billing insurance, CDS will become the payor of last resort and the payment will be made when — **Service Provider**
      1) an acceptable denial is received from the insurance company in the form of an EOB;
      2) an insurance company folds, leaves the state, or will not provide necessary denials; or
      3) after 90 days from the initial billing the provider can show a history of submission and follow-up and if they still have not received payment for the service (s), then CDS becomes the payer. It is fully understood that any future reimbursement of funds would necessitate reimbursement to CDS. It is expected that follow-up will continue for all future services as stated above.

Standards of Participation

1. All CDS sites and contracted service providers are encouraged to become enrolled providers with the Minimal Insurance Participation group. This may include other significant third party payers as defined by the communit demographics. (Please refer to page 3).

2. Local CDS boards have the authority to contract with service providers who are not enrolled with the Minimal Insurance Participation group.

3. When appropriate, all attempts **will** be made to access 3rd party dollars to fund services for children. Upon first acceptable denial, the payer source will become CDS or Medicaid as appropriate.

4. Service coordinators, whenever possible, will provide service providers with complete and accurate informatic regarding all third party payers that cover that child including but not limited to:
   A) Name of insurance (s)
   B) Policy numbers
   C) Insurance contact phone numbers and addresses
   D) Expiration Date
   E) Who the insurance is through
   F) "Bill to" information
   (When possible, photocopying the front and back of the insurance card is suggested.)

5. No service providers shall be expected to enroll with any 3rd party payer whose reimbursement is 10% or more below the current Medicaid rate for respective services. In that case, CDS will pay the difference between the contracted rate and the insurance rate

6. While providers are going through the credentialing process, CDS will be the payer for services.

7. All attempts will be made to obtain prior authorization before the commencement of services, by the service provider. If therapy commences before the authorization is obtained, CDS **may,** at the site's discretion , beco the guarantor for payment of services until such time that authorization can be obtained. If within 90 days, t authorization **can not** be obtained see Page 6 number 5.

8. All service providers that are accessing third party funding must directly bill third parties for those services a can not request that CDS bill that third party for them.

Diagnosis Code List

Printed:

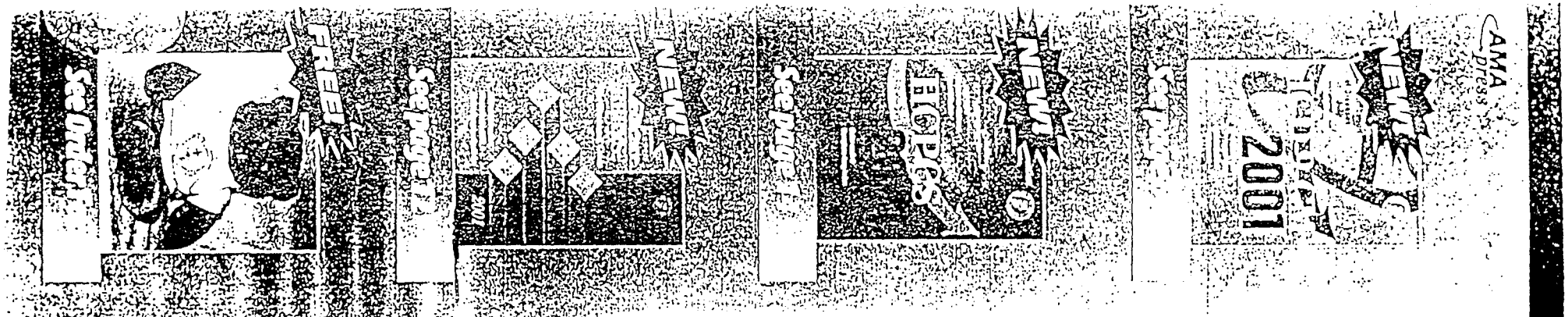
Report: M80

CODE	DESCRIPTION
333.1	Tremors, movement disord
781.2	Abnormality of Gait
460.0	Acute nasopharyngitis
335.20	ALS
755.55	Apert's Syndrome
784.3	Aphasia
784.41	Aphonia
784.69	Apraxia Oral Echolalia
348.4	Arnold-Chiari Syndrome
315.39	Articulation
781.3	Ataxia Lack Coordination
314.0	Attention Deficit Disordr
299.0	Autism
320.9	Bacterial Meningitis
389.0	Bilateral Conductive
388.12	Binaural Hearing Loss
348.9	Brain Damage
491.2	Bronchitis,Chronic Asthm
770.7	Bronchopulminary Dysplasa
230.0	Cancer(Slow to Develop)
389.14	Central
742.4	Cerebral Dysgenesis
343.9	Cerebral Palsy
436.0	Cerebral Vascular Accid
380.21	Cholesteatoma
749.24	Cleft Lip & Palate Bilat.
749.00	Cleft Palate
754.70	Club Feet
742.9	Congenital Encephalopathy
315.4	Coordination Disorder
927.0	Crushing Injury of Arm
783.4	Delayed Milestones
758.0	Down Syndrome
784.5	Dysarthria
787.2	Dysphagia
756.83	Ehlers-Danlos Syndrome
348.3	Encephalopathy
756.9	Engelmann's disease
477.8	Environmental allergy
767.0	Epidural Hemorrhage
345.9	Epilepsy
315.31	Expressive Language
315.3	Expressive Language
783.3	Feeding Difficulties
755.63	Femoral Antiversion
760.71	Fetal Alcohol Syndrome
768.4	Fetal Distress
764.9	Fetal growth retardation
764.93	Fetal growth retardation

CODE	DESCRIPTION
734.00	Flat Foot
307.0	Fluency
693.1	Food allergy
759.83	Fragile X Syndrome
300.11	Functional Dysphagia
783.40	Gross Fine Motor Delay
854.0	Head Injury
718.40	Hip Abduction
331.4	Hydrocephalus
478.29	Hyperactive Gag Reflex
728.85	Hypertonia
759.89	Hypoplasia
728.9	Hypotonia
758.7	Klinefelter's Syndrome
984.9	Lead Poisoning
342.9	Left Hemiparesis
728.4	Ligament Laxity
739.3	Lumbar Region Dysfunction
191.9	Malignent Neoplasm brain
995.2	Medicine allergy
386.0	Meniere's Disease
742.1	Microcephaly
314.9	Minimal Brain Dysfunction
389.2	Mixed Hearing Loss
352.6	Mobius Syndrome
318.0	Mod.Mental Retardation
359.0	Muscular Dystrophy
333.2	Myoclonus
237.7	Neurofibromatosis
770.8	Newborn Apnea
799.9	No Diagnosis
306.7	Nonorganic
379.59	Opsoclonia
756.51	Osteogenesis Imperfecta
388.70	Otalgia
382.9	Otitis Media Chronic
332.0	Parkinsons Disease
330.0	Pelizaeus Merzbacher Dis
384.5	Perforation Tympanic Memb
384.2	Perforation Tympanic Memb
386.40	Perilymph Fistula
E937.0	Phenobarbitol Therapy
756.0	Pierre Robin Syndrome
765.1	Premature Birth
307.9	Psychomotor Retardation
315.30	Receptive Language
315.32	Receptive Language
593.9	Renal Disease
714.0	Rheumatoid Arthritis
268.0	Rickets
780.3	Seizure Disorder
389.11	Sensory Hearing Loss
309.21	Separation anxiety
758.3	Smith-Magenis Syndrome
253.0	Sotos Syndrome
343.0	Spastic Diplegia
343.2	Spastic Quadriplegia

CODE	DESCRIPTION
741.90	Spina Bifida
322.9	Spinal Meningitis
772.8	Subarachnoid Hemorrhage
726.11	Tendinitis Shoulder
732.4	Tibia Vara
388.30	Tinnitus
755.21	Transverse Def Upper Limb
758.6	Turners Syndrome
389.	Unilateral Cochlear
389.00	Unilateral Conductive
747.9	Vascular Malformation
759.7	Velocardiofacial Syndrome
386.19	Vertigo Auditory
369.9	Visual Impairment
368.32	Visual Perceptual
478.5	Vocal Cord Nodules
784.40	Voice
389.8	Within Normal Limits

Records printed: 124



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 CPT codes

92499 Unlisted ophthalmological service or procedure

Special Otorhinolaryngologic Services

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures (eg, otoscopy, rhinoscopy, tuning fork test) does not apply.

Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using descriptors from the 92500 series.

All services include medical diagnostic evaluation. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself.

(For laryngoscopy with stroboscopy, use 31579)

92502 Otolaryngologic examination under general anesthesia

92504 Binocular microscopy (separate diagnostic procedure)

92506 Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status

92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

92508 group, two or more individuals

92510 Rehabilitation for cochlear implant (includes evaluation of auditory rehabilitation status and hearing, therapeutic services) with or without speech processor programming

92511 Nasopharyngoscopy with endoscope (separate procedure)

92512 Nasal function studies (eg, rhinomanometry)

92516 Facial nerve function studies (eg, electroneuronography)

92520 Laryngeal function studies

92525 Evaluation of swallowing and oral function for feeding

92526 Treatment of swallowing dysfunction and/or oral function for feeding

Vestibular Function Tests, With Observation and Evaluation by Physician, Without Electrical Recording

92531 Spontaneous nystagmus, including gaze

92532 Positional nystagmus

92533 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)

92534 Optokinetic nystagmus

Vestibular Function Tests, With Recording (eg, ENG, PENG), and Medical Diagnostic Evaluation

92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

92542 Positional nystagmus test, minimum of 4 positions, with recording

92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording

97001 Physical therapy evaluation

97002 Physical therapy re-evaluation

97003 Occupational therapy evaluation

97004 Occupational therapy re-evaluation

Modalities

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

Supervised

The application of a modality that does not require direct (one on one) patient contact by the provider.

97010 Application of a modality to one or more areas; hot or cold packs

97012 traction, mechanical

97014 electrical stimulation (unattended)

(For acupuncture with electrical stimulation, use 97781)

97016 vasopneumatic devices

97018 paraffin bath

97020 microwave

97022 whirlpool

97024 diathermy

97026 infrared

97028 ultraviolet

Constant Attendance

The application of a modality that requires direct (one on one) patient contact by the provider.

97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

97033 iontophoresis, each 15 minutes

97034 contrast baths, each 15 minutes

97035 ultrasound, each 15 minutes

97036 Hubbard tank, each 15 minutes

97039 Unlisted modality (specify type and time if constant attendance)

Therapeutic Procedures

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Physician or therapist required to have direct (one on one) patient contact.

(97100 has been deleted. To report, see 97110-97139)

(97101 has been deleted. To report, see 97110-97139)

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97112 neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception

97113 aquatic therapy with therapeutic exercises

(97114 has been deleted. To report, use 97530)

97116 gait training (includes stair climbing)

(97118 has been deleted. To report, use 97032)

(97120 has been deleted. To report, use 97033)

(97122 has been deleted. To report, use 97140)

97124 massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

(For myofascial release, use 97250)

(97126 has been deleted. To report, use 97034)

(97128 has been deleted. To report, use 97035)

97139 unlisted therapeutic procedure (specify)

97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

(97145 has been deleted. To report, see 97110-97139)

97150 Therapeutic procedure(s), group (2 or more individuals)

►(Report 97150 for each member of group)◄

►(Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist)◄

(97200, 97201 have been deleted. To report, see 97010-97039, 97110-97139)

(97220, 97221 have been deleted. To report, use 97036)

(97240, 97241 have been deleted. To report, see 97036, 97113)

(97250 has been deleted. To report, use 97140)

(97260, 97261 have been deleted. To report, use 97140)

(97265 has been deleted. To report, use 97140)

(For manipulation under general anesthesia, see appropriate anatomic section in Musculoskeletal System)

(For osteopathic manipulative treatment (OMT), see 98925-98929)

(97500, 97501 have been deleted. To report, use 97504)

97504 Orthotics fitting and training, upper and/or lower extremities, each 15 minutes

(Code 97504 should not be reported with 97116)

(For casting and strapping of fracture, injury or dislocation, see 29000, 29590)

97520 Prosthetic training, upper and/or lower extremities, each 15 minutes

(97521 has been deleted. To report, use 97520)

97530 Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

(97531 has been deleted. To report, use 97530)

97535 Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes

97537 Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes

(97540 has been deleted. To report, see 97535, 97537)

(97541 has been deleted. To report, see 97535, 97537)

(For wheelchair management/propulsion training, use 97542)

97542 Wheelchair management/propulsion training, each 15 minutes

97545 Work hardening/conditioning, initial 2 hours

+ 97546 each additional hour (List separately in addition to code for primary procedure)

(Use 97546 in conjunction with code 97545)

Tests and Measurements

(For muscle testing, manual or electrical, range of motion, electromyography or nerve velocity determination, see 95831-95904)

(97700, 97701 have been deleted. To report, use 97703)

Maine Partners
Central Maine Partners
BlueCross BlueShield of Maine

Getting in Touch with Us

Resources for Participating Providers and Professionals

Provider Service (7:30 a.m. - 5:00 p.m.)
1-800-832-6011 or 822-8181

Option 1 - Claim Status
- Provides claim payment date and details

Option 2 - Eligibility
- Verify member or dependent coverage including copay amounts

Option 3 - Find a Certificate Number
- Obtain patient's certificate number

Option 4 - Voice Mail
- Provide additional information on a previously processed claim

Option 0 - Provider Service Representative
- General information on benefit programs

For questions concerning:
Federal Employee Program..... 1-800-722-0203 or 822-8080
Machigonne Benefit Admin.....1-800-245-3529 or 822-5855

Network Management Representatives
Fax - 822-7906

- Orientation for managed care and traditional products
- Training and re-education for providers and their staffs
- Assistance with provider office workflows
- Guidance for physicians joining or leaving a practice
- Changes in business structure
- New medical equipment, services or technology
- Interpretation and application of contract terms

Rebecca Genest (north and east of Newport).....561-
Andy Locke (Cumberland County).....822-
Cindy Meserve (York County and mid-coast to Rockland)...822-
Eileen Nunley (Augusta, Waterville, Auburn and Lewiston).822-
Susan Rockwell (select providers and professionals).....822-

Network Quality Management
Fax - 822-5387

- Credentialing and recredentialing for professionals.....822-5373
- Requests for application for participation.....822-5341
- Status of application for participation..... 822-5373

Network Development
822-7731

- New contracts for providers and facilities
- Questions about physician or professional participation
- Questions about provider contracts

Electronic Commerce

Client Services 822-8385
- Password changes or requests
- Transmission or connection support for Electronic Commerce services
- Testing for Electronic Commerce services

General Information on Electronic Commerce Services..822-7347 or 1-800-334-8262 (within Maine)
- Electronic claims
- Electronic eligibility inquiry
- Electronic referrals

Referrals and Case Management

- Referrals for managed care plans*..... 1-800-392-1016, opti
- Referral authorization fax
  - Managed care plans..... 1-800-773-
  - Machigonne Benefit Administrators..... 822-
- Case management services*..... 1-800-231-
- Preadmission certification and second surgical opinion..... 1-800-392-1016, option 1
- Green Spring of Maine Referral Center for mental health or substance abuse admissions
  - In-state..... 1-800-392-1016 or 1-800-755-
  - Out-of-state..... 780-

* 8:00 am - 5:00 pm only

Member Service

Please advise members to use the telephone numbers on the back of their ID cards if they have questions for us.

Revised 1/00

Bureau of Medical Services Telephone Resource Page

To check eligibility, insurance coverage, PrimeCare or HMO coverage, and the status of claims, use the Vo Response Number 1-800-452-4694(in-state only) or 207-287-3081. Have your provider number and recipier ID# available when you call. ALSO DIRECT YOUR MAIL TO THE APPROPRIATE UNIT'S NAME.

Third Party Liability
1-800-572-3839 or 287-1801

- Verify and update health insurance
- Health insurance information changes or problems
- Medicare Part B file updates
- Casualty/Estate Recoveries
- Workers' Compensation Recoveries
- Missing or lost checks - Debbie Gould

Professional Claims Review Unit
(Prior Authorization)
1-800-321-5557, Ext. 72033

- Status of Medicaid prior authorizations

(Not Social Services or Child Health/Coordinated C

- Medicare Certified Lab Updates (must be in wr
- Problems with sterilization consent forms
- Medical Eye Care Program.....287-68

Pharmacy Program
1-800-321-5557. Ext. 71818

- Requests for prior authorization for medications

Provider File Unit
1-800-321-5557, Ext. 73757

- Provider Enrollments (Agreements), Additions, and Disenrollments
- Provider file problems
- Provider file updates - name, address, Tax ID#
- EPSDT enrollment
- Rate changes for ICF-MRs, all DMR facilities, codes W110 and W115, Non-Boarding Home PNMIs

Provider Account Management
1-800-321-5557, Ext. 71782

- Adjustments Questions
- Provider Additional Payment Request Form (gre
- Reimbursement Form(pink)
- Questions about Accts. Receivable and Payable section at the end of the remittance statement
- Questions about Provider initiated adjustments c remittance statements

Policy Development Unit
624-5521

- Policy Development requests
- Questions on draft or proposed policy
- Medicaid HMO contract monitoring issues

Electronic Data Unit
Valerie Howard at 287-3704

- Electronic media claims (Blast EMC) enrollmen
- Difficulties with EMC/Blast submissions
- EMC formatting

Medicaid Information & Research Unit
1-800-321-5557 or 287-3094
TTT/TDD 1-800-423-4331 or 287-1828

- Basic questions of covered services
- Billing instructions
- Basic questions about rejected claims

Provider & Consumer Relations Unit
1-800-321-5557 or 624-7539
TTT/TDD 1-800-423-4331 or 287-1828

- Policy interpretation
- Assistance with complex billing problems
- Questions from Medicaid clients

MAILING ADDRESS

BUREAU of MEDICAL SERVICES
11 STATE HOUSE STATION
AUGUSTA, ME 04333

REMEMBER TO DIRECT MAIL TO THE APPROPRIATE UNIT

Surveillance and Utilization Review
624-5220

- Reporting possible fraud and abuse of the Medica program
- Reporting client over-utilization or abuse of ser

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Department of Human Services
HealthWorks
P.O. Box 709
Augusta, ME 04332-0709
1-800-977-6740
or (207) 621-2300
Fax # : (207) 621-2332
Medicaid Voice Response: 800-452-4694
Medicaid Inquiry: 800-321-5557

State of Maine

Maine PrimeCare Referral Form

(Type or print clearly all information/multiple copies)

1. PATIENT INFORMATION: Suzie (1) (First Name) (1) Last Name)

Medicaid ID# 999999999A (Use Medicaid # only)

Date of Birth 1-1-00 (MM/DD/YYYY)

2. REFERRAL TO:

Name Provider

Address Any Street Anytown Zip

Telephone # 999-9999

Appointment Date/Time ___ (MM/DD/YYYY 00:00AM/PM)

3. TYPE OF REFERRAL: (Check all that apply)

- [x] Single consultation visit for opinion
- [x] Treatment up to 99 visits (If not specified, three visits will be authorized)
- [ ] No diagnostic procedures
- [ ] Single visit for treatment
- [ ] No lab, x-ray
- [x] Valid for 12 months (If not specified, this referral will be valid for six months)
- [ ] Surgery/Admit
- [ ] Therapy: OT ___ PT ___ SP ___
- [ ] Other, please explain in box #4.

ck the one that applies

4. CLINICAL INFORMATION:

Reason for referral

Ex: Developmental Delay, Speech Delay, etc.

5. REFERRAL AUTHORIZATION: (Authorization # must match PCP/PCPH of record. Authorized signature may be PCP or designated personnel at site)

Primary Care Provider/Site (Name) SAMPLE

Authorized Signature ___

Authorization Number ___ (HCFA1500=Block 17a/UB92=Block 11)

Date ___ (MM/DD/YY)

*This referral is not a guarantee:

A. That the service is a covered Medicaid service;

B. That the patient will be eligible for Medicaid at the time of service; or

C. That the service has received Prior Authorization from the Department. Prior Authorization is required for certain surgical procedures, durable medical equipment (DME) and all out-of-state services • 800-321-5557 ext 72033

Funding Sources for Services

Public funding for services indicated on a child's IFSP, and other health and dental services, may be available through the Medicaid Program, a branch of the Department of Human Services. Eligibility for different Medicaid programs will vary according to the program you are applying for.

Children and their families who are in need of health insurance may qualify for Medicaid or Cub Care based on family income. Families with the lowest income would probably qualify for "regular" **Medicaid**. An application for Medicaid and Cub Care can be found on pages 22 and 23. More applications can be obtained from your local Maine Department of Human Services office. Maine PrimeCare is a managed care plan for families covered by Medicaid. Providers such as speech therapists, occupational therapists, and physical therapists will need to obtain a Maine PrimeCare referral form from the child's Primary Care Physician. An authorization number will be taken from the referral form and inserted on the HCFA1500 form in block 17a to be eligible for billing. A copy of a Maine PrimeCare Referral Form is included on page 16a. Additional information regarding this plan and referral process is available from Healthworks at 1-800-977-6741.

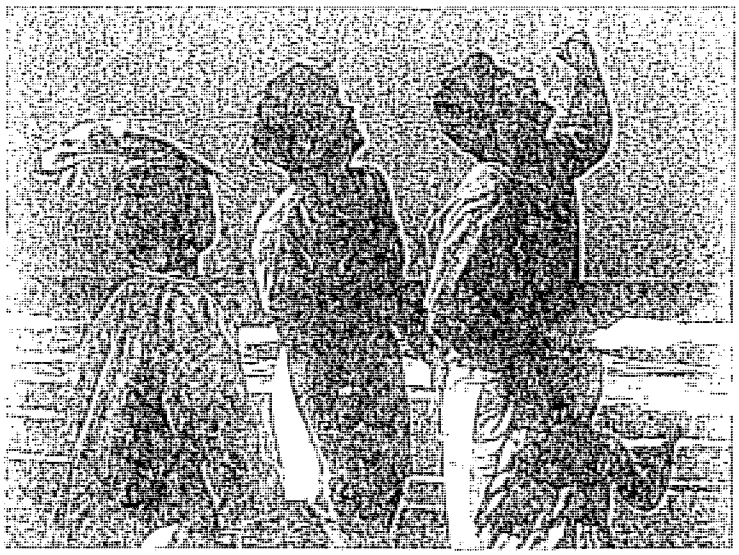
If families exceed the income guidelines for Medicaid they may qualify for **Cub Care**. For this plan, families pay a small monthly premium which covers a variety of services such as therapies, prescriptions, hospital care, dental care, family planning services, transportation for medical appointments, etc. Premiums vary between $5 and $40 per month depending on your income. Some parents pay a small co-payment for services. If children are covered under other health insurance programs, they may not be eligible for Cub Care, but they may be eligible for Medicaid. Check with your local Department of Human Services offices for further information.

Katie Beckett, another health care option, is designed for children who have numerous medical and personal care issues. As a rule, a parent's income and assets are counted when deciding if a child is eligible for "regular" Medicaid. However, if a child is severely disabled and meets certain medical criteria, only the child's income and assets are counted, not the parents'. If eligible, Katie Beckett pays for the same medical services as it does for other children receiving Medicaid.

To assist families in the application process you can call the Department of Human Services at 1-877-543-7669 (1-877-KIDS NOW). Most CDS sites have a staff member who can also provide this service.

More information regarding any questions relating to Medicaid may be made to the Medicaid Provider Relations Specialists at 1-800-321-5557.

Low-Cost or No-Cost Health and Dental Insurance for Families with Children



If you or your children need health insurance, Medicaid or Cub Care may be the answer.

Apply now. Don't wait.

Medicaid & Cub C

Department of Human Service

What services are covered

- Doctor visits:
  - well checkups and
  - medical
  - dental
- Hospital care:
  - inpatient
  - outpatient
  - emergency room
- Immunizations
- Prescriptions
- Surgery
- Laboratory & x-ray
- Dental care:
  Full coverage for children and limited coverage for adults
- Medical equipment and supplies
- Vision
- Speech, hearing and physical therapy
- Ambulance
- Case management
- Mental health and substance abuse treatment
- Family planning services
- Prenatal care
- Transportation for medical appointments

Medicaid & Cub Care
Department of Human Services

Who is eligible for this insurance?

- Children and teens age 18 and under, and pregnant women with gross monthly family income at or below the amount listed in column A on this chart. Assets are not counted.
- Parents living with their children and teens age 18 and under with monthly family income at or below the amount in column B on the chart, and with certain assets of $2000 or less.

Effective 9, 1/00 Family Size	Column A 18 & under and pregnant women	Column B Parents of children 18 & under
1	$1392	$1044
2	$1875	$1407
3	$2359	$1769
4	$2842	$2132
5	$3325	$2494
6	$3809	$2857

Note: Even if your family income is above the amount on the chart, you are encouraged to apply. Certain expenses may be taken out of your income.

How much does it cost?

- There is no cost for most families. Some families must pay a small monthly premium for their children's coverage. Premiums are between $5 and $40.00 a month. Some parents must pay a small co-payment for services.

How do I apply?

- For children, teens or pregnant women, fill in boxes 1-10 only on the attached application. Sign and date (box 12).
- For parents applying for themselves along with their children and teens, fill in box 11, plus boxes 1-10 on the attached application. Sign and date (box 12).
- Mail or drop off the attached application to the Department of Human Services nearest you. No interview is necessary.

How can I get more information or help filling out an application?

- Call the Department of Human Services toll-free at: 1-877-KIDS NOW (1-877-543-7669).
- Visit the Department of Human Services website: www.state.me.us/dhs/main/cc_menu.htm
- Call Covering Kids and Teens HelpLine toll-free and TDD/TTY at: 1-800-965-7476.

Department of Human Services Offices

Portland	161 Marginal Way, Portland, ME 04101-9977 822-2071 or 800-482-7520, TDD/TTY 822-2293
Sanford	39 St. Ignatius Street, Sanford, ME 04073-3800 490-5418 or 800-482-0790, TDD/TTY 490-5466
Biddeford	208 Graham Street, Biddeford, ME 04005-3350 286-2430 or 800-322-1919, TDD/TTY 286-2402
Lewiston	200 Main Street, Lewiston, ME 04240-7098 795-4394 or 800-482-7517, TDD/TTY 795-4595
Norway/ South Paris	243 Main Street, Suite #6, South Paris, ME 0423 744-1250 or 888-593-9775, TDD/TTY 744-1224
Farmington	129 Main St., Suite 2, Farmington, ME 04938-19 778-8223 or 800-442-6382, TDD/TTY 778-8253
Augusta	219 Capitol Street, Augusta, ME 04333-0011 624-8200 or 800-452-1926, TDD/TTY 624-8004
Rockland	360 Old County Road, Rockland, ME 04841-55 596-4217 or 800-432-7802, TDD/TTY 596-4201
Skowhegan	140 North Avenue, Skowhegan, ME 04976-19 474-4843 or 800-452-4602, TDD/TTY 474-4851
Bangor	395 Griffin Road, Bangor, ME 04401-3095 561-4333 or 800-432-7825, TDD/TTY 561-4477
Ellsworth	17 Eastward Lane, Ellsworth, ME 04605-1715 667-1656 or 800-432-7823, TDD/TTY 667-1663
Machias	13 Prescott Drive, Machias, ME 04654-9934 255-2027 or 800-432-7846, TDD/TTY 255-6833
Calais	88A South Street, Calais, ME 04619-1105 454-9020 or 800-622-1400, TDD/TTY 454-3431
Houlton	11 High Street, Houlton, ME 04730-2012 532-5055 or 800-432-7338, TDD/TTY 532-5200
Caribou	14 Access Highway, Caribou, ME 04736-9600 493-4050 or 800-432-7366, TDD/TTY 493-4036
Fort Kent	92 Market Street, Fort Kent, ME 04743-1447 834-7770 or 800-432-7340, TDD/TTY 834-7700

In Accordance with Title VI of the Civil Rights Act of 1964 (42 USC § 1981, 2000d et. seq.) Section 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), the Age Discrimination Act of 1975, as amended (42 USC § 12131 et. seq.), Title IX of the Education Amendments of 1972, (34 CFR Parts 100, 104, 106 and 110), the Maine Department of Human Services does not discriminate on the basis of sex, race, color, national origin, disability or age in admission or access to or treatment or employment in its programs and activities. Kim Pierce, Civil Rights Compliance Coordinator, has been designated to coordinate our efforts to comply with the US Department of Health and Human Services regulations (45 CFR Parts 80, 84 and 91), the Department of Justice regulations (28 CFR Part 35), and the US Department of Education regulations (34 CFR Part 106), implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to Kim Pierce, 11 State Street, Augusta, ME 04333. Telephone number (207) 287-3488 (voice) or 800-332-1003 (TDD), or Assistant Secretary of the Office of Civil Rights of the applicable department (e.g. the Department of Education). Visiting

Information to help you fill out the attached application for Medicaid and Cub Care

Note: If applying for children and teens age 18 and under, or if you are a pregnant woman, you need to fill in boxes 1-10 only.

1. Person Filling Out The Application

Provide information about the person filling out the application. This is usually the parent or guardian of the children listed under "Household Members" (#3 below). If you are applying for yourself because you are pregnant or you are under age 19 and living on your own, your name is listed here. Listing Social Security numbers will help avoid delays in processing. They are not required unless you are applying for yourself.

2. Mailing Address

This is the address where you get your mail. Write the address where you live if it is different than your mailing address.

3. Household Members

List everyone who lives in the household including the children for whom you are applying. This tells us what income to count and who may be covered. If a household member is applying due to pregnancy, special rules apply which may help get coverage.

4. Household Earnings

Attach paystubs or photocopies of paystubs for the last 4 weeks. We need proof of income before we can process the application. Gross weekly wages are multiplied by 4.3 to arrive at gross monthly wages. Gross monthly wages are what determine eligibility.

5. Self-Employment

Attach a copy of your most recent tax return including all schedules. If your business is incorporated, include the corporate income tax return as well. If you have not filed a tax return, we will send you forms to complete.

6. Unearned Income

Examples are: Unemployment Compensation, Workers Compensation, Social Security, Supplemental Security Income (SSI), VA, interest income and child support received. Attach a copy of the check, check stub or award letter from the income source. You do not need to do this for Social Security or SSI.

7. Child Care Expenses

These expenses are deductions from earnings when figuring Medicaid eligibility. The maximum monthly deduction is $200 per child under age 2 and $175 per child age 2 and over. This deduction is not used when figuring Cub Care eligibility.

8. Child Support (Paid Out)

This is the monthly amount paid to comply with a c child support order. It is used as a deduction when f Medicaid eligibility. This deduction is not used when Cub Care eligibility. Any child support received as i not listed here. It should be listed as "Unearned Inco (#6 above).

9. Health Insurance

If your children have other health insurance, they m be eligible for Cub Care, but they may be eligible for Medicaid. If this applies to you, the Department of H Services will give you more information.

10. Special Conditions

Special rules may apply for children with a disabling tion. This can help them to get coverage.

There is no Cub Care premium for American Indi children who are members of a Federally recognized for children who are Alaskan Natives.

If your children are eligible for Medicaid, their m expenses for a 3 month period prior to the month of application may be covered.

Children or pregnant women do not need to be ci be covered by Medicaid or Cub Care. Some non-citiz are here temporarily, for example, students or visitors coverage for payment of emergency services only.

If you are a parent living with your children a and under, and you want to apply for yourself with your children, fill in box 11 also.

11. Assets

List any assets owned by you, your children or g who lives with you. Include assets owned jointly or with anyone else. Medicaid has a $2000 asset limit f over age 18.

a. *Cashable Assets*—This includes savings and check accounts, certificates of deposit (CDs), credit union stocks, bonds, annuities, individuals retirement acco (IRAs), Keogh, or profit sharing.

b. *Real Estate*—This includes any property you own. Medicaid does not count the home where you live t the asset limit of $2000, or the value of property use produce income such as rental property. However, i from the rental property is counted toward the incor

c. *Vehicles*—This includes any motorized vehicle suc car, truck,boat, camper, motorcycle, snowmobile, or Medicaid does not count one of the vehicles you list equity value of others is counted toward the $2000 l except for the vehicles used to produce income, such work trucks and commercial boats.

State of Maine Department of Human Services

Application for Health Insurance

Medicaid and Cub Care for Families with Children

Return to:

REC'D 45TH DAY

1. Person Filling Out The Application

Name (first, middle initial, last)		
Social Security Number	Birthdate (month/day/year)	Sex

Check one ◯ married ◯ widowed ◯ single ◯ divorced ◯ separated

2. Mailing Address

Street, PO Box or RR (include apartment number, in care of, etc.)

City:	State:	Zip code:	Home phone:	Work phone:

If different from your mailing address, write in the address where you actually live:

3. Household Members *List the people who live with you*

Last name	First name	Middle initial	Sex	Date of birth	Social Security Number	Relationship

Is anyone in your household applying due to pregnancy? ◯ Yes ◯ No

Name: Due date:

4. Household Earnings *Attach paystubs or photocopies of paystubs for the last 4 weeks*

Name	Employer's name and phone	Amount you earn	How often you are paid	Hours w... each w...

5. Self-Employment *Attach a copy of your most recent tax return including all schedules*

Name of person who is self-employed	If you did not file a tax return, check here
Name of business	Hours worked weekly

6. Unearned Income *Attach proof of income listed below, except for Social Security or SSI*

Name of person receiving income	Where is income from? (Social Security, Unemployment, etc.)	How often received? (monthly, weekly, etc.)	Amount before deductions

7. Child Care Expenses *(Paid by a member of your household)*

Name of child care provider	Child's name	Amount paid	How often paid? (monthly, weekly, e

8. Child Support *(Paid by a member of your household)*

Name of person who pays support	Person to whom support is paid	Amount paid	How often paid? (monthly, weekly, e

9. Health Insurance

List children in your household who now <u>have</u> health insurance (except for Medicaid) which covers more than one service:

List children in your household who <u>lost</u> health insurance (except for Medicaid) in the last 3 months and why they lost insurance:

List children in your household who can be added to a household member's State employee health insurance:

10. Special Conditions

◯ Check here if your child has a disabling condition. *(There may be special help available to you.)*

◯ Check here if your child is a member of a Federally recognized American Indian tribe or an Alaskan Native. *(No Cub Care premium is required.)* Name of tribe _____

Is everyone for whom you are applying a U.S. citizen? ◯ Yes ◯ No

If English is not your first language, what language do you speak? _____

Are you asking for help with medical bills incurred in the last 3 months? ◯ Yes ◯ No

Do you want to apply for Food Stamps? ◯ Yes ◯ No

11. Assets *Complete only if you are applying for yourself along with your children and teens age 18 or*

a. Cashable Assets

Type of asset	Name(s) on account	Account number and bank	Value or balance

b. Real Estate (other than the home where you live)

Owners	Type of real estate

c. Vehicles

Year	Make/model	Owner(s)	Current value	Amount owed

12. Signature

If you have to pay a premium, coverage can start either the month the Dept. of Human Services receives this application, or the next month. Please write the name of the month you want coverage to start. _____

Social Security numbers are used to do computer matches with the IRS, the Social Security Administration, Department of Labor, other government agen private financial institutions. The Department of Human Services and federal officials may check with other persons/organizations to prove the information y I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know. I understand the Dep has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the medical card was used.

Signature of person filling out this form Date

THE KATIE BECKETT OPTION

for Children and Adolescents with Severe Emotional Disturbances

1. My child has a very disabling emotional and psychiatric disability. My child needs a lot of medical care and personal care that we cannot afford. We earn a little too much to qualify for Medicaid and we cannot afford private insurance. Is there any help for us other than hospitalizing him?

——YES, It is called the Katie Beckett option and it is part of Medicaid.

2. What is the Katie Beckett Option?

——As a rule, a parent's income and assets are counted when deciding if a child can get Medicaid. However, if a child is severely disabled and meets certain medical standards, only the child's income and assets are counted, not, the parents. If eligible, Medicaid pays for the same medical services as it does for any other child who gets Medicaid.

3. What are the medical standards?

——Your child must be:

**18 years of age or younger.*

**disabled for at least 1 year so that he cannot by himself do the same things as other children of the same age;*

**in need of care that is provided in the hospital or nursing home (your child does <u>not</u> have to be in a hospital or nursing home though);*

**able to live at home if he can get the care needed.*

4. What behaviors are considered by Medicaid in determining if my child's problems are severe enough to qualify for the Katie Beckett option?

——The child's behavior must be life-threatening, destructive or disabling to himself <u>or</u> others and exhibited by any of the following:

**Active suicidal/homicidal threats, plans or attempts*

**Self mutilation, assault or arson*

**Psychotic depression which may include:*

- **Command hallucinations*
- **Delusions*
- **Psychomotor agitation or retardation*

**Gross dysfunction resulting in inability to care for self-confusion/disorientation/memory loss (acute/sudden)*

**Anorexia nervosa*

**Severe withdrawal from life activities and relationships*

5. If my child is in a structured setting like a group home or at home with in-home supports can he still qualify under the Katie Beckett option?
——Yes. Your child may qualify because such structure may make it appear that the child's level of functioning is better than it is. Therefore, the ability to function outside the highly structured setting must be considered by Medicaid in evaluating the severity of your child's impairment.

6. What benefits will my child receive?
——Your child will get full Medicaid coverage. This includes coverage of out-patient and in-patient hospital care, physician services, most prescription drugs, dental, eye care and any service provided in home which would normally be provided in a hospital or nursing home.

7. Is there a limit on the amount of psychiatric related expenses Medicaid will pay for?
——Yes. It is $150,704.85 per year.

8. Where do I apply?
——At your local Department of Human Service Office. You can find the addresses of these by looking in your phone book under Maine, State of.

9. Do I need to bring anything with me?
——Yes. School records, medical records, anything that verifies yours and your child's income, and anything that verifies the severity of your child's emotional disability. If you have trouble getting the information together or are not sure what to bring, you will be assisted at the Medicaid office.

10. Is Katie Beckett retroactive from the date I apply?
——Yes. If you are eligible, Medicaid will pay your covered expenses, not from the date found eligible, but from the date you make the application.

11. I am not sure my child is disabled enough to qualify. Should I apply anyway?
——Yes. It is always worth a try.

12. We were receiving Medicaid for my child based on my husband's income. My husband got a new job for more money and now we are disqualified. He has no medical insurance through work and we still can't afford private insurance. What can we do?
——Re-apply for Medicaid under the Katie Beckett option.

13. I have been turned down for Medicaid in the past. Should I apply now?
——Yes. The new rules are effective as of January 21, 1994, and may make your child eligible through the Katie Beckett option.

14. What if I get turned down?
——There is an appeal process and many people, initially turned down, are successful in their appeals.

Committee Minutes

State Level Provider and CDS Director Committee

Minutes for June 21, 2000
9:00 - 2:00
24 Stone Street, Augusta

Members present: Cindy Brown, Cathy Burgess, Judy Dillon, Pamela Edgecomb, Karen Lemoine, Pamela Libby, Jane Seidenberg, Kathy Seitel, Michael Towey, Lori Whittemore

Members absent: Sue Motta, Bette Woodbury

DOE representatives: Jaci Holmes, Yellow Light Breen

The Joint Committee on Education in a memo of March 21, 2000 requested that Commission Albanese establish a joint State Level Provider and CDS Site Director Committee. Letters of Appointment were sent by the Commissioner in early June and the first meeting was convened on June 21st.

I. Introduction- Review of our purpose

Yellow opened the meeting by reviewing the purpose of our gathering. He explained that the Education Committee has been frustrated with issues being brought to them that could be addressed on other levels in the system. The intent in bringing this group together is to for the group to develop the capacity to deal with some of the issues that arise. Yellow hopes that the group can challenge each other as well as use collaborative efforts to improve communication. As the group tackles issues it is his hope that the group will focus on policies and collective roles and that legislative initiatives will be a secondary focus.

Yellow clarified that this group would not be an institutional gripe session nor an appellate process for issues. He further recognized that the regional level has an important place in handling individual policy decisions and individual issues. This group would look at systemic issues.

He indicated that it is up to this group to establish the agenda, priorities, future work as well as frequency of meetings and how long the group is in existence. He will be keeping the Education Committee apprised of our work.

II. The following ground rules were agreed on by the members.

1. Keep the focus on systemic issues. Specific examples can be used to illuminate an issue but resolve of that specific example should be through local CDS board.

2. Approach discussions with primary goal being to offer the best services to children with disabilities 0-5 years old.

3. Keep a future focus with the intent to make this a productive forum.

4. Operate by consensus. Thumbs will be used to indicate approval, disapproval, or uncertainty.

5. Members will indicate by hands when they wish to comment. They will be recognized by the facilitator.

III. The agenda was reviewed. Members inquired about the public comment section of the agenda. It was explained that people outside of this group were welcome to make comments to the committee during a specific time period. The use of a public comment section was to provide a place in the meeting that comments could be heard yet not disrupt work and focus of the committee.

IV. Review of the Requested Areas of Focus by the Joint Committee of the Legislature

These areas are as follows:

1. *Develop recommendations for improved quality and consistency of service.*
2. *Examine professional development to promote effective practice in serving eligible children.*
3. *Review and refine adequacy and consistency of documentation for justification and continuation of direct service hires.*
4. Implement time studies of CDS in house staff and a sample of independent contractors.

It was suggested that #4 be amended to state "productivity studies" rather than time studies. It was indicated that this would be in line with the intent of the Joint Committee and it would be a more useful product. Members were in agreement to this change.

V. Discussion of each member's 2-3 critical issues within Areas of Focus - Alignment and prioritization of critical issues in small groups - Next steps and needed information

Each member's concerns were discussed, noted on post-its and then placed on flip chart paper under the key words from the Areas of Focus. Issues brought forth today primarily fell within Area of Focus #1 - Improved Quality and Consistency of Service. For the purposes of our small group work that area was broken down into three sections: quality of service/

communication; billing/financial; and CDS as a system. Area of Focus #3 and #4 will be discussed at a later date. What follows are the member's concerns and the small group work in which members elaborated and prioritized these concerns.

Quality and Consistency of Service

Communication/Information (Lori, Mike, Yellow)

notes on critical issues:

- three categories of information services: service needs; resource development; choice and informed decision making
- zero tolerance for children waiting for services
- internet site for better communication re: provider openings, program spaces
- making links to share information back and forth (MADSEC, Council for Exceptional Children, DHS etc)

Small group's prioritized list of issues and next steps:

1. Establish viable local mechanisms for communication/collaboration
   - Use/revitalize regional provider advisory boards
   - Some formalized process for grievances/quality control issues
   - Problem solving/conflict resolution
   - Quality management tools established (training/facilitation)
   - "Customer relations" training attitude (internal customers)
   - Build common language/foundation of knowledge

2. Establish/sustain state-level communication mechanisms for CDS
   - Some variation on this group - ongoing
   - Performance/quality indicators for sites - outcomes
   - Quality indicators for DOE
   - Interdepartmental preschool coordination - attach to Children's Cabinet

3. Respond/address informational needs

   A. Provider availability
      - Informational needs for:
        - Immediate service capacity
        - Resource development/ In-house hires
        - Collaborative caseload management
        - Parental decision-making/choice
      - Infrastructure - e.g. Website

B. Productivity/management
Information needs
Vacancy rates/cancellations
Travel/Administrative
Outcomes
Direct Hires
Professional Development/Management training

CDS as a system (Jaci, Judy, Karen)

notes on critical issues:

- Strategic planning with site directors
- CDS not a system (not competing, interdependent, policies same across system) (relationships, collaboration, values)
- Impact of decisions on business - CDS as business and providers as business
- Very young children don't fit into the educational model - a better fit would be a developmental model - tighten the guidelines
- DT group - Developmental therapy provision - What can we learn from this group? What is transferable?
- Reinventing wheel at each site - develop resources to address issues - (e.g.: autistic kids)
- Identify gaps in CDS services - Procedure for local resource development (e.g. needs, trends)
- Public school transition (consistency of service) - linking with other children

Small group's prioritized list of issues and next steps:

1. Strategic planning to develop core values and systemic mission statement to define the CDS system role in the 0-5 child serving system

   A. To define itself in relationship to all providers
   B. To collaboratively forecast impact of Legislative and regulatory decisions on the community
   C. To identify effective practices that yield positive outcomes while assessing quality
   D. To identify gaps in services and to develop consistency in resource development

   Next Steps:

   - Review existing documents and refine with a strategic planning process.
   - State level group will discuss and establish methods for consistency in addressing the elements of A-D.

Billing and Financial (Cathy, Pam E., Pam L.)

notes on critical issues:

- Medical model - 1) Reimbursement rates 2) Affecting ability to hire staff because reimbursement rate is so low (unaffordable for outside providers - hire therapists with less experience - no salary positions, contract basis)
- Funding sources involved in collaboration - Medicaid
- How can we change regulations so that providers can get paid for report writing time? (process information and plan of care)
- Innovative approaches stymied by inability to get reimbursement
- CDS needs current information on/better understanding of third part reimbursement
- Sharing latest information regarding billing practices
- Potential shifting of costs back to DOE
- Financial reimbursement - Educational model trying to gain resources from medical model resulting in agency looking at shift of personnel needed to manage authorizations, providers, reimbursement

Small group's prioritized list of issues and next steps:

1. CDS system and vendors need current information regarding third party reimbursement and requirement

   A. Do we require all CDS sites and vendors to accept any insurance (Champus) that comes through the door, and if we do, what the impact on sites/vendors? How do we have statewide policy/consistency?

   B. Who in the system will be required to :

      - Manage, negotiate contracts and credentials with insurance companies
      - Obtain referrals, do appropriate intake, obtain and monitor authorizations, handle denials
      - Learn appropriate procedural and diagnostic coding and teach therapists
      - What is Medicaid, Prime Care, Katie Beckett, SSI and how do we bill efficiently in the Medicaid system for CDS kids?
      - Who will keep track of insurance changes?

   C. What is the financial impact?

      - What is the cost of sites doing third party billing versus vendor third party billing?
      - How is this impacting overhead staff?

Professional Development (Cindy, Jane and Cathy)

notes on critical issues:

- More training information needed to manage billing problems and issues
- Innovative models (Keep in mind medical models when thinking about this.)
- Statewide CDS/Provider conference (integrated therapy, consistency in services, best practices, review research, DHS)- use local experts - find out about local successes
- Level of consistency between CDS sites
- Increase supply/number of providers
- More innovative ways to treat children
- Universal training for all (providers and in-house staff) - advertise it - have participants contribute to the cost - topics: speech/language pathology, O.T., appropriate levels of service for developmental delay, conflict resolution training, quality management, quality indicators - identify and measure)
- Effective professional development to provide and in-depth understanding of federal statutory obligations/regulations and state regulations (including the specificity within) "Whys" would be answered.

Small group's prioritized list of issues and next steps:

Task force on Professional Development that would provide private sector and public sector access to information - Maine Advisory Committee

Key ideas:

- Consistency/ quality
- Opportunities for ongoing training
- Communication central
- Identify program development
- (CDS website)
- Look at how rates determined
- Training - allows for flexibility

Professional development needs:

- in-house - legal aspects
- contracted providers

Methods:

- Develop survey to determine innovations/expertise in state
- CDS write grants to develop flexible, creative pilot programs - dem grants
- (not just government but private foundations)

Public Comment - There was no one present for the public comment period.

Members decided to postpone the discussion regarding revisions to Chapter 180 and review of direct hires FY2001 until the next meeting. Approximately one hour will be allocated for this discussion.

The possibility of a professional development fall workshop day was discussed. Members decided to postpone that discussion. Department will conduct regional meetings to focus on the implementation of the Department's Chapter 180 Regulations.

The committee decided to meet again on July 27th from 10:00 AM - 3:00 PM at 24 Stone Street, Compensatory Education Conference Room.

Meeting was adjourned at 2:05 PM.

State Level Provider and CDS Director Committee

Minutes for July 27, 2000
10:00 - 3:00
24 Stone Street, Augusta

Members present: Cindy Brown, Pamela Edgecomb, Karen Lemoine, Sue Motta, Pamela Li
Jane Seidenberg, Kathy Seitel, Michael Towey, Lori Whittemore, Bette Woodbury

Members absent: Cathy Burgess, Judy Dillon

DOE representatives: Jaci Holmes, Yellow Light Breen

Interested parties: Representative Elaine Fuller, Cindy Spence

I. **After reviewing the agenda**, a public comment period was added to the morning to all
the members of the public the option of speaking early in the meeting in the event that
did not want to stay for the entire meeting.

II. **Public Comment** - Representative Fuller voiced her concerns regarding the accountabil
of CDS and the use of direct hires.

III. **Minutes for the June meeting** were reviewed and accepted.

III. **Systemic Interdepartmental Initiatives** - Jaci provided an overview of the Children's Ca
goals and initiatives as well as early care and education initiatives in Maine. (See handou
Maine's Children's Cabinet)

IV. **Chapter 180 Revisions** - In opening this discussion Yellow explained that the Departme
worked to create language that would provide assurance that children would not fall thr
the cracks. It was also a priority that changes in service would not be arbitrary and b
accompanied by an examination of a child's needs and a corresponding justification.

Jaci provided a handout, *Child Development Services Rule (Chapter 180) - Proposed Re*
dated April 6, 2000 which indicated the changes made in the rule to the definition of
developmental delay, extended school year and independent evaluations sections. As thes
changes were discussed the following items were noted as concerns or questions that need
included in the upcoming regional meetings on the finalized regulation.

- If a child tests out okay but everyone in the team (parent and clinicians) determin
the child needs services, can the services be provided?
- If the DT guidelines state 4 hours of service and the team recommends more, can th
child get more service?
- Is the justification for services clearly spelled out?
- Authorization to commit funds and how that fits with team discussions and decisio
- Funding issue - 1) lack of understanding of Chapter 180 can mean no consensus a
meetings 2) CDS needs alternative mechanisms when there is not consensus becau
a lack of knowledge of rules.
- Need for more information all around.
- How can CDS budgets be managed to provide funding for children that require ser
above the Federal minimum requirement.

- Providers need to understand Chapter 180 and the reality of 180 so that they can rev their programs accordingly.
- Address the perception that all services are open to children with autism.
- DD is only one criterion for eligibility for 3-5 year olds, there are thirteen other criteri
- There needs to be a different understanding of the components to be included in an evaluation report. Evaluations should not include frequency and intensity of services
- Ability to amend IFSP to recommend developmental appropriateness of services.
- The importance of attendance of all service providers at team meetings.
- CDS needs a mechanism for assuring quality performance of providers. Providers ne to be aware of this process.

Items listed above have been blended into the work from the June meeting. These chan are noted in bold and are attached on pages 4-8.

Considerations for Implementation:

- Need for independent evaluations within six months of summer for extended school yea services. How do we make this workable?
- Independent evaluation language - draft specific alternative language or draft a policy.
- Report card (with quality indicators) from CDS to providers and from providers to CDS
- Develop a mechanism to increase the understanding of the ECT process.
- Formalization of the consultation process for direct hires.

V. **Direct Hires** - The new direct hires for fiscal year '99 was 23; FY '00 was 21; FY '01 was 9.- Jaci also shared the direct hires by the three statutory categories. The categories were as follows: A.) State staff therapist was needed to perform evaluations to insure compliance wi Chapter 180. B.) Therapists who service children on a contractual basis are unable to prov required reports or services within timelines. C.) Site staff therapist was able to provide ser comparable to those provided by contract at an identifiable savings to the CDS system.

IV. **Determination of Structure of the Group** - By consensus members committed to meeti and a monthly meeting through December. (Meeting dates and times on next page.) A facil will be kept until the group is more established and can discuss the future focus and str this group. The group decided their initial focus should be the four Designated Area Teams. Four groups or "Swat Teams" were formed from a list of identified issues that group generated. Those issues - now being tackled by a swat team are as follows:

1. Chapter 180 training - ECT expectations and requirements (Cindy, Kathy, Jaci, Judy)
2. Independent evaluation issue (ESY) - Independent eval language (Jane, Karen, Sue, Lori)
3. Billing/ Financial - (Pam E., Pam L., Cathy)
4. Direct hiring practices - quality indicators - regional collaboration and communica mechanism (Yellow, Bette, Mike, Jaci)

VII. The agenda for the September meeting was created. (Included in this mailing.)

VIII. Public Comment - Cindy Spence's concerns included that there was no private provider the panel and that there is a lack of representation of the various provider disciplines. S also concerned about the use of direct hires. She also inquired about the public awarer this group and how information from this group can be dispersed.

Three of the provider members were recommended by the Early Intervention Coalition.

The minutes of the meetings are mailed to the members of the Education Committee, member the Early Intervention Coalition, and the CDS Site Directors in an effort to keep interested pa informed.

In addition to Cindy's comment the group decided that a news release would be written, prio each meeting by the facilitator and sent to everyone via email for their review.

Representative Fuller indicated that she was pleased with the open dialogue that she had obs during the course of the meeting. Representative Fuller addressed her concern of the relatio between CDS and the providers. She stated that CDS needs to do a better job determining if providers can supply a service before pursuing a direct hire. She believes that case manage ought to serve as a check and balance in this area. She is concerned about the rates of reimbursement for providers and is following this issue with Pine Tree Legal and others. She inquired about the reactivation of CDS provider/advisory committees. A chart of the status provider advisory boards was provided to the group.

The meeting was adjourned at 3:05.

Future Meetings - Swat Teams will meet in August. The purpose of these meetings i recommendations for review by the large group. Plans to be as complete as possible in recommendations as this is generally the most difficult way for large groups to move with their work.

Other meetings - The committee is trying to meet on the fourth Thursday of the month September 28th and October 26th. Because of the holidays in November and December meetings will be held on alternate Thursdays - November 16th and December 14th. The September, October and November meetings will be from 9-2. For now, the abbreviated December meeting is set for
9-11.

Quality and Consistency of Service

Communication/Information (Lori, Mike, Yellow)

Notes on critical issues:

- three categories of information services: service needs; resource development; c and informed decision making
- zero tolerance for children waiting for services
- internet site for better communication re: provider openings, program spaces
- making links to share information back and forth (MADSEC, Council for Excep Children, DHS etc)
- report card with quality indicators from CDS to providers - providers to CD
- CDS needs alternative mechanisms when there is not consensus becaus lack of knowledge of rules or because of ulterior motives
- How can CDS budgets be managed to provide funding for children that services above the Federal minimum requirement.
- Providers need to understand Chapter 180 and the reality of 180 so the can revamp their programs accordingly.
- There needs to be a different understanding of the components to be in in evaluation reports. Evaluations should not include frequency and intensity of services.

Small group's prioritized list of issues and next steps:

1. Establish viable local mechanisms for communication/collaboration
   - Use/revitalize regional provider advisory boards
   - Some formalized process for grievances/quality control issues
   - Problem solving/conflict resolution
   - Quality management tools established (training/facilitation)
   - "Customer relations" training attitude (internal customers)
   - Build common language/foundation of knowledge
   - Understanding the ECT process
   - [illegible] communication mechanisms [illegible]
   - [illegible] this group - ongoing
   - Performance/quality indicators for sites - outcomes
   - Quality indicators for DOE
   - Interdepartmental preschool coordination - attach t
     - Children's Cabinet
3. Respond/address informational needs
   - A. Provider availability
     - Informational needs for:
       - Immediate service capacity
       - Resource development/ In-house hires
       - Collaborative caseload management
       - Parental decision-making/choice
     - Infrastructure - e.g. Website
   - B. Productivity/management
     - Information needs
       - Vacancy rates/cancellations
       - Travel/Administrative
       - Outcomes
       - Direct Hires -formalization of the consultation process f hires

CDS as a system (Jaci, Judy, Karen)

Notes on critical issues:

- Strategic planning with site directors
- CDS not a system (not competing, interdependent, policies same
- across system) (relationships, collaboration, values)
- Impact of decisions on business - CDS as business and providers as business
- Very young children don't fit into the educational model - a better fit would be a developmental model - tighten the guidelines
- DT group - Developmental therapy provision - What can we learn from this grou What is transferable?
- Reinventing wheel at each site - develop resources to address issues - (e.g.: aut kids)
- Identify gaps in CDS services - Procedure for local resource development (e.g. ne trends)
- Public school transition (consistency of service) - linking with other children
- **Address the perception that all services are open to children with autis**

Small group's prioritized list of issues and next steps:

1. Strategic planning to develop core values and systemic mission statement to defi CDS system role in the 0-5 child serving system

   A. To define itself in relationship to all providers
   B. To collaboratively forecast impact of Legislative and regulatory decisions on community
   C. To identify effective practices that yield positive outcomes while assessing q
   D. To identify gaps in services and to develop consistency in resource develop

Next Steps:

- Review existing documents and refine with strategic planning process.
- State level group will discuss and establish methods for consistency in addre elements of A-D.

Billing and Financial (Cathy, Pam E., Pam L.)

Notes on critical issues:

- Medical model - 1) Reimbursement rates 2) Affecting ability to hire staff because reimbursement rate is so low (unaffordable for outside providers - hire therapists wi less experience - no salary positions, contract basis)
- Funding sources involved in collaboration - Medicaid
- How can we change regulations so that providers can get paid for report writing tim (process information and plan of care)
- Innovative approaches stymied by inability to get reimbursement
- CDS needs current information on/better understanding of third part reimburseme
- Sharing latest information regarding billing practices
- Potential shifting of costs back to DOE
- Financial reimbursement - Educational model trying to gain resources from medica model resulting in agency looking at shift of personnel needed to manage authorizat providers, reimbursement

Small group's prioritized list of issues and next steps:

1. CDS system and vendors need current information regarding third party reimburse and requirement

   A. Do we require all CDS sites and vendors to accept any insurance (Champs) that through the door, and if we do, what the impact on sites/vendors? How do we h statewide policy/consistency?

   B. Who in the system will be required to :

      Manage, negotiate contracts and credentials with insurance comp... within referrals, do appropriate intake, obtain and monitor auth... with the family is

      - Learn appropriate procedural and diagnostic coding and teach ther...
      - What is Medicaid, Prime Care, Katie Beckett, SSI and how do we bi... efficiently in the Medicaid system for CDS kids?
      - Who will keep track of insurance changes?

   C. What is the financial impact?

      - What is the cost of sites doing third party billing versus vendor third billing?
      - How is this impacting overhead staff?

   D. Understanding the ECT process:

      - **If a child tests out okay but everyone in the team determines th child needs services - can services be provided?**
      - **Authorization to commit funds and how that fits with team.**
      - **If the DT guidelines state 4 hours and the team says the child n more than 4 hours - can the child receive more services?**
      - **Not understanding Chapter 180 can mean no consensus at team meetings.**

Professional Development (Cindy, Jane and Cathy)

Notes on critical issues:

- More training information needed to manage billing problems and issues
- Innovative models (Keep in mind medical models when thinking about this.)
- Statewide CDS/Provider conference (integrated therapy, consistency in services, best practices, review research, DHS)- use local experts - find out about local successes
- Level of consistency between CDS sites
- Increase supply/number of providers
- More innovative ways to treat children
- Universal training for all (providers and in-house staff) - advertise it - have participa contribute to the cost - topics: speech/language pathology, O.T., appropriate levels o service for developmental delay, conflict resolution training, quality management, qu indicators - identify and measure)
- Effective professional development to provide and in-depth understanding of federal statutory obligations/regulations and state regulations (including the specificity with "Whys" would be answered
- Is justification of services clearly spelled out?
- Providers need to understand Chapter 180 and the reality of 180 so that th can revamp their programs accordingly.
- There needs to be a different understanding of the components to be includ evaluation reports. Evaluations should not include frequency and intensity services.

Small group's prioritized list of issues and next steps:

Task force on Professional Development that would provide private sector and p sector access to information - Maine Advisory Committee

Key ideas:

- [illegible]
- [illegible] for the ongoing training
- Communication central
- Identify program development
- (CDS website)
- Look at how rates determined
- Training - allows for flexibility

Professional development needs:

- in-house - legal aspects
- contracted providers

Methods:

- Develop survey to determine innovations/expertise in state
- CDS write grants to develop flexible, creative pilot programs - dem grants
- (not just government but private foundations)

Concerns or ideas that we want to hang on to

Best practices for kids

Overview of funding formula at one of our meetings.

Information to share regarding Chapter 180:
DD is only one criterion for eligibility for 3-5 year olds.

Approved w/amendments
October 26th

State Level Provider and CDS Director Committee
Minutes for September
9:00 a.m. - 2:00 p.m.
24 Stone Street
Augusta, Maine

Members present: Cindy Brown, Karen Lemoine, Sue Motta, Pamela Libby, Jane Seidenberg, Michael Towey, Lori Whittemore, Bette Woodbury, Judy Dillon, Cathy Burgess

Members absent: Pamela Edgecomb, Kathy Seitel

DOE representatives: Jaci Holmes, Yellow Light Breen

I. Minutes of the July meeting were reviewed and accepted.
Motion: Cindy
Second: Pam
Minutes were accepted with 11 votes to accept. 1 abstained vote.

II. Committee members shared their responses to the following two questions:
How has the work of this committee been shared with the various constituents?
Does their feedback shape our agenda or work?

Members determined that posting the minutes of the meetings on the DOE's website and then circulating the site address to interested parties would be a good way to share the work of the committee.

It was decided that the DOE would email the members the website where minutes would be located. The minutes will be e-mailed as an attachment as well as mailed through the USPS. Mike will e-mail Jaci the names and contact information for the presidents of the various related provider associations.

III. Miscellaneous

- Mike Towey indicated that several speech pathologists have voiced concern with CDS site directors over the delay v. disorder differentiation in the Chapter 180 regulations. He will draft the information that he has collected and the provider concerns to share with the group.

- Jaci shared that the DT Leadership group will provide two days of training on effective practices. She also shared that there will be Tanf and tobacco money utilized to support children in childcare programs. Maine Roads to Quality is developing a comprehensive training model that ties to bachelor

and vocational education programs in the state. Jaci also shared with the group that the Department of Mental Health is examining their capacity to serve children with severe autism.

- o There was a serious discussion on the content of Richard Nero's letter which was sent to a number of committee members. The work of the committee includes addressing the underlying issues raised by Mr. Niro. The committee will respond to Mr. Nero with a written letter and a copy of the minutes.

IV. A rich discussion on the reports by the small groups constituted the remainder of the meeting. Small groups will meet again previous to the October 26th meeting to further develop recommendations for Committee review.

A. CDS/Provider billing
Recommendations: Clarification of Medicaid billing for CDS and Providers
ICD 9 codes on evaluation

Next Steps: Jaci and Susan will review federal and Champus regulations regarding payment for services

Site directors need to be consulted about the feasibility of site staff performing some of the steps.

B. Extended school year/Independent evaluations

There was unanimous consent that the document go to the Commissioner as presented.
Next Steps: Response/reaction from Commissioner
Commissioner's comments will be shared with committee.
Discussion on the drafted language for independent evaluations. Strong views were expressed. Further discussion is needed on this item.

C. Parking lot issues:

- o DT guidelines - role of ECT
- o Relationship between CDS sites/state providers
  practice related
  consistency (decisions made before provider arrives at meeting)
  referrals
  quality of service
  reasonable expectations
- o Special Purpose DT programs funded based on medical model operating on educational model
  (special purpose rate)
- o Regional training discussion on hold until ESY and independent evaluation determinations are made

11/16/2000 Accepted

CDS - Statewide Provider Commission
Department of Education
Commissioner's Conference Room
October 26, 2000

Members present: Mike Towey, Pam Libby, Kathy Seitel, Bette Woodbury, Kathy Seitel, Pam Edgecomb, Lori Whittemore, Sue Motta, Jane Seidenberg, Karen Lemoine, Cindy Brown, Cathy Burgess, Judy Dillon, and Heidi Pulkkinen, facilitator

Members absent: none

DOE rep's.: Jaci Holmes, Yellow Breen

With the following changes, minutes were moved and accepted. 1st motion: Judy; 2nd motion: Cindy; Unanimously accepted.

Changes to minutes from 9/28/00:
Page 1:

> III. Miscellaneous: Jaci shared that the DT leadership group will provide a two day training on effective practice.

Page 2: There was a serious discussion on the content of Richard Nero's letter . . . .

> IV. A. Should include ..... "Site directors need to consult about the feasibility of site staff performing some of the tasks specified.
> B. Should include ..... "There was unanimous consent to move this as presented to the Commissioner. Strong views were expressed--further discussion is needed on drafted language for independent evaluations."

In the future all minutes will be marked with "draft" until accepted by members.

Sharing with constituents. The following is a list of some of the people and agencies with whom our members have share the work of this committee:

- Early Intervention Coalition
- CDS Androscoggin
- Head Start Directors
- MADSEC
- Piscataquis Provider Advisory Board
- Special Education Directors Fall conference
- Commissioner Duke Albanese
- Representative Elaine Fuller
- Provider Advisory, Cumberland
- Provider Advisory, Penobscot
- CDS Directors
- Provider Advisory, Oxford - ESY policy language

Extended School Year

- The Department of Education is committed to making this provision work.

- Committee members believe an outside evaluator is most needed if team cannot come to consensus. Otherwise, a 2nd evaluation causes expense and a burden that is unnecessary. They believe that the current law is a bad law They believe that it reflects poor practice and jeopardizes the integrity of the system.

- Replacing "evaluation" with "consultation" was not acceptable to members.

- Yellow explained that there may be a need for an interim policy because of the length of time involved in rule making and because of the impact of existing regulations.

- Committee members feel that changes need to be made in rule making.

- In lieu of interim interpretation on ESY language the Department will review the rule making process while ESY committee reviews proposed language.

- Yellow has asked committee to examine bottom of paragraph #3 and #4 of Draft #2 from Department on "Draft Language Pertaining to Extended School Year.") to suggest replacement language or to provide guidance on the language.

- Committee members did this over a break and made the following suggestions for change:

Paragraph 3: eliminate: "along with the report from a provider who is not the child's provider of the service in question, which is a consultation, on the recommendations for ESY contained in the process reports, relevant assessments, clinical judgment, parent report, observations, or documentation."

Paragraph 5 "In a few instances...add: 'if the ECT is unable to reach consensus'...it may be necessary or desirable to complete additional evaluations....."

Motion: Changes to ESY language should be pursued by DOE through emergency rule making for the following reasons:

1. The current law does not reflect good practice.
2. The current law creates a logistical challenge for CDS sites.
   It would be challenging to implement because:
   a. There is a lack of professionals to do the work.
   b. There may be a significant cost increase to do the evaluations.
   c. The number of children that will be out of compliance could increase.
3. The current law undermines the ECT process.
4. The current law will create an ethic conflict within the team.

Judy - 1st motion
Pam - 2nd motion
Unanimously moved

CDS/Provider Billing :

This small group has produced, "CDS & Service Providers Billing Resource Manual". There was discussion about the content of this manual and suggestions for change and additions. Directors and providers shared information on billing and situations with insurance companies. Cathy B., Pam L., and Pam E. asked committee to review draft and pencil in any corrections. They would like members suggestions by 12/15/00.

- Jaci will contact OT/PT boards regarding the Practice Act and the need for authorization of treatment for OT/PT and the timely receipt of those authorizations. Jaci will get their response in writing.

- Jaci will share with committee the "laundry" list of questions for parents to ask their insurance companies in order to make informed decisions.

Independent evaluation:

Committee discussed problems at particular sites as well as systemic problems with language as drafted. After much discussion ESY/Independent evaluation small group members agreed to meet to draft alternative language. Any ideas members have are encouraged to be shared.

- Mike Towey indicated he would speak to Denise Wilson and Jan Salis regarding the need for providers to comply with CDS reporting expectations.

- Karen indicated she would share this need with members of Early Intervention Coalition.

Parking Lot

- choice of providers as Medicaid requirement
- least restrictive/natural environment
- under the Practice Act for OT/PT need Rx authorizing treatment>>issue: timely receipt
- clarify responsibility of insurance companies as it coincides with Federal IDEA & State Law.
- Medicaid - denials requested multiple times during treatment – from primary insurance when Medicaid is secondary
- Medicaid - Managed Care Programs
- CDS as payer of last resort
- If Champus is in our community are we required to be enrolled with them? Because their reimbursement rate is less than Medicaid, it opens up providers to servicing to all Champus clients at a significant loss of income to the provider.

Public Comment Period

Representative Elaine Fuller spoke to the following items:

- Physicians are the professionals that determine need for services. Please keep this in mind.
- Single claims processing system - proposed in bill last year. Work is being done to address the enormous amount of time being used to handle insurance claims.
- Independent evaluations

- Conflict of interest
- Impact of availability of providers
- Committee discussion on Medicaid reimbursement rate
    - choice of providers is Medicaid requirement
    - would like to hear discussion on how least restrictive setting/natural environment is being used

Future meetings and important dates:

1. November 16th meeting - 9:00 - 2:00 Stone Street Conference Room

2. December 14th - 9:00 - 11:00 Define broad elements of what would be in report - UMA Classroom Room 211, Campus Center

3. January 12th - 9:00 - 10:30, review draft report; members would have received report electronically before this date to review.

4. January 16th - written report to Education Committee

State Level Provider and CDS Director Committee
Minutes for November 16, 2000
9:00 - 2:00
24 Stone St., Augusta, Maine

Members present: Mike Towey, Pam Libby, Kathy Seitel, Bette Woodbury, Pamela Ward Edgecomb, Lori Whittemore, Sue Motta, Jane Seidenberg, Karen Lemoine, Cindy Brown, Cathy Burgess, Judy Dillon; Heidi Pulkkinen, facilitator

Members absent: none

DOE representatives: Jaci Holmes and Yellow Breen,

Interested parties: Representative Elaine Fuller

I. **Minutes for the October meeting** were moved and accepted with the following change:

Page 2: "**Jody** - 1st motion" changed to "**Judy** - 1st motion";
Motion: Judy
Second: Cindy
Minutes were accepted with 13 votes to accept. 1 abstained vote.

II. Response from DOE/Yellow Breen regarding ESY:

Yellow stated that it was doubtful he could convince folks that there is a need for emergency rule-making. Therefore, standard rule-making process of 60 to 90 days would be followed.

◊ Susan Corrente is looking at language proposed by the committee at the October meeting. She will convert the language to the necessary legal language and could then put it through the rule making process.

◊ Jaci noted that if DOE receives hundreds of responses to proposed rule it will slow the rule-making process because of the time it takes DOE to respond. Therefore, the group in their role as representative should speak with folks and emphasize the importance of consolidating comments.

◊ Rule-making could begin the APA process in January, with the hope of adoption in April. This would make it easier for implementation by May,

June, or July when
the impact of current rule would be felt.

◊ By the December meeting, Susan, Yellow, and Jaci will look at the language and will attempt to get something out to the committee for review.

◊ The committee felt that it is very important for the group to speak as one voice. As well, it is important for site directors to educate their communities and communicate the importance of this process going smoothly.

◊ The committee supports the language changes because they are "child focused" and are not a management tool and/or a cost saving mechanism which is how the language in Chapter 180 was perceived.

◊ Jaci indicated that it was not the intention of the Chapter 180 language change to save money or create a management tool.. Rather the changes were made to meet the state statutory requirement not to exceed minimum federal requirements. She indicated that for clarity, it would be helpful to restate the original intention in the revisions to Chapter 180 language.

III. Independent evaluation

◊ There was discussion between committee members around language proposed by the independent evaluation small group. The proposed language is as follows:

In order to determine initial eligibility for an early intervention, special education, or related service, an individual or agency who performs the evaluation on a given child may provide service to that child when it is determined by the ECT to be in the best interest of the child, to meet compliance standards or to provide a specialized service that is otherwise unavailable. At the discretion of each Regional Board of Directors, an individual or agency may be issued a contract to provide initial evaluations and ongoing treatment.

◊ Final agreed upon language:

In order to determine initial eligibility for an early intervention, special education, or related service, an individual or agency who performs the evaluation on a given child may provide service to that

child when it is determined by the ECT to be in the best interest of the child, to meet compliance standards or to provide a specialized service that is otherwise unavailable. Each Regional Board of Directors is charged with determining whether an individual or agency may be issued a contract to provide initial evaluations, ongoing treatment, or both, based on compliance with chapter 180.

Yellow indicated that the Department would determine where in the regulation the language should be placed. It may be in more than one location

◊ Motion: Accept language with changes as noted above with DOE representatives determining the appropriate places within chapter 180 to place this language.

Motion: Judy
Second: Pam E
Vote: unanimously accepted

◊ Jaci and Yellow will bring proposed final regulatory language to the December meeting.

◊ The committee felt it is important for to make a recommendation as to how the above is going to be practiced and be consistent between sites.

◊ The committee was reminded to bring Chapter 180 to the December meeting.

C. Direct Hire's - Clarify Why? and How?

◊ The committee reviewed Mike Towey's document.
The goal is a protocol for direct hires and good communication with providers.

◊ A small group (Mike, Judy and Lori) was formed to review Mike's document and make recommendations to the large group regarding:

1. A protocol for direct hires
2. A process for documentaton of consultation regarding direct hires; Purpose of CDS direct hires; Circumstances for hiring direct hires.
3. Examine "regular periodic information" cited in Mike's document.

4. Why are providers saying no? What are we asking providers to do? What are costs impact for providers? . . . . that may be affecting their availability?

◊ Training will be needed to communicate "direct hire" policy.

D. Billing

◊ This small group would like feedback from the committee regarding:
- name for manual
- content of manual

◊ Small groups will be needed to have focused discussion on additional items:
1. developmental therapy issues
2. billing HFCA & others

◊ There was discussion around the dichotomy that exists and what needs to happen. The dichotomy is that some sites that have direct hires are not enrolling with third party payers yet, service providers are required to be enrolled with those third party payers.

◊ It was decided that everyone should be enrolled with third party payers. A future discussion is needed regarding the consistent implementation between sites of the requirement provision for enrolling with third party payers.

◊ [illegible] and regional site directors will review at their next meeting:
1. requirement for use of third party payer
2. the dichotomy that exists at some sites regarding the third party payers
3. time frame for payment of services to providers and the expectation that if insurance pays, CDS is reimbursed

◊ Training will be needed to focus on:
- managing & negotiating contracts
- coding procedures
- contract review--getting paid for services provided
- How is provider of services guaranteed payment when they are not getting what they want from third party payers?

◊ A provision is needed to ensure that::
1. providers get paid for services rendered in timely manner
2. CDS meets its financial responsibility

◊ At a future meeting the committee should clarify intent of the utilization of the billing manual now being drafted.
◊ There was discussion regarding how to share current insurance information.

◊ Committee members are encouraged to email Mike with feedback on his delay/disorder document and ideas on distribution of this document.

E. **Public Comment - Representative - Elaine Fuller**

1. Claims Processing

◊ December meeting for public programs, insurance representatives regarding claims processing; contact: Sue Menard, Southern Maine Medical Center
◊ bill in legislature regarding claims processing
◊ bill passed in recent legislature regarding number of days that insurance's must pay
◊ state insurance representative - use them to report insurance companies when frustrated with paying practice.

2. Medicaid Payment

◊ Therapist have not had a pay increase for longest period of time
◊ bill in this legislature for pay increase
◊ goal to include in department budget
◊ Medicaid provider does not get paid for travel
◊ There is an interdepartmental agreement with Departments of Education, Department of MH/MR/SAS, and Department of Corrections, to work collaboratively with public providers.

F. **Parking Lot**
1. Small group to review development therapy issues - Training for completing bills/claims.
2. Small group: expert billing group to review and effective techniques for billing; HCFA
3.Training needed for:
- managing and negotiating contracts

- coding procedures
- contract review - getting paid for services provided

- forum for provider issues

Meeting topics for December 14, 2000 at 9:00 - 11:00

◊ ESY: Review legal language for ESY changes for chapter 180.
Independent Evaluation:
◊ Review legal language for independent evaluation changes to chapter 180 and proposed locations for language in 180.
◊ Discussion on practice of independent evaluation and consistency between sites.
◊ Direct Hire--review of proposal from small group
◊ Billing--review of manual
◊ Check in on "Requested Areas of Focus" draft response proposal by Jaci and Yellow.
◊ Review and prioritize parking lot issues.

Future meetings:

December 14 9:00 - 11:00 @ UMA Campus Center Room 211 (Augusta Campus)
January 12 9:00 - 10:30 @ to be announced
February 23 9:00 - 2:00 @ to be announced

It was noted that there should be discussion at January or February meetings on our continued existence as a committee and next steps on the parking lot issues.

State Level Provider and CDS Director Committee
Parking lot issues

From July 27th meeting:

◊ Best practices for kids
◊ Overview of funding formula
◊ Information to share regarding Chapter 180
DD is only one of fourteen criterion for eligibility for 3-5 year olds.

From September 28th meeting:

◊ DT guidelines - role of ECT
◊ Relationship between CDS sites/state/providers
practice related
consistency (decision made by provider before provider arrives at meeting)
referrals
quality of service
reasonable expectations
◊ Special purpose DT programs funded based on medical model operating on educational model
(special purpose rate)

From October 26th meeting:

◊ Choice of providers as Medicaid requirement
◊ Least restrictive /natural environment
Under the Practice Act for OT/PT need Rx authorizing treatment >> need to check with the licensure boards re script issue
Clarify responsibility of insurance companies as it coincides with Federal IDEA and State law
◊ Medicaid - denials requested multiple times during treatment - from primary insurance when Medicaid is secondary
◊ Medicaid - Managed Care Programs
◊ CDS as payer of last resort
◊ If Champus is in our community are we required to be enrolled with them? Because their reimbursement rate is less than Medicaid, it opens up providers to servicing to all Champus clients at a significant loss of income to the provider

From November 16th meeting:

Small group to review development therapy issues - Training for completing bills/claims.

- ◊ Small group: expert billing group to review and effective techniques for billing; HCFA
- ◊ If model shifts then . . . training needed for:
  - managing and negotiating contracts
  - coding procedures
  - contract review - getting paid for services provider
- ◊ forum for provider issues

- ◊ Billing: 1. developmental therapy issues
  2. billing HFCA & others

State Level Provider and CDS Director Committee
Minutes for January 16, 2001
9:00 - 10:30
5th floor Cross State Office Building, Augusta

Members present: Pam Libby, Kathy Seitel, Bette Woodbury, Pamela Ward Edgecomb, Lori Whittemore, Cindy Brown, Cathy Burgess, Heidi Pulkkinen, facilitator

Members absent: Mike Towey, Sue Motta, Jane Seidenberg, Karen Lemoine, Judy Dillon

DOE representatives: Jaci Holmes and Yellow Breen

I. Agenda topics drafted at the November meeting were reviewed and prioritized

II. Review draft response to "Requested Areas of Focus" and Modifications to Direct Hire and Documentation of Consultation Form

Jaci requested the members begin by offering any conceptual changes they might suggest. Fine edits such as changes in wording, spelling etc. could be emailed to her.

Requested Areas of Focus:

- Judy Dillon's feedback was reviewed with the group serving as a springboard for discussion and more suggestions.
- It was suggested that members of the committee, their addresses, phone numbers and email be included.
- Minutes of each of the committee's meetings should be included.
- Page numbers be added to the bottom of the pages.
- A motion to accept the draft response with the above changes was made by Pam Edgecomb.

Second: Cathy
Vote: Unanimous

- The committee approved the addition of "Next Steps" being added to the Response. In the next steps section the following statement would appear:

"The committee has scheduled a meeting for February 23, 2001 at which time the committee will discuss outstanding issues and develop a workplan for the remainder of this fiscal year."

Motion: Pam Edgecomb
Second: Pam Libby and Cathy Burgess
Vote: Unanimous

Direct Hire Justification and Documentation of Consultation Forms

- The following should be added to the form:

1. "Please attach the minutes of the Regional Provider Advisory Meetings"
2. Date contacted
3. This form should contain a minimum of 3 months of data.

- Also, the document should be reformatted to bigger and provide more space to write.

- It was noted that in the Direct Hire Justification Part D may be very difficult to fill out.

- Cathy Burgess stated her concerns and interest in discussing what other thinks could be put into place that can address the needs CDS sites have other than direct hires. She would like to talk more at future meetings about innovative practices that could address CDS's needs. (see Parking Lot)

- A motion to accept the draft response with the above changes was made by Pam Libby
- Second: Cathy Burgess
- Vote: Unanimous

III. Review legal language for ESY and Independent Evaluation changes to Chapter 180

Review legal language for ESY

- It was noted that the MADSEC board of directors unanimously accepted the draft changes to ESY section of Chapter 180. A written response indicating this is coming.

- There was a review and discussion of emailed responses to the draft changes.

- Jaci is assuming that no feedback from absent members means that they have no more feedback regarding the changes. Committee members present agreed that she should proceed with that assumption.

- It was suggested that in Section 3 Implementation of the IFSP/IEP Part A the wording be changed to: ECT of **all relevant info including but not limited to:** progress reports received...or documentation:

- Motion to accept with the above change: Lori Whittemore
  Second: Pam Libby
  Vote: Unanimous

Review legal language Independent Evaluation

One changes was suggested to Section 3 IDENTIFICATION BY SCREENING, EVALUATION AND ASSESSMENT paragraph 3 A qualified individual or agency who performs the evaluation for initial eligibility on a given child may provide services to that child when it is determined by the regional Board to be in the best interest of the child **and/or** necessary to meet compliance requirements **and/or**....services.

- Motion to accept with the above change: Lori Whittemore
  Second: Cathy Seitel
  Vote: Unanimous

IV. Updates

- Jaci reviewed the process of making these changes with the committee. She explained that she hopes the new rules will be in effect in 8 - 10 weeks. The goal is April 1st - 15th.

- She also explained to the committee that July 1st is the deadline for permanent funding formula. She reviewed the current issues with the funding formula and indicated that the Department is striving for durable long term language.

- Yellow provided a budget update for members. He explained that part 1 of the biennial budget will be discussed by the Education Committee on the afternoon of January 24th.

- The Education Committee had their first meeting on Wednesday, January 10th. Many of the new members, which is about half of the Education Committee, come with training and experience in early education and elementary education.

- He has heard that there are several CDS bills. He hopes that sponsors of those bills will share the issues within those bills with members of this committee. By the February meeting the bills will be available for committee review.

VI. Billing Manual

- The billing manual will be given some formatting attention and provided with a professional appearance.

- It is the intention of this committee that each site will follow the manual and not make substantive changes.

- Changes/Additions:

  A table of contents will be added.
  An introductory page will be added.
  Page 4, 2B will read, "All **available** insurance..."
  Page 4, 6 will read, "Evaluation is.....referral. **Diagnosis ICD-9 code should be included**"
  Page 5, 1Bg will read "Diagnosis **with ICD-9 code**"

- Motion to accept with the above changes: Cindy Brown
  Second: Lori Whittemore
  Vote: Unanimous

Next Steps:
Some kind of committee like this with mix of providers and CDS site directors.
Create workplan for the remainder of fiscal year. (through June 30th)
The meeting adjourned at 10:50.

Next meeting: **February 23rd 9:00 - 2:00**
5th floor - Department of Education Cross Office Building

Bring your April and May calendars.

There is no food allowed in the conference room.
We will be eating at the snack bar in the building.

◊

Regional CDS Site
Provider Advisory Boards

Provider Advisory Boards

Site	Active	Meetings Scheduled	Inactive	Plans to Rejuvenate
Androscoggin	√	Monthly		
Aroostook	√			
Cumberland	√	Monthly – 3rd Thursday		
Franklin			√	Sent Letter in Fall
Hancock	√	Monthly 2nd Tuesday		
Knox	√	Every other month		
Lincoln	√			
Opportunities	√	Every six weeks		
PEDS	√			
Penobscot	√			
Piscataquis	√	Monthly		
Search	√	Monthly		
So. Kennebec	√	Six times a year		
Waldo	√			
Washington	√	Three times a year		
York	√	Monthly		

Proposed Revision

to

Chapter 180:

Independent Evaluation

Extended School Year

3. IDENTIFICATION BY SCREENING, EVALUATION AND ASSESSMENT

The process of identifying children with disabilities begins with screening. Screening is a brief procedure done periodically to identify children who may need more in depth evaluation. It assists in identifying children who may have developmental delays or disabilities in order to initiate access to early intervention services. Developmental screening services are available on a recurrent or periodic basis. CDS sites within the Child Development Services System serve as centers for referral for ensuring that children are screened; and for ensuring that appropriate plans are made for continuing the process of determining needs and services. Screening begins the process of identification.

Following this review, an evaluation may be needed to provide a closer and more complete examination of the child by one or more professionals qualified and certified in a specialized field. The Administrative Case Manager assists the family through the screening and evaluation, both of which are part of the assessment process that is ongoing throughout the period of a child's eligibility.

~~Until July 1, 2001 the individual who performs the evaluation on a given child may provide services to that child when necessary to meet federal timelines or provide a specialized service that is otherwise unavailable.~~ A qualified individual or agency who performs the evaluation for initial eligibility on a given child may provide services to that child when it is determined by the regional Board to be in the best interest of the child, and/or necessary to meet compliance requirements and/or necessary to provide a specialized service that is otherwise unavailable. This determination may, at the discretion of the Board, be reflected in an agreement with the individual or agency providing the services.

A. Evaluation and assessment must be:

i. conducted by personnel trained to utilize appropriate methods and procedures;
ii. provided and administered in the child's and family's native language or other mode of communication, unless it is clearly not feasible to do so;
iii. selected and administered so as not to be racially or culturally discriminatory;
iv. utilized to assess special areas of educational or developmental need and not merely a single IQ;
v. validated for the specific purpose for which they are used and based on informed clinical opinion;
vi. administered in such a way that no single procedure is used as the sole criterion for determining an appropriate early intervention program for a child;
vii. selected and administered to ensure accurate reflection of the child's aptitude (or strengths), achievement level or other factor tested for, rather than the child's impaired skill level; and
viii. comprehensive, covering all areas related to the child's suspected disability.

Re-evaluations for children age 3-5 will occur minimally every three years. Evaluations or assessments are made by multidisciplinary teams, when appropriate, including specialists with knowledge in the area of the suspected disability and all information drawn from tests, recommendations, and physical and psychosocial assessments is to be considered in making decisions about the provision of services to the child and family.

B. Screening

Screening assesses one or more developmental and/or health area, on the basis of the referral received, including any supporting documentation. the

2. COMPLETION OF INITIAL IFSP/IEP

Initial IFSPs/IEPs for children B-2 must be completed within forty-five (45) days from the regional site Board's receipt of referral. Initial IFSPs/IEPs for children age 3-5 must be completed within sixty (60) days from the point a child has been referred for evaluation. For purposes of this rule, the word "day" refers to calendar day unless otherwise specified in the rule. An IFSP/IEP must be in effect before early intervention services are provided to a child.

3. IMPLEMENTATION OF IFSP/IEP

The IFSP/IEP is to be implemented as soon as possible after the IFSP/IEP is completed and the parent has signed the initial IFSP/IEP. **The IFSP for a child age B-2 is to be written on the basis of a twelve month program year, unless the ECT recommends that the duration of services be less than twelve months (e.g., center-based developmental therapy), based on the individual needs of the child.**

The IFSP/IEP for a child age 3-5 may provide for services throughout the year, provided that the ECT recommends those particular services are required to provide an appropriate program for the child. Extended school year (ESY) services are special education and related services that are provided to a child age 3-5 with a disability beyond the normal school year; they are provided in accordance with the child's IFSP/IEP at no cost to the parents and they meet the standards set forth in this rule. Regional site Boards must ensure that extended school year (ESY) services are available as necessary to provide children age 3-5 with FAPE, as determined by the ECT on an individual basis. Regional site Boards may not limit extended school year (ESY) services to particular categories of disability, or unilaterally limit the type, amount, or duration of those services. Eligibility for ESY services must be determined by particular service.

The need for the particular services is demonstrated by means of:

A. ~~an evaluation by a qualified evaluator, who is not the child's provider of service in question, that includes a recommendation of a duration beyond the school year for the service in question; and~~ a review by the child's ECT of relevant information including but not limited to progress reports received in March, April, May or June, and any other relevant assessments, clinical judgment, parent report, observations or documentation;

B. consideration by the child's ECT of the significance of the discrepancy in the area of delay or disability between the child's chronological age and developmental age, progress toward IFSP/IEP goals and objectives, ability to meet annual goals without ESY services, and the impact of previous service interruptions on these three factors; and

C. consideration and documentation, in the child's IFSP/IEP, of the modifications and supports that have been tried or considered in the provision of this service, at the frequency, intensity and duration considered typical for the age of the child and that were rejected as inappropriate, and why.

If the ECT, after consideration of Section IX.3(A)-(C), above, determines that there is a high probability that the child would be unable to maintain current skills, or unable to meet annual IFSP/IEP goals without ESY services, the ECT may recommend ESY services at the appropriate frequency and intensity. If the ECT is unable to reach consensus regarding eligibility for ESY services, the ECT may recommend additional evaluations in order to determine the need for ESY services; in this case, the evaluation must be conducted by a provider who is not the child's provider of the service in question.