Department of Health and Human Services
Maine People Living
Safe, Healthy and Productive Lives

John E. Baldacci, Governor
Brenda M. Harvey, Commissioner

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May 14, 2010

Senator Justin L. Alfond, Chair
Representative Patricia B. Sutherland, Chair
Members of the Joint Standing Committee on Education
and Cultural Affairs
#100 State House Station
Augusta, ME 04333-0100

Dear Senator Alfond, Representative Sutherland, and Members of the Joint Standing Committee on Education and Cultural Affairs:

Please find attached an Interim Report to the Joint Standing Committee on Education and Cultural Services pursuant to LD 1804. This report has been prepared by the Departments of Health and Human Services and Education at request of the committee

The attached report summarizes the status of several MaineCare rulemakings of interest to the Committee and the Departments' efforts to enroll and train providers of those services, particularly those providers in school based settings. The report also summarizes Departmental efforts to consult with Interested Parties in MaineCare policy initiatives of interest to the Joint Standing Committee. The report is accompanied with attachments that illustrate the completion of activities requested by the Committee.

I will believe that you will this report and attachments document significant progress in addressing the Committee's concerns. I am happy to discuss the report and concerns you may have.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

Angela Faherty
Acting Commissioner

BMH/klv

Attachment

Interim Report to the Joint Standing Committee on Education and Cultural Services pursuant to LD 1804
May 15, 2010

Rule Status

The Departments of Health and Human Services and Education have been asked to submit this report regarding the status of the changes in various sections of MaineCare policy, specifically, sections 28 (Rehabilitation and Community Support Services for Children with Cognitive Impairments and Functional Limitations), 41 (Day Treatment) 65 (Behavioral Health Services), 68 (Occupational Therapy Services), 85 (Physical Therapy Services), 96 (Private Duty Nursing and Personal Care Services) and 109 (Speech and Hearing Services) which are services provided and billed by schools. Also of concern to the Committee was the repeal of sections 27 (early intervention) and 104 (School Based Rehabilitation). Attached to this report is the most recent Rule Status Report which addresses changes in each of those rules, as well as any other change in any of the MaineCare rules. This monthly report will be forwarded to the Joint Standing Committee on Education and Cultural Services from now on.

Section 28 addresses services for children with developmental disabilities and allows services to be provided in the child's home, community and in the schools. This rule has been adopted and is effective now.

Section 41, day treatment services has been repealed and the services formerly provided under that section have been moved to section 65. The revisions to section 65 are currently in the APA process. The public hearing was held and the comment period has ended. Once the Department has responded to the comments, the process will be complete. The rule will be effective when the new claims system becomes operational.

Sections 68 (Occupational Therapy Services), 85 (Physical Therapy Services), and 109 (Speech and Hearing Services) are being revised to include schools as an allowable place of service and to make some other changes to accommodate school billing. These changes will be proposed shortly and will then proceed through the APA process in time to be effective when the new claims system becomes operational.

Section 96 (Private Duty Nursing and Personal Care Services) is not being changed, but schools may be able to bill if personal care services are provided to a student during school and both the student and the provider meet the qualifications in the section. This is principally a medical service that would apply only to a medically fragile student.

Section 104 has been repealed effective when the new claims system becomes operational. All of the services that were included in that section can be billed to the section covering the specific service, i.e. occupational therapy, speech therapy, etc.

Provider Training and Resource Material

As with any rule change, the Office of MaineCare Services (OMS) will be doing training statewide on the new rules and how schools will need to bill for the services they provide. There are trainings scheduled across the state and that schedule is attached. As part of the training, school personnel will receive the names of individuals at OMS who are available for assist them individually if issues arise. The training materials are also attached. In addition to the typical training that OMS always does when there are new rules, representatives from both OMS and from APS health care have agreed to participate in the MADSEC Director's Academy and the Superintendent's meeting to explain the changes and answer any questions.

OMS is working to produce a resource manual/guide book which will walk schools through the billing process and will be available to schools by the beginning of the 2010-11 school year. That is a work in progress and we will report more on that in July.

Finally, staff from both Departments have been working to assure that the IEP used by schools statewide contains all of the information necessary to comply with any and all requirements to establish medical necessity for MaineCare billing. If changes need to be made, the IEP form will be revised and distributed statewide by July 1, 2010.

Rule Consultation and Review

LD1804 requires the Department of Health and Human Services to consult with the Commissioner of Education, and the Executive Directors of Maine School Management Association, MADSEC, the Disability Rights Center and the Developmental Disabilities Council. The most effective way to assure that this consultation occurs is to invite these people to attend meetings of the MaineCare Advisory Committee (MAC) which is a statutory committee designed to advise MaineCare about, among other things, policy issues. This group meets once each month and when appropriate forms ad hoc subcommittees to evaluate specific issues. The five individuals have received letters from the Chair of the MAC, Ana Hicks, inviting them to attend the meetings. Copies of those letters are attached. Additionally, whenever changes are considered in any rule which might affect services provided in a school, a separate invitation will be sent to those five individuals, along with a description of the considered changes and their consultation will be requested.

DHHS is also required to invite the Attorney general, and the executive directors of Maine School Management Association, MADSEC, the Disability Rights Center and the Developmental Disabilities Council to review any changes in sections 28, 41, 65, 68, 85, 96 and 109, specifically to determine the impact on schools of any proposed changes in those rules. To that end, Patricia Dushuttle, Director of the OMS Office of Policy and Procedure has notified those individuals that she will be alerting them when any change is contemplated to any of those sections of rule and she will seek their review prior to making any changes in those rules. Copies of those letters are attached.

Both the Departments of Health and Human Services and Education look forward to our continued collaboration in providing appropriate, high quality medical and educational services to the children of Maine.

List of Attachments

1. Monthly Office of MaineCare Rule Status Report
2. Training Materials
3. Copy of Letter Ana Hicks, Maine Advisory Committee
4. Copy of Letter from Patricia Dushuttle, Office of MaineCare Policy Director

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In APA Process

Chapter II, Section 4, Ambulatory Surgical Centers- The Department of Health and Human Services, MaineCare Services, proposes changes to Chapter II, Section 4.04, Section 4.05 and Section 4.07 in order to update and clarify policy language. In Section 4.04-A, the Department is adding language to state that payment for implanted presbyopia-correcting intraocular lens and astigmatism correcting intraocular lens will be paid at the rate of a conventional intraocular lens. In section 4.04-B, the Department is eliminating website information that is stated in 4.04-Covered Services and adding language that states that ASC covered services may be billed in addition to the surgical procedure. In Section 4.05, Non-Covered Services, the Department is deleting the 3rd and 4th paragraph "Payment for" Presbyopia-Correcting Intraocular Lens, etc, as this is clarified in Section 4.04-A. In section 4.07-2 the Department is proposing to change the language to clarify that when there are multiple procedures in the same operative session MIHMS will pay for one procedure, which has the highest payment amount.

Estimated Fiscal Impact: Cost Neutral

Proposed:	March 10, 2010	Public Hearing:	None Scheduled
Staff:	Cindy Boucher	Comment Deadline:	April 14, 2010

Chapters II and III, Section 5, Ambulance Services- The Department of Health and Human Services proposes language in Chapter II to lift prior authorization requirements for all four air ambulance transportation services when performed within state borders. All out of state air ambulance services continue to require prior authorization, following the guidelines set forth in Section 1.14-2 of the Maine Care Benefits Manual.

Reflecting the 2010-2011 Supplemental Budget (P.L. 2009, c. 571, Part A, Section 26) allowance, Chapter III contains proposed rate changes to 70% of Medicare-allowed rates. These proposed set-rate fees are in response to the CMS requirements 42 CFR 414.601 et seq., as well as serve to replace the supplemental payments used in previous rulemakings under this Section. Other edits and clarifications.

Expected Fiscal Impact: Projected to cost $876,186 for SFY11 and $1,024,150 for SFY12, respectively.

Proposed:	April 27, 2010	Public Hearing:	May 24, 2010
Staff:	Delta Cseak	Comment Deadline:	June 6, 2010

Chapter III, Section 7, Free-Standing Dialysis Services- The Department of Health and Human Services, MaineCare Services, is proposing changes to Chapter VIII, Section 7, Free-Standing Dialysis Services. Specifically, the Department proposes to require that providers bill using HCPCS codes along with Revenue codes when billing for Free-Standing Dialysis Services. This will be effective upon implementation of the new claims system, MIHMS, with a 30 day notice to providers. This is necessary in order to be consistent with Medicare guidelines, satisfy correct coding, and to remain HIPPA compliant.

Expected Fiscal Impact: Cost Neutral

Proposed:	April 13, 2010	Public Hearing:	None Scheduled
Staff:	Cindy Boucher	Comment Deadline:	May 28, 2010

Chapters II and III, Section 12, Consumer Directed Services- The Department is proposing changes to the above named sections of the MaineCare Benefits Manual. Specifically, proposed changes to Chapter II include adding two services: care coordination and skills training. These

services were formerly billed under Section 13, Targeted Case Management, as part of a per member per month fee. In addition, all references to "provider" are replaced with "Service Coordination Agency". Proposed changes also include the addition of a "limits" section, which outlines the allowed maximum number of billable hours for each service. Finally, chapter II changes include structural reorganization as well as elimination of any redundancy found throughout the rules. In Chapter III, the Department is proposing to add the two HIPAA-compliant service codes needed to bill for care coordination and skills training. A new rate is also proposed for attendant care services. All changes proposed in these rules support implementation of the Maine Integrated Health Management System (MIHMS).
Estimated Fiscal Impact: This proposed rule is expected to increase expenditures by $42,000 in SFY 10 and $126,000 in SFY 11.

Proposed:	January 19, 2010	Public Hearing:	February 18, 2010
Staff:	Alyssa Morrison	Comment Deadline:	February 28, 2010

Chapter II and III, Section 19, Home and Community Benefits for the Elderly and Adults Disabilities- The Department is proposing changes to the above named sections of the MaineCare Benefits Manual. Specifically, the Department proposes changes to the arrangement and billing of case management services. These changes include unbundling the three main services that formulate the current case management service. These services are skills training, financial management services, and care coordination. Historically, these services have been bundled together and paid with a per member, per month rate. In addition, all references to the term Home Care Coordination Agency (HCCA) are deleted because the functions of the HCCA are no longer necessary. Also, the proposed language consistently refers to "personal support specialist (PSS)" throughout the rules. Several definitions are also added to rule, including: Care Coordination, Financial Management Services, Service Coordination Agency, Skills Training, Supports Brokerage, and Waiver Services Provider. Proposed changes also include adding a limits section, which outlines the allowed maximum number of billable hours for care coordination and skills training. Additionally, these rules propose that the Office of Elder Services maintain member wait lists and that the Division of Finance under DHHS collect any cost of care that has been determined by MaineCare eligibility from the member. Both functions are currently performed by the HCCA. Finally, chapter II changes include structural reorganization as well as elimination of any redundancy found throughout the rules. In Chapter III, the Department is proposing the elimination of local codes and replacing with HIPAA-compliant service codes. In some instances, new rates and billing increments for services are proposed. All changes proposed in these rules support implementation of the Maine Integrated Health Management System (MIHMS).
Some of the changes proposed in this rule-making will require amendment of the waiver document filed with the Federal Centers for Medicare and Medicaid Services (CMS), and these amendments will require CMS approval before they are effective.
Estimated Fiscal Impact: These proposed changes are expected to be cost neutral.

Proposed:	January 19, 2010	Public Hearing:	February 17, 2010
Staff:	Alyssa Morrison	Comment Deadline:	February 27, 2010

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Chapters II and III, Section 22, Home and Community Benefits for Adults with Physical Disabilities- The Department proposes changes to the above named Section of policy. Specifically, these proposed changes impact Section 22.05, Covered Services, by separately identifying the services that make up the current case management service. These services are skills training, financial management services, and supports brokerage. In addition, all references to "provider" are replaced with "Service Coordination Agency". Proposed changes also include clarification under Section 22.06, Limits, which outlines the allowed maximum number of billable hours for each service. Additionally, these rules propose that the Office of Adults with Cognitive and Physical Disabilities maintain member wait lists and that the Department collect the cost of care from the member. Both functions are currently performed by the provider agency. Finally, chapter II changes include structural reorganization as well as elimination of any redundancy found throughout the rules. In Chapter III, the Department is proposing to add three HIPAA-compliant service codes needed to bill for skills training, financial management services and supports brokerage. The Department is also proposing to allow providers to bill for installation of the Personal Emergency Response System (PERS), which is consistent with other Home and Community Based waiver programs. Additionally, the Department proposes that the attendant care rate increase from $2.61 to $2.72 per fifteen minutes.

Estimated Fiscal Impact: These proposed changes are expected to be cost neutral

Proposed:	January 19, 2010	Public Hearing:	February 18, 2010
Staff:	Alyssa Morrison	Comment Deadline:	February 28, 2010

Chapters II and III, Section 25, Dental Services- In Chapter II of Section 25, Dental Services, the proposed rule change requires, for Temporomandibular Joint Treatment (TMJ), that providers access prior authorization criteria that are industry recognized criteria utilized by a national company under contract, in addition to prior authorization criteria set forth in the rule itself. Providers can access these prior authorization criteria by accessing the OMS website at: http://www.maine.gov/dhhs/oms/provider_index.html which will have a link to the PA portal. In cases where the portal requires that certain criteria be met, and the member fails to meet those criteria, such services will not be covered or allowed under the MaineCare program.

In Chapter III of Section 25, the Department is clarifying that PA is not required for D4341, if a member has a diagnosis code 101. To the extent that payment for D4341 has been denied is a member has a diagnosis of 101, the Department will approve reimbursement retroactively.

Estimated Fiscal Impact: Cost Neutral

Proposed:	April 6, 2010	Public Hearing:	May 3, 2010
Staff:	Nicole Rooney	Comment Deadline:	June 3, 2010

Chapter II, Section 35, Hearing Aids and Services- The Department of MaineCare Services is proposing changes to MaineCare Benefits Manual, Chapter II, Section 35, Hearing Aids and Services. The proposed rule change requires, for some services, providers to access prior authorization criteria that are industry recognized criteria utilized by a national company under contract, in addition to prior authorization criteria set forth in the rule itself. Providers can access these prior authorization criteria by accessing the OMS website at: http://www.maine.gov/dhhs/oms/provider_index.html which will have a link to the PA portal. In cases where the portal requires that certain prior authorization criteria be met, and the member

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fails to meet those criteria, such services will not be covered or allowed under the MaineCare program. Also in this rulemaking, the Department will require documented evidence that a hearing test has occurred within preceding 6 months. Finally, in Section 35.07 B, the Department is now requiring a trial period of 30 days, after which the Audiologists or Hearing Aid Dealer and Fitter must provide written confirmation that the device meets the member's need and should be purchased.

Expected Fiscal Impact: Cost Neutral

Proposed:	April 6, 2010	Public Hearing:	May 3, 2010
Staff:	Nicole Rooney	Comment Deadline:	June 3, 2010

Chapters II and III, Sections 41, Day Treatment, and 65, Behavioral Health Services- Chapters II & III, Section 41, Day Treatment of the MaineCare Benefits Manual is being repealed and the service Day Treatment is being moved to Chapters II & III, Section 65, Behavioral Health Services. The service as described in Section 65 must be medically necessary and provided by qualified staff. HIPAA compliant coding will be utilized. Behavioral Health Professionals and Licensed Clinical Staff will be allowed to provide Children's Behavioral Health Day Treatment Service in a school setting; reimbursement will be based on level of credential. The maximum number of hours reimbursed will be reduced from eight (8) to six (6) per day. In addition, Section 65 imposes additional eligibility requirements for Children's Behavioral Health Day Treatment.

Behavioral Health Day Treatment may be provided by Schools and by mental health agencies who provide programs in private special purpose schools. Additionally, Schools will be allowed to provide the following services, as long as they have enrolled to provide them and the qualified staff: 65.06-3, Outpatient Services, 65.06-4 Family Psychoeducational Treatment, 65.06-7 Neurobehavioral Status Exam and Psychological Testing, 65.06-9 Children's Home and Community Based Treatment, 65.06-10 Collateral Contacts Children's Home and Community Based Treatment, and 65.06-13 Children's Behavioral Health Day Treatment.
There are routine technical changes in order to prepare for the implementation of MIMHS. HIPAA compliant coding for Children's ACT services is being proposed. The requirement for a hospital to have a Mental Health License is being removed. The limit for members in a Differential Substance Abuse Treatment (DSAT) substance abuse group is being changed. Other routine technical changes to Section 65, Behavioral Health Services have also been proposed.
Estimated Fiscal Impact: Cost Neutral

Proposed:	March 10, 2010	Public Hearing:	April 2, 2010
Staff:	Ginger Roberts-Scott	Comment Deadline:	April 12, 2010

Chapter II, Section 45, Hospital Services- These proposed rules seek to add admission eligibility and continuing eligibility criteria for hospital detoxification services. The Department needs to ensure that MaineCare services are delivered only to individuals who are eligible for those services. These changes will assure the efficient operation of the MaineCare program. Further, the administrative burden of utilization review will be lessened if the admission and continuing eligibility criteria are clear from the beginning. These proposed rules also seek to remove specifics in billing instructions and reporting of rebatable drugs in favor of listing those

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specifics on the DHHS website. These changes would consolidate those instructions to one location.

Expected Fiscal Impact: Cost Neutral

Proposed:	December 22, 2009	Public Hearing:	January 20, 2010
Staff:	Derrick Grant	Comment Deadline:	January 31, 2010

Chapter III, Section 45, Hospital Services- The rule proposes to change the reimbursement methodology for acute care non critical access hospitals as follows: Inpatient discharges would be reimbursed on a Medicare DRG-based system, and would include a direct care DRG rate, as well as estimated capital and medical education costs. This reimbursement would be subject to interim and final settlements. Outpatient services would be reimbursed based on a percentage of Medicare Ambulatory Payment Classification (APC) rates, which would include lab and radiology costs. APC would be reimbursed based on submitted claims and would not be subject to settlement. Hospital-based physician costs would be paid based on submitted claims and subject to settlement.

Acute care non-critical access hospitals will continue to be reimbursed under the PIP methodology for services provided until the first day of the hospital's first fiscal year after MIHMS goes live, at which time the proposed DRG and APC methodologies would go into effect. There will be no PIP reimbursement for services provided on or after that date.

In addition, effective July 1, 2010, the rule proposes to: reduce the inpatient portion of the PIP rate for acute care non-critical access hospitals by 4%; reduce the inpatient DRG rate by 4%; and reduce the distinct psychiatric unit discharge rate by $500 per hospital. Effective April 1, 2010, the rule proposes to reduce reimbursement to acute care critical access hospitals to 101% of allowable inpatient and outpatient costs.

These proposed changes are subject to CMS approval. Hospitals will receive at least a 30 day notice of "go live" date for MIHMS.

Estimated Fiscal Impact: Estimate of any expected increase or decrease in annual aggregate expenditures: these changes will result in an estimated total reimbursement reduction to hospitals in the amount of $1,605,082 in SFY 10 and $14,055,559 in SFY 11.

Proposed:	January 13, 2010	Public Hearing:	February 17, 2010
Staff:	Derrick Grant	Comment Deadline:	March 1, 2010

Chapter II, Section 46, Psychiatric Hospital Services- These proposed rules seek to add admission eligibility and continuing eligibility criteria for psychiatric hospital detoxification services and developmental disorders unit services. The Department needs to ensure that MaineCare services are delivered only to individuals who are eligible for those services. These changes will assure the efficient operation of the MaineCare program. Further, the administrative burden of utilization review will be lessened if the admission and continuing eligibility criteria are clear from the beginning.

Expected Fiscal Impact: None

Proposed:	December 22, 2009	Public Hearing:	January 20, 2010
Staff:	Derrick Grant	Comment Deadline:	January 31, 2010

Chapter III, Section 50, Principles of Reimbursement for ICF-MR- This proposed rule does away with costs for Community Support Services (formerly called Day Habilitation Services) as

part of the cost basis of the per diem rate for Intermediate Care Facilities for persons with mental retardation. Instead, the rule refers providers to the reimbursement methods and rate for Community Support Services set forth in MBM, Chapters II and III, Section 21. The amendment is made necessary by the repeal of MBM, Section 24, Day Habilitation Services. The amendment will also allow the billing code for this service to conform to federally required codes and the implementation of the Department's new claims processing system. Since this rule is a Major Substantive rule, it will not be finally adopted until approved by the Legislature.
Expected Fiscal Impact: The Department anticipates the following savings: SFY11 - Total $148,011.94 / Federal $102,172.64 / State $45,839.30. SFY12 - Total $148,011.94 / Federal $94,431.62 / State $53,580.32.

Proposed:	April 6, 2010	Public Hearing:	May 4, 2010
Staff:	Ginger Roberts-Scott	Comment Deadline:	May 14, 2010

Chapter II, Section 60, Medical Supplies and Durable Medical Equipment- The Department of MaineCare Services is proposing changes to MaineCare Benefits Manual, Chapter II, Section 60, Medical Supplies and Durable Medical Equipment. The Department proposes, to require, for some services, providers to access prior authorization criteria that is industry recognized criteria utilized by a national company under contract. Providers can access prior authorization criteria by accessing the OMS website at: http://www.maine.gov/dhhs/oms/provider_index.html which will include a link to the PA portal. In cases where the portal requires that certain criteria be met, and the provider fails to meet those criteria, such services will not be covered or allowed under the MaineCare program. Also, in this rulemaking, the Department proposes the addition of coverage for Microprocessor Controlled Knee Protheses when certain criteria are met. Providers can access the criteria at the above web portal. Furthermore, the Department is now requiring all repairs to DME equipment with total cost that exceed 60% of replacement, require prior authorization. Finally, the Department is clarifying current incontinence limitations in this rule, in addition to making re-formatting changes in this rulemaking.
Expected Fiscal Impact: Cost Neutral

Proposed:	April 6, 2010	Public Hearing:	May 3, 2010
Staff:	Nicole Rooney	Comment Deadline:	June 3, 2010

Chapter II, Section 90, Physician Services- The Department is making changes to MaineCare Benefits Manual, Chapter 101, Section 90, Physician's Services Ch II. The changes increase the MaineCare reimbursement rate for physician services from 56.94% to 70% effective March 1, 2010. This increase will not include reimbursement for procedures performed by radiologists, radiation oncologists, and pathologists, who currently receive a higher rate of reimbursement. No procedure codes are decreased as a result of this rulemaking. Furthermore, this increase does not apply to other sections of policy within the MaineCare Benefits Manual, Chapter 101. Providers can visit the Office of MaineCare's website for the current fee schedule. The fee schedule can be found at http://portalxw.bisoex.state.me.us/oms/proc/pub_proc.asp?cf=mm.

Proposed:	March 17, 2010	Public Hearing:	April 5, 2010
Staff:	Nicole Rooney	Comment Deadline:	April 15, 2010

Chapters II and III, Section 90, Physician's Services- In Chapter II of this rulemaking, the Department proposes, to require, for some services, providers to access prior authorization

criteria that is industry recognized criteria utilized by a national company under contract. Providers can access criteria by utilizing the following portal: http://www.maine.gov/dhhs/oms/provider_index.html. In cases where the portal requires that certain criteria be met, and the provider fails to meet those criteria, such services will not be covered or allowed under the MaineCare program. The proposed rule also changes the reimbursement methodology by reimbursing providers at 70% of the Medicare fee schedule effective March 1, 2010 consistent with the March 1, 2010 Emergency rulemaking and another rulemaking proposed on March 17, 2010. Upon implementation of the MIHMS system, MaineCare will require providers to utilizing Medicare's fee schedule based on place of service and modifiers. Finally, the Department has changed transplant criteria to require members to be free of alcohol and drug use for 6 months prior to transplant.

In Chapter III of this rulemaking, upon implementation of Maine's Integrated Health Management System (MIHMS), the Department will repeal Chapter III, Section 90, since all necessary methodology and billing information can be found at either Chapter II or on the Department's website.

Expected Fiscal Impact:	Cost Neutral		
Proposed:	April 6, 2010	Public Hearing:	May 3, 2010
Staff:	Nicole Rooney	Comment Deadline:	June 3, 2010

Chapter II, Section 95, Podiatric Services- In Chapter II of this rulemaking, the Department proposes, to require, for some services, providers to access prior authorization criteria that is industry recognized criteria utilized by a national company under contract. Providers can access criteria by utilizing the following portal: http://www.maine.gov/dhhs/oms/provider_index.html. In cases where the portal requires that certain criteria be met, and the member fails to meet those criteria, such services will not be covered or allowed under the MaineCare program.

Expected Fiscal Impact:	Cost Neutral		
Proposed:	March 16, 2010	Public Hearing:	May 3, 2010
Staff:	Cindy Boucher	Comment Deadline:	June 3, 2010

Chapters II and III, Section 96, Private Duty Nursing and Personal Care Services- The Department is proposing changes to the above named sections of the MaineCare Benefits Manual. Specifically, proposed changes to Chapter II include adding two services: care coordination and skills training. These services were formerly billed under Section 13, Targeted Case Management, as part of a per member per month fee. In addition, the proposed rules remove the term "Personal Care Assistant (PCA)" from rule and replace with "Personal Support Specialist (PSS)". The Department also proposes to remove the definition of and reference to the Home Care Coordination Agency (HCCA), as the functions of the HCCA are no longer needed. Instead, the Service Coordination Agency will be providing the care coordination and skills training services. Proposed changes also include the addition of a "limits" section, which outlines the allowed maximum number of billable hours for each service. The Department also proposes to extend suspension of services from 30 days to 60 days. Changes are also proposed to PSS training requirements, allowing for job shadowing and on-the-job training to count toward the required number of training hours. In Chapter III, the Department proposes to

eliminate all local codes and replace with HIPAA-compliant service codes needed to bill for all services covered under Chapter II.
Estimated Fiscal Impact: State expenditures are expected to increase $5,500 for SFY10 and $12,644 in SFY11.

Proposed:	January 19, 2010	Public Hearing:	February 17, 2010
Staff:	Alyssa Morrison	Comment Deadline:	February 27, 2010

Chapter VI, Section 3, MaineNET- The Department is proposing to repeal this Section of MaineCare policy, since this demonstration has not been in use for at least ten years.
Expected Fiscal Impact: Cost Neutral

Proposed:	March 3, 2010	Public Hearing:	None Scheduled
Staff:	Cindy Boucher	Comment Deadline:	April 12, 2010

Rules Adopted or Provisionally Adopted Since Last Status Update

Chapter III, Section 21, Home and Community Benefits for Members with Mental Retardation or Autistic Disorder - The final adopted rules specify rates. Additionally, the final rules specify changes to billing codes necessary to comply with federal coding requirements. The coding changes will take effect when the Department's new claims processing system (MIMHS) becomes operational, which is expected to occur in August, 2010. Providers will receive 30 days notice of the effective date of the coding changes.
Expected Fiscal Impact: $217,758.00 for SFY 10 and $ 435,516 for SFY 11

Staff:	Alyssa Morrison	Effective Date:	June 1, 2010

Chapters II and III, Section 31, Federally Qualified Health Center (FQHC) Services- The rule adds a new provision under "reimbursement" which sets forth the Department's legal obligations for individuals who are eligible for Medicare, some of whom are also eligible for Medicaid (QMB only, QMB plus and non QMBs). This section complies with federal regulations on Medicare cost sharing. Also, the Department intends to transition to a new information system, MIHMS in 2010, with 30 days notice to providers. Upon implementation of MIHMS, the Department deletes the current local billing codes in Chapter III, Table 1, and replace them with the codes in Chapter III, Table 2 to become compliant with Federal HIPAA regulations. Further the Department will require providers to bill services, including documenting the type of visit, diagnoses and procedures on the UB04 claim form, which will replace the CMS 1500 form.
Expected Fiscal Impact: Cost Neutral

Staff:	Cindy Boucher	Effective Date:	May 1, 2010

Chapter III, Section 50, Principles of Reimbursement for Intermediate Care Facilities for the Mentally Retarded- This emergency rule does away with costs for Community Support Services (formerly called Day Habilitation Services) as part of the cost basis of the per diem rate for Intermediate Care Facilities for persons with mental retardation. Instead, the rule refers providers to the reimbursement methods and rate for Community Support Services set forth in

MBM, Chapters II and III, Section 21. The amendment is made necessary by the repeal of MBM, Section 24, Day Habilitation Services. The amendment will also allow the billing code for this service to conform to federally required codes and the implementation of the Department's new claims processing system. This rulemaking will not be finally adopted until approved by the Legislature.
Estimated Fiscal Impact: The Department anticipates the following savings:
SFY11 - Total $148,011.94 / Federal $102,172.64 / State $45,839.30
SFY12 - Total $148,011.94 / Federal $94,431.62 / State $53,580.32.

Staff: Ginger Roberts-Scott Effective Date: April 1, 2010

Chapter II and III, Section 67, Nursing Facilities- The Department adopted the following changes to Chapter II, Section 67, Nursing Facility Services: adds language describing the practice of continued stay in a NF when a resident is no longer medically eligible for NF services and is awaiting placement for a residential care setting; adds a service for residents who have been receiving services under Section 24, Day Habilitation Services, which are being repealed; complies with State statute that allows residents to receive maintenance-level therapy when it has been determined the services are medically necessary in order to avoid a significant deterioration in ability to communicate orally, safely swallow or masticate; expands eligibility for specialized services for members with MR or "other related condition"; and changes terminology that is compliant with the new claims system. Furthermore, the Department adopted changes to Chapter III, Principles of Reimbursement for Nursing Facilities, by changing the methodology establishing the direct care cost components and consequently the prospective per diem rates for facilities. Additionally, methodology is added under principal 70 to support facilities billing for community support services, formerly billed under Section 24. The Department also amended language that is now in state statute regarding depreciation recapture. Finally, changes also include adding the OBRA Assessment definition as well as deleting the DRI definition.
Estimated Fiscal Impact: The rules will increase expenditures by $216,159.79 for SFY 10 and $336,104.95 for SFY 11.
Staff: Alyssa Morrison Effective Date: Chapter II, Section 67.05-13(G) and Chapter III, Principle 70 are effective retroactive to April 1, 2010. All other adopted changes are effective April 25, 2010 and will be implemented upon MIHMS go-live. Providers will be notified at least thirty (30) days prior to the MIHMS start-date.

Chapter II, Section 94, Early Prevention, Screening, Diagnosis and Treatment Services (EPSDT) - The Department of Health and Human Services adopted changes to this section to update terminology and make technical corrections to prepare for the Maine Integrated Health Management Solution (MIHMS). Additionally, the rule is being renamed.
Expected Fiscal Impact: Cost Neutral
Staff: Delta Cseak Effective Date: May 1, 2010

Chapter III, Section 97, and Appendix D and E, Private Non-Medical Institution Services- The Department finally adopted a major substantive rulemaking to make permanent the August 1, 2009 Emergency Substantive PNMI, Ch. III rule, currently in effect as well as propose other additional clarifications. The Department amended Appendix D (Child Care PNMI Facilities) by deleting the cost settlement requirement. The Department provisionally adopted a standardized

capitated rate for five (5) levels of child services based on a child's diagnosis and level of acuity. These rates were established by analyzing data from claims and time studies and unbundling service components to establish an Upper Payment Limit. The Department added new billing codes for children's services. The capitated rate includes reimbursement for all PNMI services required by a child for his/her category of level of care including all staffing required both by Maine licensing guidelines, and as identified in the child's individual service plan, The Legislature mandated the 5 levels of child services in P.L. 2009, ch. 213, Part CC. The Department also amended Appendix E (Community Residences for Persons with Mental Illness) by deleting "scattered site" PNMI services. The Department anticipates that those services will still be provided to members in their apartments, but instead will be reimbursed through Community Support Services under Section 17 of the MaineCare Benefits Manual. Other proposed changes in Ch. III update billing codes for the Department's new claims system for all other PNMI services, and clarify in Ch. III where language pertaining to auditing cost reports no longer applies to Appendix D PNMI services.
Estimated Fiscal Impact: Savings of $6.8 million per State Fiscal year for children's PNMI services and $1.7 million per State Fiscal year for Adult PNMI services.
Staff: Patty Dushuttle Effective Date: May 15, 2010

Chapter 104, Maine State Services Manual, Section 4, Maine Part D Wrap Benefits- Effective January 1, 2010, the Department is adopting this Emergency rule to increase the member co-payment for generic drugs under the Part D Wrap Benefits from $2.40 to $2.50 per prescription. The co-pay increase is necessary in order to comply with the federal adjustments to copayment requirements under 42 U.S.C. § 1395w-102(b). The Department will propose rules that will make the change permanent.
Expected Fiscal Impact: Since the State pays 100% of generic drug co-pays and 50% of brand-name drugs, the increased co-pay will increase State expenditures by $.10 cents per claim for generic drugs for an estimated cost of $73,000.
Staff: Nicole Rooney Effective Date: April 1, 2010

Chapter 115, Principles of Reimbursement for Residential Care Facilities- Room and Board: In this rulemaking, the Department changed Section 20, Fixed/Capital Costs of this Section to make this language consistent with language in State statute regarding depreciation recapture for nursing facilities. The changes are for chapter 115, Section 20, Fixed Capital Costs only. This will make regulations for residential care facilities consistent with the regulations for nursing facilities in this aspect. These regulations define how recapture depreciation is calculated upon the sale of a facility, and will be retroactive to January 1, 2010 as authorized by 22 M.R.S.A § 42(8), since these changes are beneficial to RCF providers.
Estimated Fiscal Impact: Cost Neutral
Staff: Patricia Dushuttle/Margaret Brown Effective Date: May 15, 2010

In Draft (Intended to be Effective upon MIHMS Implementation):

******Several Sections of Chapter III will be opened in the near future to reflect budget reductions recently approved in the Supplemental budget. The Department has been given**

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authority to do emergency rulemaking for these reductions, to be in effect for July 1, and in some cases, upon MIHMS go-live if the change is not possible in MECMS. Workgroups to finalize the implementation of these reductions are ongoing, and further detail will be provided as available.

Chapter I, General Administrative Policies and Procedures-The Department will file emergency rules in an Appendix of Chapter I to implement several 10% rate reductions directed by the Maine State Legislature. Ten percent rate reductions for several sections will be summarized in an Appendix of Chapter I for those Sections earmarked for reductions that include rates that are "by report" or "negotiated." For Sections with specific rates listed in Chapter III of the respective sections, a separate rulemaking will be done for each section.
Estimated Fiscal Impact: TBA
Expected Filing: July 1 Staff: Cindy Boucher

Chapter I, General Administrative Policies and Procedures- The Department will propose language intended for compliance with all MIHMS changes. The Department will also add an appendix detailing the percentage of adjustment as a result of the approved Supplemental budget.
Expected Fiscal Impact: Cost Neutral
Expected Proposal: May Staff: Cindy Boucher

Chapters II and III, Targeted Case Management Services- The Department will make changes to this section to remove the adult target group- Adults with Long Term Care Needs. These individuals will get care management services under other sections of the MaineCare Benefits Manual, including Sections 12, 19, 22, and 96. The Department is also converting several services from monthly to weekly billing to reflect CMS requests. Language regarding documentation of allowable costs will be added for those government providers who qualify to be Certified Public Expenditure providers.
Expected Fiscal Impact: Cost Neutral
Expected Proposal: May Staff : Margaret Brown

Chapter II, Section 21, Home and Community Benefits for Members with Mental Retardation or Autistic Disorder - The Department proposes changing the term "mental retardation" with "intellectual disabilities", where appropriate to conform to more modern terminology proposed for the newest revision to the Diagnostic and Statistical Manual and the Department's focus on respectful language. The initial classification process is re-named more accurately "Determination of Eligibility." Provisions regarding owned-operated businesses in the employment setting are clarified. Furthermore, the Department proposes to reduce the maximum allowance for community support service hours and work support service hours. The Department also proposes clarification language around work support services provided by a Direct Support Professional (DSP) to one member at a time. The Department establishes two additional grounds for involuntary termination of services to a member. Qualifications for DSPs and Employment Specialists are amended in this proposed rule-making. The proposed rules specifies use of the appeals process for members outlined in Chapter I of the MBM. Finally, the Rule includes a new Appendix IV, which outlines the various combinations of community support and work support hours available.
Expected Fiscal Impact: Cost Neutral

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Expected Proposal: May Staff: Alyssa Morrison

Chapter III, Section 23, Behavioral and Developmental Clinics- The Department will apply a 10% rate reduction to this Section.
Expected Fiscal Impact: TBA
Expected Proposal: July 1 Staff: Ginger Roberts-Scott

Chapters II and III, Chapter 32, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations- The Department will make changes to eligibility to allow some children who have chronic medical conditions as defined in Section 13, Targeted Case Management, to receive this service. The Department will also clarify that this service may be delivered in a school based setting.
Expected Fiscal Impact: TBA
Expected Proposal: Fall Staff: Ginger Roberts-Scott

Chapters II and III, Section 40, Home Health Services- The Department will amend this rule to include plan of care reviews and billing for medical supplies. Chapter III will also reflect HIPAA-compliant codes needed for MIHMS go-live.
Expected Fiscal Impact: cost neutral
Expected Proposal: Major Substantive Staff: Alyssa Morrison/Margaret Brown

Chapter II, Section 68, Occupational Therapy Services- The Department will propose allowing services to be authorized by a practitioner of the healing arts, removing a limitation on sensory integration, and other clarification language related to school based rehabilitative services.

Estimated Fiscal Impact: TBA
Expected Proposal: May Staff: Derrick Grant

Chapter III, Section 68, Occupational Therapy Services- The Department will apply a 10% rate reduction to this Section.
Expected Fiscal Impact: TBA
Expected Proposal: July 1 Staff: Derrick Grant

Chapter II, Section 85, Physical Therapy Services- The Department will propose allowing services to be authorized by a practitioner of the healing arts, removing a limitation on sensory integration, and other clarification language related to school based rehabilitative services..
Estimated Fiscal Impact: TBA
Expected Proposal: May Staff: Derrick Grant

Chapter II, Section 109, Speech and Hearing Services- The Department will propose allowing services to be authorized by a practitioner of the healing arts, and other clarification language related to school based rehabilitative services.
Estimated Fiscal Impact: TBA

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Expected Proposal: May Staff: Derrick Grant

Chapters II and III, Section 113, Transportation Services- The Department will be proposing a major rewrite of Chapter II that will clarify language to reflect current practices and waiver criteria, strengthen principles of the policy language, and address other non-substantive changes to correct format and grammar.. Chapter III will contain HIPAA compliant coding and new standardized fee-for-service rates. Proposed language will also clarify billing codes for providers transporting members receiving waiver services.
Estimated Fiscal Impact: TBA
Expected Proposal: May Staff: Delta Cseak

Chapter III, Section 150, STD Clinics- The Department will apply a 10% rate reduction to this Section.
Expected Fiscal Impact: TBA
Expected Proposal: July 1 Staff: TBA

MaineCare Benefits Manual, Chapter X, Section 3, Katie Beckett Benefits- The Department will move eligibility from institutional services rules into this Section to clarify Katie Beckett eligibility. Medical eligibility criteria from Sections 45, Hospital Services; 46 Psychiatric Hospitals; 50, ICF-MR; and 67, Nursing Facility Services will be removed and added to this Section of policy.
Expected Fiscal Impact: Cost Neutral
Expected Proposal: Spring Staff: Ginger Roberts-Scott

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State Plan Amendment Status:

09-011, Targeted Case Management- This SPA adds new target groups and associated eligibility and reimbursement.
Status: Submitted 9/30/09. Under Review by CMS. RAI issued, and official responses were submitted to CMS 3/18/10. CMS has asked that DHHS withdraw the responses to take the SPA "off clock" so that CMS can work with DHHS on this SPA.

09-015, Inpatient Hospital Reimbursement- The SPA addresses P.L. 2009, ch. 213, Part CC, effective July 1, 2009, which reduced hospital reimbursement. For acute care non-critical access hospitals, inpatient discharge rates (except for those from psychiatric units) were reduced 6.7% and reimbursement for outpatient services was decreased to 83.8% of costs. For critical access hospitals and hospitals reclassified to a wage area outside Maine, reimbursement for inpatient and outpatient services was reduced to 109% of costs. For all acute care hospitals, including critical access, hospital based physician reimbursement was decreased from 100% to 93.3% of allowable costs for inpatient non-emergency physicians, to 93.4% of costs for inpatient emergency physicians and to 83.8% of costs for outpatient non-emergency physicians. In addition, these state plan amendments eliminate the COLA adjustment for SFY's 2010 and 2011 for non critical access acute care hospitals for inpatient discharge rate and for psychiatric unit discharge rates. They cap the PIP payment so that the total payment to all hospitals is not less than 80% of the calculated amount. These changes must be submitted in state plan amendments to receive approval from CMS.
Status: Submitted 9/30/09. Under Review by CMS. A formal RAI was issued and responses were sent to CMS on 2/26/10.

09-016, Transportation, Bus Passes This SPA adds bus passes as a covered service when transportation providers find this the most cost effective method to provide transportation to medically necessary services.
Status: Submitted 9/30/09. "Off Clock", as CMS is reviewing a related 1915B waiver.

09-017, Pharmacy Reimbursement- This SPA addresses pharmacy reimbursement and reporting of J-codes by hospital based pharmacies. The Department will add a $5 administration fee for seasonal and H1N1 vaccines.
Status: Submitted 9/30/09 RAI issued, and responses submitted to CMS 4/12/10.

09-018 Primary Care Case Management- This SPA adds patient centered medical home services as reimbursable under PCCM.
Status: Submitted 12/20/09 Approved 3/11/10

10-001, Tribal Consultation- This SPA will assure CMS compliance with new requirements for consultation with Federally recognized Tribes when submitting state plan amendments and waivers. The Department is submitting this state plan amendment to assure compliance with

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ARRA protections for Indians in Medicaid and CHIP services, as directed in a State Medicaid Director Letter dated January 22, 2010.
Status: Submitted March 12, 2010 Under Review by CMS. CMS has asked that the State withdraw the SPA and resubmit when more process has been established. The process will be discussed at a Tribal Council in May.

10-002, DME Reimbursement- This SPA updates reimbursement methodology for DME to reflect recent rule changes.
Status: Submitted March 31, 2010 Under Review by CMS. Informal Request for Additional Information received with "same page" questions, conference call being set up to discuss responses.

10-003, Estate Recovery- The SPA will implement liens and resource recovery provisions included in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (MIPPA), P.L. 110-275. Section 115 of MIPPA requires States to exempt Medicare cost-sharing benefits paid under the Medicare saving programs from estate recovery under section 1917(b)(1) of the Act.
Submitted: March 31, 2010 Under Review by CMS

10-004, Physician Reimbursement: The SPA details MaineCare's reimbursement for non-hospital based physician services. MaineCare will reimburse all non-hospital based physician's 70% of the Medicare Maine Area 99 fee schedule. CMS has requested this SPA even though the Department is not changing its reimbursement methodology.
Submitted: March 31, 2010 Under Review by CMS

Waivers

1915B- Transportation Waiver-This waiver seeks to continue non-emergency medical transportation operations and reimbursement unchanged and is being submitted to bring Maine into formal compliance with CMS requirements. As such, no change in providers, expenditures or utilization volume or patterns is anticipated.
Status: Submitted January, 2010 Under Review by CMS. Formal Request for Additional Information issued by CMS. Responses sent to CMS on April 27, 2010.

1915C- Children's Waiver- Home and Community Based Waiver- Draft in progress. Provider and MAC workgroup meetings ongoing. Meeting with CMS held April 14, 2010 to discuss draft. Implementation date: January 1, 2011.

1915C – Home and Community Benefits for Members with Mental Retardation or Autistic Disorder – Renewing waiver for an effective date of 7/1/10. CMS has submitted informal RAI and the Department is in the process of responding to these questions/comments.

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MaineCare Provider Training for Medically Necessary School Based Services

With the repeal of MaineCare Policy Chapters II & III, Section 104, **School Based Rehabilitative Services**, Chapters II & III, Section 27, **Early Intervention Services** and Chapters II & III Section 41 **Day Treatment Services,** MaineCare will be holding training sessions in July for providers who provide medically necessary services for MaineCare members in a school setting.

This training will provide information that is needed for providers to continue providing medically necessary services under the following sections of MaineCare Policy:

- ☑ Section 65 Behavioral Health Services
- ☑ Section 68 Occupational Therapy
- ☑ Section 109 Speech Therapy
- ☑ Section 85 Physical Therapy
- ☑ Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations
- ☑ Section 96 Private Duty Nursing and Personal Care Services

The agenda will include:

- ☑ Highlights of these policy guidelines, presented by MaineCare Provider Relations staff.
- ☑ A presentation on Prior Authorization guidelines, provided by APS.
- ☑ A presentation from Molina Medicaid Solutions on the new MIHMS system including:
    - Provider enrollment changes that will need to be made on the enrollments that have already been approved in the new system.
    - Health Pas demonstration of Direct Data Entry and billing instructions.

Dates, times and locations for these trainings can be found on the next page. Please register soon as space will be limited!

MaineCare Provider Training for Medically Necessary School Based Services

Registration Form

Please circle the date you wish to attend.

Date & Time	**Location**
July 13th 9am-12pm	Presque Isle High School 16 Griffin Street Presque Isle, Maine 04769
July 14th 9am-12pm	Reeds Middle School 28A Main Road North Hampden, Maine 04444
July 20th 9am-12pm	South Portland High School 637 Highland Avenue South Portland, Maine 04106
July 28th 9am-12pm	Hall-Dale High School 97 Maple Street Farmingdale, Maine 04344

Provider Name:_____

Contact Name (if different than name above):_____

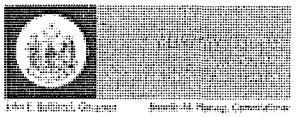
Organization / School:_____

Address:_____

Phone #:_____Number of persons attending:_____

Please return completed registration form to:
Attn: DHHS Customer Service Provider Training
State House Station # 11
Augusta, Maine 04333

If you have questions, please contact Linda Leet (linda.leet@maine.gov or 287-9377).



School Billing for Medically Necessary Services

Caring..Responsive..Well-Managed..We are DHHS

The Department has proposed to repeal MaineCare Benefits Manual effective 07/31/2010:

Chapters II & III, Section 27, Early Intervention Services

Chapters II & III Section 104
School Based Rehabilitation

Chapters II & III Section 41 Day Treatment Services

Chapter I, Section I

General Administrative Policies and Procedures which apply to all providers

Chapter I guidelines to remember

1.14-4 Medical Necessity

In determining medical necessity for a covered service, the Department reserves the right to refer members to appropriate providers so that the information needed to support such necessity may be obtained. In addition, the Department may ask an outside competent professional to evaluate claims of medical necessity where such an evaluation is necessary in order to authorize services. The Department may use evidence-based criteria and/or may use criteria based on national standards for evaluating what is considered medically necessary.

1.16 AUDITS

The Division of Audit or duly Authorized Agents appointed by the Department have the authority to monitor payments to any MaineCare provider by an audit or post-payment review

1.06-1 Covered Services

All covered services reimbursable by MaineCare must be medically necessary and described in the MaineCare Benefits Manual. MaineCare members are eligible for as many covered services that are medically necessary and within the limitations outlined in applicable sections of this Manual. The Department reserves the right to require additional medical opinions or evaluations by appropriate professionals of its choice concerning medical necessity or expected therapeutic benefit of any requested service.

Provider Enrollment

All providers under these sections must be enrolled and approved as MaineCare providers by the Office of MaineCare Services (OMS).

For Provider Enrollment Questions please call 866-690-5585 option 1

The services covered under th e sections previously mentioned as being repealed can be provided by qualified providers under oth er sections of the MaineCare Benefits Manual:

- Section 65Behaviora l Health Services
- Section 68Occupational Ther apy
- Section 109 Speech Therapy
- Section 85Phys ical Therapy
- Section 96Private Duty Nurs ing and Personal Care Services
- Section 28Rehab ilitative and Community Support Services for Children with Cognitive Impairments and Fundional Limitations

Member Eligibility

- Individuals must meet the eligibility criteria a s set forth in the Maine Care Eligibility Manual. Som e members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare, as described in MaineCare Benefits Manual, Chapter I, prior to providing services.
- Additional specific eligibility criteria are set forth for each service

Physical Therapy

Occupational Therap y

Speech Therapy

Covered Services

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Behavioral Health
- Personal Care Services

PT OT ST

These therapy services ordered by a physician or practitioner of the healing arts provided by or under the supervision of a licensed therapist for the purposes of evaluating a member's condition, planning and implementing a program of medical services to develop or maintain adaptive skills necessary to achieve the maximum physical and mental functioning of the member in his or her daily pursuits as documented in the ITP.

PT OT Covered Services

- Evaluations or Re-evaluations
- Modalities
- Therapeutic Procedures
- Tests
- Supplies

Limitations

- Physical and Occupational Therapy have a limitation of 2 hours per day
- Services must be conducted on a one on one basis
- Medical versus Educational

Speech Therapy Covered Services

- Evaluation
- Re-Evaluation
- Individual services
- Group services

Specific Eligibility For Care

Services for members of all ages must be medical necessary and ordered by a practitioner of the healing arts. The Department or its authorized agent has the right to perform medical eligibility determination and/or utilization review to determine if services are medically necessary.

Billing for PT OT ST

When billing for the following you will be using standard (CPT) Current Procedural Terminology codes published by (AMA) American Medical Association

Section 28

Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Provider Enrollment for Section 28

All providers under these sections must be enrolled and approved as MaineCare providers by the Office of MaineCare Services (OMS).
Schools must:
Show evidence of annual School approval and must meet all applicable provider requirements of this Section.
Providers are also subject to all requirements of MaineCare Benefits Manual (MBM), Chapter I, General Administrative Policies and Procedures.

Providers billing medically necessary treatment under section 28

Must bill under Chapter III Section 28 Children with Cognitive Impairments and Functional Limitations
the charts below give the eligible HCPC codes and descriptions eligible when medically necessary with prior authorization

Specific eligibility criteria

In addition to General Eligibility criteria the member must meet the medical necessity criteria to be eligible for services Section 28.02-2

A. Comprehensive Assessment
B. Family Participation

Non covered Services

Non-covered services are described in chapter I of the MaineCare Benefits Manual

MaineCare does not cover services that are primarily academic, vocational, social, recreational, or custodial in nature

Staff Requirements

A. **Qualification Requirements for Direct Care Staff:**

1. Direct care staff must meet the following minimum requirements:
   - Be at least 18 years of age;
   - Have a high school diploma or equivalent;
   - All direct care staff must obtain a Behavioral health professional (BHP) certification within one (1) year of hire.

Specific Criteria for Billing under Section 28

- Have completed Axis I or II behavioral health diagnosis
- Have a functional assessment administered within one (1) year prior to the date of the referral documenting functional impairment measured as two (2) standard deviations below the mean on the composite score or have one point five (1.5) standard deviations below the mean on the composite score and two standard deviations below the mean in the communication or social domain sub score of the most current version of the Vineland Adaptive Behavior.
- Family Participation is **REQUIRED**

Billing for Section 28 Chapter III

Procedure Code	Modifier	Description	Unit of Service	Maximum allowance
H2021	HI	SERVICES FOR CHILDREN WITH COGNITIVE IMPAIRMENTS AND FUNCTIONAL LIMITATIONS (COMMUNITY BASED WRAP AROUND SERVICES) 1:1	15 Minutes	$9.12
H2021	HQ HI	SERVICES FOR CHILDREN WITH COGNITIVE IMPAIRMENTS AND FUNCTIONAL LIMITATIONS (COMMUNITY BASED WRAP AROUND SERVICES) GROUP	15 Minutes	$2.28
H2021	HK	SPECIALIZED SERVICES FOR CHILDREN WITH COGNITIVE IMPAIRMENTS AND FUNCTIONAL LIMITATIONS(COMMUNITY BASED WRAP AROUND SERVICES) 1:1	15 Minutes	$12.26
H2021	HQ HK	SPECIALIZED SERVICES FOR CHILDREN WITH COGNITIVE IMPAIRMENTS AND FUNCTIONAL LIMITATIONS (COMMUNITY BASED WRAP AROUND SERVICES) GROUP.	15 Minutes	$3.05

Section 65
Mental Health

Children's Behavioral Health Day Treatment must be provided by one of the following:

- OPsychologist
- OLCSW Licensed Clinical Social Worker
- OLMFT Licensed Marriage and Family Therapy
- OLCPC Licensed Clinical Professional Councilor
- OLMSW Licensed Master's Social Work
- OBHP Behavioral Health Professional
- OMental Health Agency
- OSchool

Duration and Intensity of Services

Eligible MaineCare Members are entitled to receive up to the approved number of hours of services under this Section as are medically necessary, approved by DHHS or Its Authorized Agent, and described in an approved treatment plan

65.13BILLING INSTRUCTIONS

A.Providers must bill in accordance with DHHS' billing requirements for the CMS 1500 claim form.

B.In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, providers must follow the appropriate MaineCare provider billing instructions.

65.13 BILLING INSTRUCTIONS (cont)

C. All services provided on the same day must be submitted on the same claim form or MaineCare reimbursement.

D. For billing purposes, the unit is based on member time rather than staff time.

E.Providers must document appropriate and current ICD-9 diagnostic codes for members receiving medically necessary services in order to be reimbursed.

Providers billing medically necessary treatment under section 65

Must bill under Chapter III Section 65 Mental He alth the charts below give the eligible CPT/HCPC codes and descriptions eligible. when medically necessary with prior authorization

Chapter III Behavioral Health Services

Procedure Code	Modifier	Modifier	Unit	Service Description	Maximum Allowance per unit	PA/UR
H2000			½ hour	Independent LCSW, LCPC, LMFT – non Agency	$13.75	Y
H0004			½ hour	Independent LCSW, LCPC, LMFT-Non Agency	$13.75	Y
H0004	HQ		½ hour	Independent LCSW, LCPC, LMFT-Non Agency	$3.44	Y
H0025			Monthl y	Family Psychocducation Treatment Program Services for Children	$82.03	Y
H2027			1 Hour	Family Psychoeducation Treatment Program Services-Adult's	$10.50	Y

Chapter III Behavioral Health Services (cont)

Procedure Code	Modifier	Modifier	Units	Service Description	Maximum Allowance per unit	PA/UR
96116			1 hour	Neurobehavioral Status exam-Psychologist or Physician (includes face-to-face with the member and repot preparation)	$89.00	N
96101			1 hour	Psychological testing -Psychologist or Physician	$88.00	N
96102			1 hour	Psychological testing- Psychological Examiner face-to-face	$55.80	N
H2021	HN		½ hour	Comprehensive Community Support Services-Bachelor's level	$14.65	Y
H2021	HO		½ hour	Comprehensive Community Support Services-Master's level	$23.75	Y

Chapter III Behavioral Health Services (cont)

Procedure Code	Modifier	Modifier	Units	Service Description	Maximum Allowance per unit	PA/UR
G9007	HN		½ hour	Collateral Services - Bachelor's level	$14.65	Y
G9007	HO		½ hour	Collateral Services - Master's level	$23.75	Y
H2012	HN		½ hour	Children's Behavioral Health Day Treatment-Bachelor's Level	$58.60	Y
H2012	HO		½ hour	Children's Behavioral Health Day Treatment-Master's Level	$95.00	Y

Section 96
Private Duty Nursing and Professional Care Service

Eligible Providers

Private Duty Nursing Services are those services that are provided by a registered nurse and/or alicensed practical nurse, in accordance with the Board ó Nursing Regulations.

Personal Care Servicesare those Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and medcation administration services provided to a membeby a home health aide, certified nursing assistant, personal careassistant (also known as a personal support spcialist) (PSS), or certified residential medication aide (CRMA), as appropriate, while completing tasks in accordance with an authorized Individual Treatment Plan.

Eligible providers Cont:

Licensed PracticalNurse: A licensed practical nurse employed directly by or through a contractual relationship with a licensed home health agency may provide private duty nursing services by virtue of possession of a current license to practicetheir health care discipline in the state in which the services areperformed provided they are supervised by a processional nurse.

Registered Professional Nurse: A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting practitioner may provide private duty nursing services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed.

PDN and Personal Care Services

Appendix #2
Level of Care Caps

Task time allowances are used for the authorization of covered services under this Section. Refer to Section 96.04(C).

These allowances reflect the time normally allowed to accomplish the listed tasks. The Authorized Agent and PDN provider will use these allowances when authorizing a member's authorized plan of care. If these times are not sufficient when considered in light of a member's unique circumstances as identified by the Authorized Agent, the Authorized Agent may make an appropriate adjustment as long as the authorized hours do not exceed the limits established for the member's level of care.

PDN and Personal Care Services

Appendix #2
Level of Care Caps

Members are assigned to a level of care basedupon the eligibility criteria in Section 96.02. Levels of care I through V have financial caps as follows below. Members under the age of 21years can exceed the capswhen it is medically necessary outlined under Section 96.03(A). Reimbursement of carecoordination and skills training do not counttoward the monthly cost caps.

Level I	$750/month
Level II	$950/month
Level III	$1,550/month
Level IV (under 21 years of age, only)	$3,133/month
Level V	$20,682/month
Level VIII	$750/month

PDN CAPS

PDN agencies Case Managers track members benefits. If the member is close to reaching the cap the case manager will contact the school for a copy of the ITP/IEP and send to the authorized agent who will be review any PDN/PCA for medical necessity and authorize additional benefits if medically necessary.

The authorized agent will not be doing any PAs to the schools; they will only authorize a PA over PDN/PCA cap to the PDN agency.

Chapter III PDN and Personal Care Services

Providers billing for PDN and Personal Care Services must bill in accordance to Chapter III section 96 the eligible codes would be as follows:

Procedure Code	Description	Units	Amount
T1002	RN Services	15 Minutes	$11.07
T1003	LPN Services	15 Minutes	$6.32
T1019	Personal Support Service	15 Minutes	$3.75

(ITP) Individual Treatment Plan

The following information on the ITP applies to all School Based Services

Individual Treatment Plan (ITP)

Must be completed within 30 days of initiation of service.
The ITP is based on the comprehensive assessment and is appropriate to the developmental level of the member and contain the following documentation.

1. The Member's diagnosis and reason for receiving the service.
2. Specific medically necessary treatment services to be provided. Methods, frequency, duration and designation of who will provide the service.

ITP continued

3. Objectives with target dates that allow for measurement of progress toward meeting identified developmentally appropriate goals
4. Special accommodations needed to address barriers to provider the service
5. The parent or guardian must sign and date the ITP (prior to the start of service)
6. Be reviewed every 90 days by the treatment team

ITP Continued

7. If indicated, the member's needs may be reassessed and the ITP revised, signed and dated
8. The provider will provide the parents with a copy of the initial and reviewed ITP within ten days of signing.
9. Include a discharge plan with the following
   a. Discharge criteria that are related to the goals and objectives described in the ITP
   b. Identify the individuals responsible for implementing the plan; and
   c. identify supports necessary for the member and family to maintain the safety and well-being of the member, as well as sustain progress made during the course of treatment; an
   d. be reviewed by the treatment team every 90 days

ITP continued

Number 10 only applies to provider billing for medically services under section 65 and section 28

10. Crisis/Safety Plan. As applicatte
    The plan must:
    a. Identify the potential triggers which may result in crisis;
    b. identify strategies and techniques that may be utilized to assist the member whois experiencing a crisis and stabilize the situation;
    c. Identify the indviduals responsible for the implementation of the plan including any individuals identified by the parents or guardian, as significant to the member's stability and well-being

Progress notes

Providers must maintain written progress notes for all treatment services, in chronological order. All entries must include the treatment service provided, the provider's signature, the date on which the service was provided, the duration of the service, and the progress the member is making toward attaining the goals or outcomes identified in the ITP.

APS Authorization Process Presented by Kelly Bickmore

APS Healthcare
600 Sable Oaks Drive Suite 100
South Portland, ME 04106
www.qualitycareforME.com
Toll free: 866-521-0027
Fax: 866-325-4752

Slide Title

Body text

Caring..Responsive..Well-Managed..We are DHHS

MaineCare Advisory Committee
442 Civic Center Dr
Augusta, ME 04330

May 11, 2010

Angela Faherty, Acting Commissioner
Department of Education
23 State House Station
Augusta, ME. 04333-0023

Dear Commissioner Faherty,

During the last session, the legislature passed a new statute aimed at increasing the communication between the Departments of Education and Health and Human Services. Of particular concern was communication around changes in MaineCare rules that affect billing done by schools and/or Child Development Services for services provided the children in the school setting. The statute r
consult on any rule change that might have

Letter also Sent to:
Kim Moody, Disability
Julia Bell
Jill Adams
Dale Douglas

To that end, we would like to invite you to j
Advisory Committee (MAC). The MAC m
Civic Center Drive from 10-12. The purpo
into MaineCare policy and rules and all pol

Additionally, whenever a change is contem
we will issue a special invitation to you to a
This will assure that those who work with a
proposed rule changes.

Please let me know if you will be attending
individual will be. We look forward to wo

Sincerely,

Ana Hicks
Maine Equal Justice Partners
Chair, MaineCare Advisory Committee

Cc: Brenda Harvey
Kathy Bubar

MaineCare Advisory Committee Letter also sent to:

Kim Moody, Disability Rights Center
Julia Bell, Maine Developmental Disabilities Council
Jill Adams, MADSEC
Dale Douglas, Maine School Management Association

Attachment #4

MaineCare Services
An Office of the
Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
MaineCare Services
442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-2674; Fax: (207) 287-2675
TTY: 1-800-606-0215

May 6, 2010

Janet Mills, Attorney General
Office of the Attorney General
6 State House Station
Augusta, ME 04333-0006

MAY 0[illegible] 2010

Dear Ms Mills,

During the last session, the Maine State Legislature passed a new statute aimed at increasing the communication between the Departments of Education and Health and Human Services. Of particular concern was communication around changes in MaineCare rules that affect billing done by schools for services provided to children in school settings. The statute requires that you or your designee be asked to review changes in particular sections of the MaineCare Benefits Manual. The sections that must be reviewed are 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations, 41 Day Treatment, 65 Behavioral Health Services, 68 Occupational Therapy Services, 85 Physical Therapy Services, 96 Private Duty Nursing and Personal Care Services and 109 Speech and Hearing Services.

Changes are being made to many of those sections to assure that schools will be able to bill for the MaineCare reimbursable services they provide now that they can no longer bill on a bundled basis. The principal changes include adding schools as an appropriate location for providing the services, redefining some provider qualifications, allowing services to be authorized by practitioners of the healing arts in addition to physicians, and adding rates for services provided in a group setting.

The revisions to each of these sections have been made and, with the exception of Section 65, the APA process has been completed. Training will be provided to school personnel this summer and that schedule is nearly complete and will be published shortly. If, however, you would like to review any of these rules with staff of the Department, we will certainly accommodate that. Going forward, in order to assure optimal communications, we will notify you whenever a change is proposed in any of these rules and will provide an opportunity for you to review the rule prior to the rule being formally proposed.

Please let me know if you will be participating or if you will appoint a designee and who that individual will be. We look forward to working with you.

Sincerely,

Patricia J Dushuttle

Patricia Dushuttle
Director of Policy Division

Office of MaineCare Services Policy Director (Patty Dushuttle) Letter also sent to:

Dale Douglas, Maine School Management Association
Jill Adams, MADSEC
Julia Bell, Maine Developmental Disabilities Council
Kim Moody, Disability Rights Center