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 CHAPTER II

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		LAST UPDATED 4/1/10

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102.01 PURPOSE

The purpose of this rule is to cover rehabilitative services for eligible members who have sustained a brain injury. This section does not include coverage for services for people with brain injuries that are congenital or induced by birth. Rehabilitative services are specialized, interdisciplinary, coordinated, and outcomes focused. The services are designed to address the unique medical, physical, cognitive, psychosocial, and behavioral needs of members with acquired brain injuries. Limitations apply; services are appropriate if there is the potential for rehabilitation and the expectation of functionally significant improvements in the member's status, or in certain cases where services are necessary because their withdrawal would result in the member's measurable decline in functional status.

102.02 DEFINITIONS

102.02-1 **Authorized Agent** is an organization authorized by the Department to perform functions under a valid contract or other approved signed agreement.

102.02-2 **Brain Injury** is an insult to the brain resulting directly or indirectly from trauma, infection, anoxia, or vascular lesions, and not of a degenerative or congenital nature, but which may produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment. This does not include brain injuries that are induced by birth.

Effective
4/1/10

102.02-3 **CARF** is the Commission on Accreditation of Rehabilitation Facilities.

102.02-4 **Collateral Contact** is a direct (face-to-face) contact on behalf of the member by a provider to obtain information from, or discuss the member's case with, other professionals, caregivers, or others included in the treatment plan in order to achieve continuity of care, coordination of services, and the appropriate services for the member. Discussions or meetings among staff employed by a single provider on behalf of the member are not to be considered collateral contacts, and are not a billable service.

Effective
4/1/10

102.02-5 **Family** is a person with a demonstrated family relationship to a member with Brain Injury whose Brain Injury has led to challenging behaviors. For the purposes of this section, family may include only the following; parents, spouse, siblings, children, legal guardian, caregiver, significant other of the member with Brain Injury or the significant other's children.

102.02-6 **Functionally Significant Improvement** is the demonstrable measurable increase in the member's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

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102.02 **DEFINITIONS** (cont.)

Effective 4/1/10 102.02-7 **Individualized Treatment or Service Plan** is a person centered plan of rehabilitative care based on an individual assessment made by a professional or other qualified staff of a member's medical and social needs with specific functional and measurable goals and objectives, authorized by the Department, or the Department's Authorized Agent, at the discretion of the Department.

102.02-8 **Intensive Rehabilitation Nursing Facility (NF) Services for Individuals with a Brain Injury** means services that are delivered in a part of a NF and reimbursed a special rate pursuant to Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities, Intensive Rehabilitation NF Services for Brain Injured Individuals.

Effective 4/1/10 102.02-9 **Rehabilitation Potential** is the documented expectation of measurable, functionally significant improvement in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan, as determined by a qualified professional. The documentation of rehabilitation potential must include the clinical justification used for this expectation.

102.02-10 **Rehabilitative Provider** is a distinct organizational entity in a distinct physical setting, which provides coordinated and integrated services that include evaluation and treatment related to the member's functional limitations and the member's response to treatment. Members may require some services in the home and community away from the provider's physical setting in order to obtain optimal level of functioning. The services are designed to prevent and/or minimize chronic disabilities while restoring the member to the optimal level of physical, cognitive, and behavioral function within the context of the person, family, and the community. The services are highly specialized to address unique service needs of the individual, and designed to prevent deterioration and maintain an optimal level of function over time.

102.02-11 **Rehabilitative Services** are those covered services provided under the direction of a neuropsychologist or physician and delivered by a neuropsychologist, physician, occupational therapist, physical therapist, registered nurse, speech-language pathologist, or other qualified staff meeting the qualifications identified in Section 102.08-5.

Effective 4/1/10 102.02-12 **Significant Change/Relapse** is indicated when the member's score on the Department's authorized brain injury assessment tool increases from the most recent score to a score of at least three (3) on one (1) item, in two (2) or more domains.

102.03 **ELIGIBILITY FOR CARE**

A member is eligible to receive services under this Section if he or she meets both the General Eligibility Requirements for MaineCare and the Specific Eligibility Requirements detailed in

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102.03 **ELIGIBILITY FOR CARE** (Cont)

this Section. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I.

102.03-1 **General Eligibility Requirements for MaineCare**

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual (MEM). Some members may have restrictions on the type and amount of services they are eligible to receive, based on the MEM.

Effective
4/1/10

102.03-2 **Specific Eligibility Requirements**

A member must meet the following criteria:

Effective
4/1/10

A. Has a diagnosis of brain injury, as defined in Section 102.02-2 and confirmed by a clinical evaluation as defined in Section 102.05-1; and

B. Is not receiving acute hospital rehabilitation services; and

Effective
4/1/10

C. Is not receiving intensive rehabilitation NF services for individuals with a Brain Injury as defined in Section 102.02-8; and

D. If the member is currently receiving services in a nursing facility setting that are not intensive rehabilitative NF services, then the member must meet all of the following criteria:

i) The member's clinical evaluation documents rehabilitation potential (defined Section 102.02-9); and

ii) The member requires licensed/certified services to continue improvement; and

iii) The member has limited or no other access to rehabilitative services; and

iv) The member expresses a desire to move to a less restrictive setting; and

v) Discharge to a less restrictive living arrangement has been identified in the discharge potential section of the Minimum Data Set (MDS) (which is conducted by the NF) and active planning for discharge is documented in the member's NF plan of care.

102.03 ELIGIBILITY FOR CARE (Cont)

Effective
4/1/10

E. Meets the requirements of one of the following three Covered Services:

1. **Intensive Integrated Neuro-rehabilitation.** A member meets the medical eligibility requirements for **Intensive Integrated Neuro-rehabilitation** if he or she:

Scores at least “3” on one item, in two or more domains in the Department’s authorized Brain Injury Assessment Tool, (see Section 102.03-3); and

Has documented rehabilitation potential (defined in Section 102.02-9).

OR

2. **Neurobehavioral Rehabilitation.** A member meets the medical eligibility requirements for **Neurobehavioral Rehabilitation** if he or she

Scores at least “2” on one item, in any two or more domains in the Department’s authorized Brain Injury Assessment Tool, (see Section 102.03-3); and

Scores at least a “2” on any one item on questions 14, 15, 18, 19, 21, 22, 23, 24, 41, 42 or 43 in the Department’s authorized Brain Injury Assessment tool and

Has documented rehabilitation potential (defined in Section 102.02-9).

OR

3. **Community/Work Reintegration or Self Care/Home Management Reintegration.**

Scores at least “2” on one item, in two or more domains in the Department’s authorized Brain Injury Assessment Tool, (see Section 102.03-3); and

Requires this level of service to achieve documented rehabilitation potential or maintain function.

102.03-3 **Brain Injury Assessment Tool Criteria**

The member must have each item below rated by clinicians (any of the following, as appropriate: physician, neuropsychologist, registered nurse, occupational therapist, physical therapist, speech-language pathologist, social worker, professional counselor, or therapeutic recreation specialist) who have evaluated the member, are familiar with the member and the member’s history, including the clinical assessment, and have

102.03 **ELIGIBILITY FOR CARE** (Cont)

experience in the treatment of brain injury. Each item must be rated on the Department's Brain Injury Assessment Tool (BIAT) to indicate the level at which the member being evaluated experienced problems during the last two (2) weeks. The number of hours authorized to match the individual member's needs must be included on the Start of Care (SOC) and Utilization Review (UR) Form (see Section 102.08-3). The Brain Injury Assessment Tool is available to view and copy on the Department's website. The Department or its Authorized Agent may conduct an assessment as a part of utilization review.

The following scale, or variations set forth within the BIAT, is used for rating.

- 0** None
- 1** Mild problem but does not interfere with activities, or interferes less than 5% of the time; may use assistive device or medication
- 2** Mild problem; interferes with activities 5-24% of the time
- 3** Moderate problem; interferes with activities 25-75% of the time
- 4** Severe problem: interferes with activities more than 75% of the time

The BIAT measures the following domains and elements:

A. Physical Function

- Mobility
- Use of hands
- Dizziness
- Vision
- Audition

B. Language/Cognition

- Attention/Concentration
- Motor speech
- Verbal communication
- Nonverbal communication
- Visuospatial abilities
- Memory
- Novel problem solving
- Executive function/prospective memory
- Initiation
- Impaired self-awareness

C. Emotional Adjustment

- Anxiety
- Depression
- Inappropriate social interaction
- Irritability, anger, aggression
- Sensitivity to mild symptoms
- Psychotic symptoms

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102.03 **ELIGIBILITY FOR CARE** (cont.)

Problem behaviors
Danger to self or others

D. Independence

Eating/Self-care
Dressing/Self-care
Bathing/Self-care
Hygiene/Self-care
Toileting/Self-care
Information management and self-advocacy
Residence
Constructive roles
Managing money and finances

E. Medical

Pain and headache
Fatigue
Sleep disturbance
Medical self-care
Medication management and compliance

F. Substance Use

Alcohol use
Drug use
Nicotine use

G. Scoring

Effective
4/1/10

Please refer to 102.03-2 for specific eligibility requirements for pertinent scoring information.

Note: BIAT items adapted from the Mayo-Portland Adaptability Inventory-4 (MAPI). Original MAPI available on line at <http://www.tbindsc.org>

102.04 **DURATION OF CARE**

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MaineCare will only cover medically necessary services for eligible members. Covered services are subject to utilization review (UR), as well as the limits in Section 102.06. Rehabilitative services are covered for an approved period for each eligible MaineCare member. Beginning and end dates of the member's approved service period correspond to beginning and end dates for MaineCare reimbursement. MaineCare coverage will end on the period end date unless the Department or its Authorized Agent has authorized a new period. The Department reserves the right to request additional information to evaluate medical necessity.

102.05 COVERED SERVICES

A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual. The types of rehabilitative services that are covered for eligible individuals are the following:

102.05-1 **Clinical Assessment Services (96150, 96151)**

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A qualified neuropsychologist (defined in Section 102.08-5(B)) and/or a licensed physician who is Board certified, or otherwise Board eligible, in either physical medicine and rehabilitation or neurology, must conduct and supervise a Clinical Assessment, face-to-face with the member, in collaboration with the interdisciplinary team, as part of the admission process. The findings of the Clinical Assessment form the basis for the specific rehabilitation goals and describe the types and frequencies of each service and the expected outcomes and timeframes. The Clinical Assessment must indicate the degree of functional impairment, assess the member's potential for physical and/or behavioral and/or cognitive rehabilitation, include the BIAT and the health and safety assessment and meet the requirements of Section 102.08-7(A)(1). Reimbursement for brain injury Clinical Assessment services must not exceed eight (8) hours (32 units) of service, per member.

MaineCare will reimburse for the Clinical Assessment to confirm the diagnosis of brain injury, even if the member is not found eligible for services under this Section. These members should be provided with other service recommendations, as appropriate, to address needs identified by the Clinical Assessment. The provider will also conduct a Reassessment once every six months. All Clinical Assessments will be completed within thirty (30) days of initiation of services. If the Clinical Assessment cannot be completed within this time frame, case record documentation will reflect the reason and plans for completion.

102.05-2 **Intensive Integrated Neurorehabilitation (97532)**

Integrated treatment includes the rehabilitation of physical, cognitive, psychological, and behavioral issues including restorative and compensatory approaches. These treatments are provided on a 1:1 basis by licensed/certified medical/rehabilitative personnel within a coordinated team process. Care coordination is an integral component of this process.

102.05-3 **Neuro-behavioral Rehabilitation (96152, 96153, 96154)**

Integrated treatment includes interventions for biopsychosocial factors associated with brain injury: disruptive and non-compliant behaviors, cognitive unawareness, health and physically related risk-taking behaviors, and emotional adjustment to brain injury. These treatments are provided by licensed/certified medical/rehabilitative personnel and their extenders within a coordinated team process. Care coordination is included.

102.05 COVERED SERVICES (cont)

102.05-4 Self Care/Home Management Reintegration (97535, 97535-HQ)

Effective
4/1/10

Integrated treatment includes compensatory interventions and treatment focused on functional improvement and reinforcement of self care and home management. These treatments are provided on a 1:1 and group basis by licensed/certified medical/rehabilitative personnel and their extenders within a coordinated team process. Care coordination is included. Group services are coded with **HQ**.

102.05-5 Community/Work Reintegration (97537, 97537-HQ)

Integrated treatment includes compensatory interventions and treatment focused on functional improvement and reinforcement of community and work reintegration. These treatments are provided on a 1:1 and group basis by licensed/certified medical/rehabilitative personnel and their extenders within a coordinated team process. Care coordination is included. Group services are coded with **HQ**.

102.06 LIMITATIONS

Effective
4/1/10

A. Exclusive of Clinical Assessment and Reassessment, Services are limited to a combination of no more than eighteen (18) hours (72 units) per week. MaineCare will only cover one service at a time for each eligible member under this Section.

B. A member may not receive coverage for services under this Section if he or she is involved in acute hospital rehabilitation services.

C. A member may not receive coverage for services under this Section if he or she is receiving intensive rehabilitative NF services, as defined in Section 102.02-8.

Effective
4/1/10

D. Services must not duplicate services delivered under any other Section of the MBM, including but not limited to: Section 97, Private Non-Medical Institution Services; Section 12, Consumer Directed Attendant Services; Section 22, Home and Community-Based Waiver Services for the Physically Disabled; Section 19, Home & Community Benefits for the Elderly and for Adults with Disabilities; Section 96, Private Duty Nursing & Personal Care Services; Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; Section 109, Speech and Hearing Services; Section 111, Substance Abuse Treatment Services; Section 17, Community Support Services; Section 24, Day Habilitation Services for Persons with Mental Retardation; Section 26, Day Health Services; and Section 65, Behavioral Health Services.

E. MaineCare will only reimburse for initial clinical Assessment services (described in Sections 102.05-1 and 102.08-7(A)(1) up to eight (8) hours (32 units) of service, per member, per occurrence of acquired brain injury. MaineCare will reimburse Clinical Reassessment for up to eight (8) hours (32 units) per year.

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102.06 **LIMITATIONS** (cont)

- F. MaineCare will reimburse for a covered service provided in an individual or a group session. A "group" must not exceed four (4) members per each licensed or certified clinician or other qualified staff person. When group services are provided, a brief notation must be made for each member in his or her medical record.

102.07 **NON-COVERED SERVICES**

Refer to Chapter I, General Administrative Policies and Procedures for rules governing non-covered services. Services that are primarily vocational, custodial, academic, socialization, or recreational are not covered.

102.08 **POLICIES AND PROCEDURES**

102.08-1 **Rehabilitative Services**

In order for services to be reimbursable, a service must meet the following standards:

The provider must be accredited by the Rehabilitation Accreditation Commission (CARF) to provide brain injury rehabilitation services (other than vocational services, which are not covered by MaineCare,) or otherwise have an eighteen (18)-month provisional certification from the Maine Department of Health and Human Services to cover the period the provider is working to secure CARF accreditation. The Department is responsible for determining compliance with the provisional certification standards in Appendix I of this Section. A copy of the Department issued provisional certification, or evidence of current CARF accreditation, must be on file with the MaineCare Services. Additionally, the provider must also supply the Department with a copy of the current CARF accreditation survey and if applicable, any plans of corrections.

Providers must maintain CARF accreditation to receive MaineCare reimbursement. CARF accreditation is for a specified period of time and requires periodic review and approval. To maintain accreditation beyond the expiration date, a provider must be resurveyed by CARF by the expiration date or be in the process of a resurvey by the expiration date. Evidence that the resurvey visit has been scheduled can indicate that the resurvey process is underway, as long as the visit was scheduled prior to the expiration date. MaineCare reimbursement will be subject to recoupment, back to the day on which accreditation expired, if CARF accreditation is denied. The facility must provide to the office listed below written evidence of the scheduled CARF survey visit. Evidence of current CARF accreditation, upon receipt, must also be submitted to this office:

Provider File Unit
MaineCare Services
11 State House Station
Augusta, ME 04333-0011

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

AND

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Office of Adults with Cognitive and Physical Disabilities-Brain Injury Services
11 State House Station
Augusta, ME 04333-0011

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Each provider must have a written agreement for services with a clinical director, or shall employ a physician, a neuropsychologist, and other professional personnel to assure appropriate supervision, medical review, and approval of services provided. The clinical director must have responsibility for the overall management of the service and have two (2) years experience in the rehabilitation of individuals with brain injury, as well as have management and specific training that will enable the director to understand and respond to the unique needs of individuals with brain injuries. The clinical director must be actively involved in the service and provide oversight for day-to-day operations.

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If a Provider plans to add a new BI service component that will require additional CARF accreditation (CARF requires new services to be delivered for at least six (6) months prior to a survey visit), the provider may receive MaineCare reimbursement for these new services while working toward CARF survey and certification, so long as the Department is notified in writing at least two (2) months in advance of the intent to seek CARF certification and the date services will start. Additionally, the CARF survey visit must be scheduled prior to the end of the six (6)-month period, i.e. a survey visit must be scheduled, not necessarily completed, and the Department notified in writing of the CARF survey appointment date. Reimbursement for the new service component will be subject to recoupment, back to start date of the new services, if CARF accreditation is denied.

102.08-2 **Setting**

Effective
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These services are intended to be provided on an outpatient basis. However, services may, in some instances, be provided in Home and Community settings if the treatment plan addresses the medical necessity for the member to receive services outside of the outpatient setting. All facilities providing rehabilitative services must be accessible to people with disabilities, in accordance with Section 504 of the Rehabilitation Act of 1973, as amended (29 USC, Section 794), and the Americans with Disabilities Act of 1990, (42 USC, 1281 *et seq.*).

102.08-3 **Start of Care**

Effective
4/1/10

- A. The provider must notify the Department of a member's start of care (SOC) date, which is the first billable day of service. The SOC and UR Form must be submitted to the Department prior to reimbursement. All services must be prior authorized by the Department or its Authorized Agent.

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

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Providers must submit some or all of the following documents to the Department or its Authorized Agent:

1. Start of Care and Utilization Form;
 2. A completed Brain Injury Assessment Tool, which must include the Eligibility Scoring pages that indicate the actual number of service hours per week the member is anticipated to receive for his or her specific eligibility level;
 3. A copy of the completed Clinical Assessment and health and safety assessment; and
 4. A copy of the individual treatment plan.
- B. If a member receives a Clinical Assessment, and the provider determines that the member does not have a qualifying brain injury diagnosis, or otherwise does not qualify for services under this Section, then the member will only be covered for the Clinical Assessment service.
- C. If the number of service hours for the member needs changes from the reported number on the SOC and UR Form, the provider must send in a new SOC and UR Form to submit a request to change within fourteen (14) days.

102.08-4 **Utilization Review**

A. The member's ongoing need for services is subject to utilization review according to the schedule in Section 102.08-4(B) below. Utilization review must:

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1. Be based upon the member's Clinical Assessment or Reassessment, treatment plan and progress notes (described in Section 102.08-7), the completed Brain Injury Assessment Tool and other relevant documents as may be requested by the Department. Copies of these documents must be submitted to the Department or its Authorized Agent, upon request;

2. At the discretion of the Department, include a face-to-face assessment of the member by the Department or its Authorized Agent;

Effective
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3. Assess the member's progress toward goals in the individual treatment plan;

4. Determine the member's rehabilitation potential (defined in Section 102.02-8);

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5. Determine the member's continued eligibility and appropriate services, according to Section 102.03;

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102.08 POLICIES AND PROCEDURES (cont)

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6. Determine and/or authorize the appropriate amount, duration and frequency of specific services to be delivered. UR may result in changes to the member's individual treatment plan, including reductions in or termination of services (see Section 102.08-4(C) below);
7. Review all other relevant services (regardless of payer) the member is receiving and coordinate rehabilitative services with other services to avoid any duplication;
8. Approve the member's next classification period start and end dates, as appropriate, and notify the Department;
9. Document UR findings in a format approved by the Department.

Effective
4/1/10

- B. Utilization review is required for each member every six (6) months:
- C. If UR findings show the member no longer needs services, or needs fewer services, the member must be given thirty (30) calendar days advance written notification (except in certain circumstances as set forth in Chapter I, Member Appeals) of the effective termination or reduction in services. A member has the right to appeal a decision to reduce or terminate services, unless it is the result of the application of service caps outlined in the MaineCare Benefits Manual. For detailed requirements regarding advance notifications and member appeal rights, refer to the Member Appeals section of Chapter I, MaineCare Benefits Manual.

Effective
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- D. The Department or its Authorized Agent, or the provider agency will conduct utilization review activities, at the discretion of the Department. Providers will be responsible for performing utilization review activities until such time as the Department provides advance written notice regarding the appointment of an Authorized Agent responsible for all or some utilization review activities.

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- E. The Department must authorize rehabilitative services for a specified period in order for services to be covered. In order for reimbursement to continue uninterrupted from one period to the next, it is the responsibility of the provider to submit a request for UR fourteen(14) calendar days prior to: 1) the end date of the member's current classification period; and/or 2) the member's scheduled UR, as required by the Department. If the provider does not submit a timely request for UR, and continuing services are delivered without an authorized period, the services will be not reimbursable. The provider must not bill the member for any unauthorized services that are delivered. (Refer to Chapter I, Section 1.06-4 for details regarding the billing of members for non-covered services.) Timely performance of UR is the responsibility of the Authorized Agent when the Authorized Agent is performing this function. If the provider is performing UR, it must be done according to the timeframes described in this Section.

102.08 POLICIES AND PROCEDURES (cont.)

102.08-5 Professional and Other Qualified Staff

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All professional staff must be conditionally, temporarily, or fully licensed/certified as documented by written evidence from the appropriate governing body for the State or province in which services are provided. All professional staff must provide services only to the extent permitted by licensure. All staff will have expertise in brain injury rehabilitation as demonstrated by achieving the Certified Brain Injury Specialist (CBIS) designation from the Academy of Certified Brain Injury Specialists (ACBIS) or demonstrating competency through an approved equivalent training program supervised by the provider. New staff will achieve CBIS or demonstrate equivalent competency within fourteen (14) months from date of hire. If an equivalent training program is used, the provider must submit documentation and receive approval from the Department (Brain Injury Services) for this program. The provider must demonstrate the equivalency of its alternate training and evaluation methods used to determine the staff member's competence in brain injury rehabilitation. The provider will submit a detailed curriculum, training and evaluation plan. Approval of equivalent training programs will occur annually. Documentation of plan approval and results of all training and evaluation of staff will be maintained by the provider for Department inspection.

A roster of provider staff, their CBIS (or equivalent) status, date of hire, and professional license status (type, number & standing) if applicable, will be submitted to the Department (Brain Injury Services) annually. Failure to meet minimum training or licensing standards will result in disallowance of services provided by the staff member failing to meet the standard, and referral to Program Integrity.

The following staff may provide services:

A. Physician can include a MD or DO.

Physician services may include, but are not limited to the following:

1. Clinical Assessment of the member's medical and rehabilitation needs; and provides the physician component of decisions regarding rehabilitation potential and the determination of predicted outcomes;
2. Regular and direct contact with the member to provide services that meet the identified medical and rehabilitative needs; active management and direction of the member's rehabilitation services to ensure these are consistent with the predicted outcomes; provision of medical care for continuing, unstable, or complex medical conditions, directly or through arrangements with other physicians; and
3. Collateral contact with other professionals, caregivers, and others included in the member's treatment plan, as defined in Section 102.02-4.

102.08 POLICIES AND PROCEDURES (cont.)

B. Neuropsychologist

In addition to licensure as a psychologist, a neuropsychologist must meet either criterion 1, 2, or 3 below:

1. Be board certified by The American Board of Professional Psychology-American Board of Clinical Neuropsychology (ABPP-ABCN);
2. Be board eligible: meets training and experience requirements, for The American Board of Clinical Neuropsychology (ABCN) as documented by their letter to that effect, but has not taken the examinations; or
3. Be a Ph.D. in neuropsychology, or Ph.D. in clinical psychology, and have knowledge of neuroanatomy, neuropathology and neuropsychology, as demonstrated by formal course work (documented on transcripts) and/or American Psychological Association (APA) approved workshops (one hundred (100) clock hours); and must have three (3) years full-time equivalent experience in neuropsychology in a clinical setting, one year of which must have been supervised. The supervised year must be made up of at least fifteen hundred (1500) clock hours, accumulated over no more than three (3) calendar years.

Neuropsychologist services may include, but are not limited to the following:

Effective
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- a. Assessment of intelligence, memory, and ability to learn, sensory-motor functions, speech and language abilities, spatial and construction abilities, academic skills, reasoning, personality, and vocational interest;
- b. Treatment including individual and/or group cognitive and behavioral remediation services, individual and/or group psychotherapy; and
- c. Collateral contact with other professionals, caregivers, and others included in the member's treatment plan, as defined in Section 102.02-4.

C. Registered Nurse

The registered nurse in the rehabilitation setting focuses on promoting health and maximizing human potential. The registered nurse is an integral member of the health care team whose priorities are based on each patient's needs at any given time.

The registered nurse assists the member in developing appropriate responses to situations, adjusts the environment to meet the needs of the person with a disability, and promotes participation in society.

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102.08 POLICIES AND PROCEDURES (cont.)

D. Certified Therapeutic Recreation Specialist

A certified recreational therapist must have completed a four (4)-year program in therapeutic recreation from an accredited college or university, and be certified as a therapeutic recreation specialist under the National Council for Therapeutic Recreation Certification.

Effective
4/1/10

Therapeutic recreation services are directed toward the correction of physical and mental impairments, and may include, but are not limited to, the amelioration of disorders such as attention-span deficits, cognitive difficulties, or dysfunctional behaviors.

E. Occupational Therapist

The occupational therapist maximizes the member's ability to perform functional daily living tasks such as feeding, bathing and dressing. The therapist's emphasis is on providing tasks meaningful to members with the goal of remediating perceptual and functional deficits, which affect performance.

F. Certified Occupational Therapy Assistant, Licensed (COTA, L)

An occupational therapy assistant must work only under the supervision of an occupational therapist.

G. Physical Therapist

Effective
4/1/10

The physical therapist uses a variety of modalities to maximize the member's physical capabilities. Treatment goals may include but are not limited to maintaining flexibility, facilitating movement, providing movement experiences and stimulation, especially tactile, vestibular, kinesthetic or proprioceptive.

Treatment may be directed toward organizing functional learning in normal motor development sequence, teaching appropriate-level functional skills, as well as necessary collateral contacts.

H. Licensed Physical Therapist Assistant

A physical therapist assistant must work only under the supervision of a physical therapist.

I. Speech Language Pathologist

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The speech-language pathologist provides diagnosis and treatment for members with varying degrees of impairment in their communicative abilities.

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102.08 POLICIES AND PROCEDURES (cont.)

Effective 4/1/10 Services for members may address speech, language, voice, and swallowing disorders. Group therapy may address communication skills, feeding problems, and higher level cognitive/linguistic problems.

J. Speech-Language Pathology Assistant

Effective 4/1/10 A speech-language pathology assistant must be registered under the license of a speech-language pathologist in the state or province in which services are provided; and work only under the supervision of that speech-language pathologist.

K. Social Worker

Effective 4/1/10 The social worker provides services that enable a member to integrate into the community by assisting the member to develop appropriate responses to his or her environment.

L. Licensed Professional Counselor

The professional counselor provides counseling services to assist the member in achieving more effective personal, emotional, social, educational, and vocational development and adjustment.

M. Licensed Clinical Professional Counselor

The professional counselor provides counseling services to assist the member in achieving more effective personal, emotional, social, educational, and vocational development and adjustment.

N. Other Qualified Staff

Other qualified staff are staff members, other than professional staff defined above, who have appropriate education, training, and experience in treatment of individuals with brain injury as approved by CARF, have a satisfactory criminal background check annually, and work under documented supervision, conducted at least monthly, by the professionals defined above.

102.08-6 Interdisciplinary Team

Assessment, coordinated service planning, and direct services on a regular and continuing basis must be provided by a coordinated, interdisciplinary team. This team must:

- be the major decision-making body in determining the goals, process, and time frames for accomplishment of the goals and expected benefits of the admission;

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

- be composed of the treating member of each discipline essential to the individual's accomplishment of the goals and expected benefits of the admission; and
- meet on a formalized basis at a frequency necessary to carry out their decision-making responsibilities. A team conference should occur for each member served at least monthly.

This team, comprised of the member, family, legal guardian, professional and other qualified staff, must be specifically designated to serve members requiring rehabilitative services and must include a physician and a neuropsychologist. In addition, the interdisciplinary team must include the disciplines in Section 102.08-5 as required on an individual basis in order to receive reimbursement for covered services.

102.08-7 **Clinical Records**

A. **Diagnosis and Treatment Plan**

1. **Clinical Initial Assessment and Reassessment**

A Clinical Initial Assessment and Reassessment, which must confirm a tentative diagnosis of brain injury, must be done face-to face with a member and by a licensed physician who is Board certified, or otherwise Board eligible, in either physical medicine and rehabilitation or neurology, or a neuropsychologist meeting the requirements of Section 102.08-5(B) and by an interdisciplinary team that meets the requirements of Section 102.08-6, and be included in the member's clinical record. The Clinical Initial Assessment and Reassessment must include the member's medical and social history, an assessment of the scope and success of acute care provided as a result of the brain injury, and the member's diagnosis. The Clinical Initial Assessment and Reassessment must also identify and list all other relevant services the member is currently receiving, regardless of payer, so that services can be coordinated and any duplication of services avoided.

2. **Individual Treatment Plan**

Based on the Clinical Initial Assessment or Reassessment of the member, an individual treatment plan must be developed. This plan must be in writing and identify all specific services to be provided (including those services not MaineCare reimbursable), the frequency and duration of each service, who will provide the service and the goals of each service. The plan will include measurable goals with target dates for achieving the goals with objectives that allow for measurement of progress.

The member shall be informed about the treatment options available to meet his or her needs and the member's preferences shall be taken into consideration in the development of the treatment plan. The plan must be specific to meeting the member's identified needs. Rehabilitative services

Effective
4/1/10

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must be coordinated with all other services the member is receiving as well as avoid any duplication of services. The plan must be approved, signed, and dated by a physician or neuropsychologist within thirty (30) days of the date the member began treatment and must specify the clinical rehabilitative services to be provided, the frequency and duration of each phase of service, the expected duration of treatment, and the expected rehabilitative goals or outcomes of services.

Effective
4/1/10

The individual treatment plan must be reviewed by a professional staff member and reauthorized, signed, and dated by a physician or neuropsychologist at least every one hundred and eighty (180) days or more frequently based on the member's needs. The individual treatment plan will be updated when there is a change in the member's condition, when the service appears not to be benefitting the member or when the member is over or under utilizing a service. Goals attained or not attained are identified and the individual treatment plan updated concerning goals not met.

3. Treatment Documentation

Written treatment or progress notes must be maintained in accordance with the treatment plan and be made every time a service is provided. All entries must identify the qualified staff and credentials who provided the service, date of each service, its duration and progress the member is making toward attaining the goals stated in the treatment plan. The qualified staff performing the services must sign all entries. The interdisciplinary team must maintain written notes of all meetings.

For each service covered under this Section that is delivered in the member's home or residence (including PNMI's), the provider must maintain records that show the arrival and departure times of each care provider, for type of provider (e.g. RN, OT, PT, therapeutic recreation specialist, other qualified staff, etc.), for each visit, and the total time spent in the home/residence for each provider, excluding travel time. This information must be documented in a clear and concise format and available to the Department, upon request.

The clinical record must also include written reports on all medication reviews, consultations, testing, evaluations, and collateral contacts made on behalf of the member.

B. Referral, Discharge, and Follow-up

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A discharge summary must be signed and dated and included in the clinical record and provided to the member or guardian, if applicable. The summary must include:

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1. Indicators used to determine the success of all goals and objectives identified in the plan(s) of service, including a summary of services received; and
2. A written plan of follow-up care. The rehabilitative provider must provide for its own follow-up care when this is appropriate for those people who remain in its service area. Arrangements to facilitate follow-up care must be made for those who will leave the geographic service area. The follow-up plan must provide for:
 - a. referral and forwarding of clinical information to a designated physician and/or service program;
 - b. provisions for re-evaluation of status as appropriate and feasible;
 - c. specific recommendations for medical, neurological, physical, cognitive, behavioral, psychological, and family management; and
 - d. identification of an individual responsible for support after discharge to assure continuity and coordination of post discharge services.
 - e. a member's rights of appeal.
3. an updated Brain Injury Assessment Tool done upon discharge.
4. The Department must be notified in writing when a member is discharged within ten (10) days of discharge.

Effective
4/1/10

102.08-8 Program Integrity

All providers are subject to the Department's Program Integrity activities. Refer to Chapter I, General Administrative Policies and Procedures, for rules governing these functions.

102.09 REIMBURSEMENT

The amount of payment for services will be the lowest of the following:

Effective
4/1/10

- A. the appropriate amount listed in the Chapter III, Section 102, "Allowances for Rehabilitative Services"; or
- B. the amount allowed by the Medicare carrier.

102.10 BILLING INSTRUCTIONS

Providers must bill on the CMS 1500 using the procedure codes in Chapter III and in accordance with the Department's billing instructions for Rehabilitative Services.

Appendix I

PROVISIONAL ACCREDITATION PROCESS

The purpose of this Appendix is to describe the initial eighteen (18) month approval process for providers who are not ready to undergo the Rehabilitation Accreditation Commission (CARF) survey and certification and are requesting MaineCare reimbursement under this Section. The initial approval process is intended to assure the Maine Department of Health and Human Services that the applicant agency has a thorough understanding of the requirements of this Section, has sufficient clinical and administrative capability to carry out the intent of this Section, and has taken steps to assure the safety, quality, and accessibility of the service.

The Department will administer the initial approval process.

Step #1 - Identification of Provider and Verification of the Provider's Intent to Undergo the Provisional Accreditation Process

- A. The director or administrator of the applicant agency must contact the Department to request the initiation of the process. The applicant agency's request must be accompanied by the following information:
 - 1. Name of the agency (and the legal entity sponsoring the facility if different);
 - 2. Address of the agency;
 - 3. Name of agency contact person;
 - 4. Telephone number of agency contact person; and
 - 5. Estimated number of individuals to be served (service capacity).

- B. The Department will start the review process. A representative of the Department will contact the agency within ten (10) working days of receipt of the identification information in order to:
 - 1. Identify the Department's representative assigned to carry out the review process;
 - 2. Provide clarification regarding the process; and
 - 3. Request written information to use in the document review phase of the process.

Step #2 - Document Review

This part of the process must be initiated at least thirty (30) days prior to the date when the agency proposes to provide services for MaineCare reimbursement under this Section. If the agency satisfies the requirements of this review, the Department will provisionally certify the agency for ninety (90) days from the first date of service for which MaineCare reimbursement is requested. In order to continue

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certification beyond this period, the agency must (during the ninety (90) day period) have undergone the on-site survey described in Step #3 of this Appendix and been granted continued approved status as a result of that review.

The following requirements must be satisfied to gain ninety (90) day provisional certification. Additionally, the provider must show it will be in compliance with the MaineCare Benefits Manual requirements.

- A. Compliance with applicable legal requirements and regulations of all governmental and legally authorized agencies under whose authority the agency operates. These include, but are not limited to, those regulations regarding equal employment opportunity, state and federal wage hour regulations, health and safety codes, and affirmative action. The applicant must submit documents demonstrating compliance with such regulations.
- B. Provision of documents providing the legal basis for the organization and identifying the members of the governing body or, in the case of a proprietary organization, the designated authority. The documents must identify the chief executive of the organization.
- C. Provision of by-laws, or other applicable documentation, describing and governing the purpose, scope and activities of the organization.
- D. A narrative history of the organization, which provides a brief history of the agency's activities.
- E. A description of the agency's services, with particular attention to those governed by Section 102 of the MBM. Service descriptions must include the purpose of each service and be written so as to govern the direction and character of each service.
- F. The agency's criteria for admission/entrance to the service being reviewed.
- G. Policies and procedures that address activities associated with member intake, assessment, individual planning, case coordination, and record keeping.
- H. The agency's actual or projected staffing plan. This plan must identify staff providing covered services. There must be clear indication of which staff are actually employed by the agency at the time of Document Review.
- I. Qualifications of all staff, consultants, independent contractors, trainees/interns, and volunteers.
- J. Policies that address member rights and preserve confidentiality. These policies must meet the requirements of Chapter I of the MaineCare Benefits Manual.
- K. Policies and procedures regarding quality assurance.
- L. Proof of liability insurance covering the services reimbursed under this Section.

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Within thirty (30) days of receipt of all information required by Step #2, the Department will issue a decision regarding the findings of the Document Review to the agency and to the Office of MaineCare Services. The finding will document all areas found to be non-compliant with the requirements of Step #2 and will stipulate corrective action, which must be accomplished to obtain 90-day provisional certification.

The agency must request an application for MaineCare enrollment from Provider File at the Office of MaineCare Services. Provider File will then process the agency application in order to begin MaineCare reimbursement after receiving the ninety (90) day provisional certification.

Step #3 - On-Site Review

Within ninety (90) days of the first date of service provided under this Section, the agency must have undergone an On-Site Review.

It will be the responsibility of the applicant agency to contact the Department's representative who conducted the Document Review to arrange for the On-Site Review. The agency must request the On-Site Review at least thirty (30) days prior to the requested date of the Review.

The On-Site Review Team will consist of at least two (2) representatives of the Department of Health and Human Services. The team may also include a licensed practitioner of the medical profession with expertise in the area of brain injury rehabilitation. In the event the Department requires such a clinician as a member of the review team the costs of the clinician's services must be reimbursed by the agency being reviewed.

The On-Site Review will be scheduled for up to four (4) days. The reviewers will, through the inspection of the agency documents, interviews and observation, determine the extent to which the agency is in compliance with the policies and procedures previously submitted by the agency as well as the agency's compliance with all requirements of this Section of the MaineCare Benefits Manual. Particular attention will be given to items identified as requiring correction in the Document Review report.

The following represents the On-Site Review Team activities:

1. Orientation Session. The On-Site Review Team meets with agency staff and representatives of the governing body to clarify the purpose of the survey and explain each team member's role in the review. This is an opportunity for agency staff and representatives to ask questions about the process and provide files and records necessary to carry out the review. At this time the review team must be assigned a secure work space (where confidential material can be safely stored) and a separate area where interviews can be held. Staff interviews shall be arranged at this time.
2. A tour of the physical plant.
3. Record reviews, interviews with staff, board members, members, family members, representatives,

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- or others, and program observation. The agency must post signs on a readily viewed area that the review is being performed and reviewers are available to meet with members in private, if requested.
4. On-Site Review Team meeting to coordinate findings and clarify questions requiring more attention.
 5. Information gathering.
 6. Exit interview with representatives of administration, the governing body, and staff. This is the agency's opportunity to question interpretations or findings of the Review Team. Any member or legal guardian who requests to attend the exit interview shall be allowed to do so.

The On-Site Review Team will write a report of its findings, including strengths and areas requiring improvement. The report will make recommendations regarding the continuation of provisional certification as well as listing corrective action the Team deems necessary. The report will be submitted to the Director of the Office of MaineCare Services and to Provider File at the Office of MaineCare Services within twenty (20) days of the completion of the On-Site Review. A copy of the report will be sent to the contact person at the applicant agency.

The Department will notify the agency of the decision regarding continuation or revocation of the agency's provisional certification status within ten (10) days of the receipt of the On-Site Review Team report. Agencies that fail to substantially meet the requirements outlined in Step #3 will have their provisional certification revoked. In the event of revocation, the Office of MaineCare Services will stop MaineCare reimbursement as of the date of revocation. Any agency that is denied the continuation of provisional certification may appeal this decision. The appeal process is defined in Chapter I of the MaineCare Benefits Manual.

All three (3) steps defined in this Appendix must be completed in order for the agency to receive the eighteen (18) month provisional certification.

The provisional certification will be awarded one time only, for a total of eighteen (18) months from the first date of service, including the ninety (90) day certification defined in Step #2 of this Appendix.

Complaints made to the Department regarding an agency that has a provisional certification or is in the process of receiving a provisional certification will be investigated. The Department must determine the validity of the complaint and must withdraw the provisional certification or discontinue the process of reviewing the agency for provisional certification; whichever is appropriate, if the Department determines that the health or safety of a member receiving services is in jeopardy.

In the event that the Department determines the applicant is out of compliance with the requirements of any applicable policy, or when non-compliant items represent a threat to the health, safety, or rights of members to be served under this policy, the Department must refuse or withdraw provisional certification to the applicant. In the event the provisional certification is refused or withdrawn, the Department's decision may be appealed. Requests for hearings must be made, in writing, within ten (10) days of agency

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notification of an adverse decision. The appeal process is defined in Chapter I of the MaineCare Benefits Manual.

Each eligible program is allowed one eighteen (18) month provisional certification only. CARF accreditation must be obtained by the end of the eighteen (18) month provisional certification, or MaineCare will stop reimbursement until CARF accreditation is obtained.

If the application for CARF accreditation has been submitted and a review is scheduled, one three (3) month extension of the provisional certification will be granted by the Department.