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65.01 INTRODUCTION

This Section of the MaineCare Benefits Manual consolidates what were previously four separate Sections; Section 58 Licensed Clinical Social Worker, Licensed Clinical Professional Counselor and Licensed Marriage and Family Therapist Services; Section 65 Mental Health Services; Section 100 Psychological Services; and Section 111 Substance Abuse Treatment Services. This Section consolidates all Outpatient Services into one Section.

65.02 DEFINITIONS

Definitions for the purposes of Section 65 are as follows:

65.02-1 **American Society of Addiction Medicine Criteria (ASAM)** is level of care criteria establishing what services are medically necessary for a member. Members must meet Level 0.5 or Level I for individual, family or group Outpatient services. Members must meet Level II.1 or II.5 for Intensive Outpatient Services. ASAM Criteria is available at www.asam.org.

65.02-2 **Affected Other** is a member with a demonstrated family relationship with an addicted member whose substance abuse has led to the Affected Other's clinically significant impairment or distress. The Affected Other family member must have MaineCare coverage if the addicted member refuses to participate. For the purposes of this section, an Affected Other may include only the following; parents, spouse, siblings, children, legal guardian, significant other of the addicted member, or the significant other's children. If the Affected Other is not MaineCare eligible, the services are not covered unless the addicted member is present and participating with the family in the family therapy session.

65.02-3 **Authorized Agent** is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

65.02-4 **Best Practices** are treatment techniques, procedures and protocols that have been established and described in detail. The effectiveness of these practices has been established through consensus among experts in the field. Key portions of these practices have been documented in research studies to be effective in selected treatment settings.

65.02-5 **Central Enrollment** is a process of determining baseline eligibility for behavioral health treatment. DHHS or its Authorized Agent shall facilitate referrals through Central Enrollment to appropriate service providers, expedite delivery of service to members, and reliably track the service status of members enrolled in the system and gather data that will inform DHHS of resource development needs.

65.02 DEFINITIONS (cont)

65.02-6 **Certified Clinical Supervisor** (CCS) is a clinician who is credentialed by the Maine State Board of Alcohol and Drug Counselors, 02-384 CMR chapter 6, and must conduct supervision as defined in the regulations for Licensing/Certifying of Substance Abuse Programs, 14-118 CMR chapter 5, section 11, in the State of Maine.

65.02-7 **Child** is a person between the ages of birth through twenty (20) years of age. Children aged eighteen (18) through twenty (20) years of age and children who are emancipated minors may choose to receive children's mental health services or adult mental health services, both of which are covered under this Section, whichever best meets their individual needs.

65.02-8 **Child and Adolescent Functional Assessment Scale (CAFAS)** is a multi-dimensional rating scale, which assesses a member's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.

65.02-9 **Clinician** is an individual appropriately licensed or certified in the state or province in which he or she practices, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section. A clinician includes the following: licensed clinical professional counselor (LCPC); licensed clinical professional counselor-conditional (LCPC-conditional); licensed clinical social worker (LCSW); licensed master social worker conditional clinical (LMSW-conditional clinical); licensed marriage and family counselor (LMFT); licensed marriage and family counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), Certified Alcohol and Drug Counselors (CADC); physician; psychiatrist; advanced practice registered nurse psychiatric and mental health practitioner (APRN-PMH-NP); advanced practice registered nurse psychiatric and mental health clinical nurse specialists (APRN-PMH-CNS); psychological examiner; physicians assistant (PA); registered nurse or licensed clinical psychologist.

65.02-10 **Community Inclusion** means the participation of a member in typical community activities that are both age and developmentally appropriate and are identified in the Individualized Treatment Plan (ITP).

65.02-11 **Comprehensive Assessment** is an integrated evaluation of the member's medical and psycho-social needs, including co-occurring mental health and substance abuse needs to determine the need for treatment and/or referral, and to establish the appropriate intensity and level of care.

65.02 DEFINITIONS (cont)

65.02-12 **Continuing Education Unit (CEU)** is a measure used in continuing education programs, particularly those required in a licensed profession. The Maine Department of Education recognizes CEUs as approved continuing education credits that teachers, education technicians and others can apply to licensure or certification requirements. DOE recognizes 4.5 CEUs as equal to 3 semester hours.

65.02-13 **Co-occurring Capable** providers are organized to welcome, identify, engage, and serve members with co-occurring mental health and substance abuse disorders, and to incorporate attention to these issues in all aspects of Co-occurring Services including linkage with other providers, staff competency and training. Clinicians must practice within the scope of their individual license(s) and follow all applicable mental health and substance abuse regulations in regards to member records including, but not limited to Comprehensive Assessments, Individual Treatment Plans (ITP) and progress notes.

65.02-14 **Co-occurring Disorders** are any combination of a mental health and substance abuse diagnosis.

65.02-15 **Co-occurring Services** are integrated services provided to a member who has both a mental health and a substance abuse diagnosis. This includes persistent disorders of either type in remission; a substance related or induced mental health disorder and a diagnosable disorder that co-occurs with interacting symptoms of the other disorder.

When mental health and substance abuse diagnoses occur together, each is considered primary and is assessed, described and treated concurrently. Co-occurring Services consist of a range of integrated, appropriately matched interventions that may include Comprehensive Assessment, treatment and relapse prevention strategies that may be combined, when possible within the context of a single treatment relationship. Co-occurring services also include addressing family therapy or counseling issues involving mental health, substance abuse or other disorders where MaineCare services cover family therapy or counseling.

65.02-16 **Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood:** (also known as DC 0-3), formulates categories for the classification of mental health and development disorders manifested early in life. The DC: 0-3 is published by Zero To Three: National Center for Infants, Toddlers and Families.

65.02-17 **Diagnostic and Statistical Manual of Mental Health Disorders** (DSM) is the most current version published by the American Psychiatric Association. The manual is used to classify mental health diagnoses and provide standard categories for definition of mental health disorders grouped in five axes.

65.02 DEFINITIONS (cont)

65.02-18 **Evidence Based Practices** (Practices Based on Scientific Evidence): are prevention or treatment practices that are based on consistent scientific evidence demonstrating that the treatment improves member outcomes. Elements of the practice are standardized, replicable and effective within a given setting and for particular populations and diagnosis or behavior. The practice is sufficiently documented through research to permit the assessment of fidelity to the model. As a result, the degree of successful implementation of the service can be measured by the use of a standardized fidelity tool that operationally defines the essential elements of practice. There must be no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving the treatment, compared to its likely benefits.

65.02-19 **Family,** unless otherwise defined in this Section, means the primary caregiver(s) in a member's daily life, and may include a biological or adoptive parent, foster parent, legal guardian or designee, sibling, stepparent, stepbrother or stepsister, brother-in-law, sister-in-law, grandparent, spouse of grandparent or grandchild, a person who provides kinship care, or any person sharing a common abode as part of a single family unit.

65.02-20 **Functional Family Therapy (FFT)** is a family-based clinical prevention and intervention model that targets members between the ages of eleven (11) and eighteen (18) who exhibit delinquent behavior or are at risk for delinquent behavior. This short-term evidence based practice usually takes place over a three (3) month period. FFT includes the three (3) stages of treatment: engagement and motivation, behavior change, and generalization. The intervention averages eight (8) to twelve (12) sessions for mild to moderate needs and up to thirty (30) sessions for members with complex needs.

65.02-21 **Imminent Risk** is the immediate risk of a child’s removal from the home and/or community due to the specific circumstances as described in Children’s Home and Community Based Treatment.

65.02-22 **Individualized Treatment Plan (ITP)** for the purposes of this section is a plan of rehabilitative care based on a Comprehensive Assessment developed by a clinician.

65.02-23 **Kinship Care** is the full-time care, nurturing, and protection of members by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child.

65.02 DEFINITIONS (cont)

65.02-24 **Medically Necessary Services** are services provided as described in Section 65.06 Covered Services and as defined in Chapter I, Section 1.02-4.D. of the MaineCare Benefits Manual.

65.02-25 **Multi-Systemic Therapy** (MST) is an intensive family-based treatment that addresses the determinants of serious disruptive behavior in members and their families. It is a short-term treatment approach that usually takes three (3) to six (6) months. The treatment typically includes three (3) to six (6) hours/week of clinical treatment. MST is a manualized, researched practice with a strong evidence base: MST therapist must be highly accessible to members, and typically provide twenty-four (24) hour a day, seven (7) days a week coverage for members which may include non face-to-face and telephonic collateral contact. Outcomes are evaluated continuously. MST services must maintain treatment integrity and meet the fidelity criteria developed by MST Services, Inc. MST therapists must be certified by MST Services, Inc. (http://www.mstservices.com). MST-Problem Sexualized Behavior (MST-PSB) includes additional training and supervision in addition to standard MST protocols.

65.02-26 **NTA/Psychometrician** is a Neurobehavioral Testing Assistant/Psychometrician. Psychometrics is the field of study concerned with the theory and technique of psychological measurement, which includes the measurement of knowledge, abilities, attitudes, personality traits, and education.

65.02-27 **Natural Supports** include the relatives, friends, neighbors, and community resources that a member or family goes to for support. They may participate in the treatment team, but are not MaineCare reimbursable.

65.02-28 **Parent or Guardian** may be the biological, adoptive, or foster parent or the legal guardian. They may participate in the treatment team, but are not MaineCare reimbursable.

65.02-29 **Parental Participation** means that the parent or caregiver is involved in the treatment team; participates in the assessment process; and helps develop the ITP for the purpose of the design, delivery and evaluation of treatment specific to the member's mental health needs. The parent or caregiver participates in treatment and models and reinforces skills learned.

65.02-30 **Permanency** means that a member lives in a planned living arrangement either with a parent or other caregiver and can return to the parent or caregiver from a stay in a hospital, a residential treatment or correctional facility.

65.02-31 **Practice methods** shall mean treatment techniques, procedures, therapeutic modalities and protocols. For example, a practice method is Dialectical Behavior Therapy or Cognitive Behavioral Therapy.

65.02 DEFINITIONS (cont)

65.02-32 **Preschool and Early Childhood Functional Assessment Scale (PECFAS)** is a multi-dimensional rating scale that assesses the psychosocial functioning of members aged three (3) to seven (7) years.

65.02-33 **Prior Authorization (PA)** is the process of obtaining prior approval as to the medical necessity and eligibility for a service.

65.02-34 **Promising and Acceptable Treatment** is defined as treatment that has a sound theoretical basis in generally accepted psychological principles. There must be substantial clinical literature to indicate the value of the treatment with members who experience the diagnostic problems and behaviors for which this treatment is needed. The treatment is generally accepted in clinical practice as appropriate for use with members who experience these diagnostic problems and behaviors. There must be no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. The treatment must have a book, manual, or other available writing that specifies the components of the treatment protocol and describes how to administer it. An individual, who has been certified in the provision of the promising and acceptable treatment, if such certification exists, must provide services. The existence of a certification standard for a treatment does not, by itself, indicate that the treatment meets the standard for a promising and acceptable treatment.

65.02-35 **Serious Emotional Disturbance (SED)** is when a member has a mental health and/or a co-occurring substance abuse diagnosis, emotional or behavioral diagnosis, under the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), that has lasted for or can be expected to last for at least one (1) year, and is at risk for more restrictive placement, including but not limited to, psychiatric hospitalization, as a result of this condition for which other less intensive levels of service have not been effective (e.g. traditional outpatient services).

65.02-36 **Strengths-Based Approach** is defined as a way to assess, plan, and deliver treatment incorporating the identified strengths and capabilities of the member and family.

65.02-37 **Substance Abuse Qualified Staff** in order to provide substance abuse outpatient therapy, must be Licensed Alcohol and Drug Counselors (LADC), Certified Alcohol and Drug Counselors (CADC); or a Physician (MD or DO), Licensed

65.02 DEFINITIONS (cont)

Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), Licensed Marriage and Family Therapist (LMFT), Registered Professional Nurse certified as a Psychiatric Nurse or Advanced Practice Psychiatric and Mental Health Registered Nurse (APRN), who meet the education and experience as defined in the regulations for Licensing/Certifying of Substance Abuse Programs in the State of Maine.

All services are provided under the direction of a Physician (MD or DO) or Psychologist and supervised by a Certified Clinical Supervisor (CCS).

65.02-38 **Trauma Informed Care** is the provision of behavioral health services that includes:

1. An understanding of psychological trauma, symptoms, feelings and responses associated with trauma and traumatizing relationships, and the development over time of the perception of psychological trauma as a potential cause and/or complicating factor in medical or psychiatric illnesses.

2. Familiarity with current research on the prevalence of psychological (childhood and adult) trauma in the lives of members with serious mental health and substance abuse problems and possible sequelae of trauma (e.g. post traumatic stress disorder (PTSD), depression, generalized anxiety, self-injury, substance abuse, flashbacks, dissociation, eating disorder, revictimization, physical illness, suicide, aggression toward others).

3. Providing physical and emotional safety; maximizing member choice and control; maintaining clarity of tasks and boundaries; ensuring collaboration in the sharing of power; maximizing empowerment and skill building.

4. Consideration of all members as potentially having a trauma history, understanding as to how such members can experience retraumatization and ability to interact with members in ways that avoid retraumatization.

5. An ability to maintain personal and professional boundaries in ways that are informed and sensitive to the unique needs of a member with a history of trauma.

6. An understanding of unusual or difficult behaviors as potential attempts to cope with trauma and respect for member’s coping attempts and avoiding a rush to negative judgments.

65.02 DEFINITIONS (cont)

65.02-39 **Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis. The provider is required to notify DHHS or its Authorized Agent upon initiation of all services provided under Section 65 in order for the Authorized Agent to begin utilization review.

65.02-40 **V-9 Extended Care or Status** is a written agreement for continued care allowing a member eighteen (18) through twenty (20) years of age to continue to be under the care and custody of DHHS. Normally, a member who reaches the age of eighteen (18) is automatically dismissed from custody and achieves full adult rights and responsibilities. The member may negotiate a written agreement with DHHS, Office of Child and Family Services for the following reasons:

1. To obtain a high school diploma or general equivalency diploma, or obtain post-secondary educational or specialized post-secondary education certification;

2. To participate in an employment skills support service;

3. To access mental health or other counseling support, including co-occurring services;

4. To meet specialized placement needs;

5. Is pregnant and needs parenting support; or

6. Has medical and special health conditions or needs.

7. No member in care may be accepted for continuing services after his or her eighteenth (18th) birthday unless an "Application and Agreement of Responsibility for Continued Care" (V-9) has been signed by both the member and the member's caseworker prior to the member's eighteenth (18th) birthday. Most members having this status must participate in full time secondary or post-secondary education approved by the DHHS caseworker and that caseworker's supervisor.

65.03 PROVIDER QUALIFICATIONS

The following providers are qualified to provide Behavioral Health Services as listed in 65.14 Appendix I.

65.03-1 **Independent Practitioner** is a licensed Psychologist, Psychological Examiner, Licensed Clinical Professional Counselor (LCPC), Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) who practices independently, has a Provider Agreement with DHHS, is co-occurring capable, knowledgeable in Trauma Informed Care, practices within the scope of his or her licensure and adheres to all state and federal rules and regulations concerning confidentiality and the Americans with Disabilities Act.

65.03-2 **Mental Health Agencies** are providers licensed pursuant to 34-B MRSA §1203-A, contracted by DHHS, and enrolled as MaineCare Providers. In order for these agencies to provide adult mental health services or children's mental health services, including Trauma Informed Care services, they must contract with DHHS, Office of Adult Mental Health Services or Office of Child and Family Services to provide covered adult mental health services or children's behavioral and mental health services, including services for members with co-occurring mental health and substance abuse diagnosis. DHHS will contract with any licensed provider willing to contract and able to meet standard DHHS contract requirements for mental health services. Agencies must adhere to the Rights of Recipients of Mental Health Services and the Rights of Recipients of Mental Health Services Who are Children in Need of Treatment. Providers must maintain all appropriate Licensing and Credentialing and must notify DHHS of any changes in Licensing or Credentialing status.

Only Mental Health Agencies that have a contract for specific covered services may provide covered mental health services for members in the care or custody of DHHS, Office of Child and Family Services. Providers of Functional Family Therapy (FFT) for members served by the Department of Corrections, Juvenile Services, must have a contract with the Department of Corrections, as described in Home and Community Based Treatment. Those agencies licensed by DHHS as a ambulatory health care unit, allied health care facility, or as a residential childcare facility must also have a mental health agency license to be reimbursable under this Section.

65.03-3 **Substance Abuse Agencies** are providers who are licensed and contracted by the Office of Substance Abuse (OSA), DHHS and enrolled as MaineCare Providers. Only providers who hold a valid contract to deliver covered services as described under this Section will be enrolled or continue to be enrolled as MaineCare providers of substance abuse treatment services including services for members with co-occurring mental health and substance abuse diagnoses. OSA will contract with any licensed provider willing to contract and able to meet standard OSA contract requirements for substance abuse treatment services.

65.03 PROVIDER QUALIFICATIONS (cont)

Providers must maintain all appropriate Licensing and Credentialing and must notify DHHS of any changes in Licensing or Credentialing status.

65.03-4 **School** is a program that has been approved by the Department of Education, as either a Special Purpose Private School or a Regular Education Public School Program under 05-071 C.M.R., Chapter 101, § XII and 20-A MRSA §7204 (4), 7252-A and 7253, and 05-071 C.M.R., Chapter 101, §12, or a program operated or contracted by the Child Development Services System 20-A MRSA § 7001(1-A) that has enrolled as a provider and entered into a provider agreement, as required by MaineCare. For the purposes of this rule, a school may provide the following services:
(1)Neurobehavioral Status Exam, Neuropsychological Testing and Psychological Testing, as described in Section 65.06-7, and
(2) Children's Behavioral Health Day Treatment, as described in Section 65.06-13.

All services must be provided by qualified staff, as described in the corresponding sections of this policy. .

65.04 ELIGIBILITY

Individuals must meet the eligibility criteria as set forth in the MaineCare Eligibility Manual. Some 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.

65.05 DURATION OF CARE

Each eligible member may receive covered services that are medically necessary within the limitations of this section. DHHS reserves the right to request additional information to evaluate medical necessity and review utilization of services. DHHS requires prior authorization (PA) for some services reimbursed under this section. DHHS may require utilization review for all services reimbursed under this section.

65.06 COVERED SERVICES

65.06-1 **Crisis Resolution Services**

Services are immediate crisis-oriented services provided to a member with a serious problem of disturbed thought, behavior, mood or social relationships. Services are

65.06 COVERED SERVICES (cont.)

oriented toward the amelioration and stabilization of these acute emotional disturbances to ensure the safety of a member or society and can be provided in an office or on scene. "On scene" can mean a variety of locations including member homes**,** school, street, emergency shelter, and emergency rooms.

Services include all components of screening, assessment, evaluation, intervention, and disposition commonly considered appropriate to the provision of emergency and crisis mental health care, to include co-occurring mental health and substance abuse conditions. Crisis Resolution Services are individualized therapeutic intervention services available on a twenty-four (24) hour, seven (7) day a week basis and provided to eligible members by providers that have a contract with DHHS to provide these services.

Covered services include direct telephone contacts with both the member and the member's parent or guardian or adult's member's guardian when at least one face-to-face contact is made with the member within seven (7) days prior to the first contact related to the crisis resolution service. The substance of the telephone contact(s) must be such that the member is the focus of the service, and the need for communication with the parent or guardian without the member present must be documented in the member's record.

Staff providing Crisis Services must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Supervisors of MHRT staff must be clinicians as defined in 65.02-9, within the scope of their licensure.

A treatment episode is limited to six (6) face-to-face visits and related follow up phone calls over a thirty (30) day period after the first face to face visit.

65.06-2 **Crisis Residential Services**

Crisis Residential Services are individualized therapeutic interventions provided to a member during a psychiatric emergency to address mental health and/or co-occurring mental health and substance abuse conditions for a time-limited post-

crisis period, in order to stabilize the member's condition. These services may be provided in the member's home or in a temporary out-of-home setting and include the development of a crisis stabilization plan. Components of crisis residential services include assessment; monitoring behavior and the member's response to therapeutic interventions; participating and assisting in planning for and implementing crisis and post-crisis stabilization activities; and supervising the member to assure personal safety.

65.06 COVERED SERVICES (cont.)

Services include all components of screening, assessment, evaluation, intervention, and disposition commonly considered appropriate to the provision of emergency and crisis mental health care.

Staff providing Crisis Services must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Supervisors of MHRT staff must be a clinician, as defined in 65.02-9, practicing within the scope of their licensure.

For children's Crisis Residential Services determination of the appropriate level of care shall be based on tools approved by DHHS and clinical assessment information obtained from the member and family.

65.06-3 **Outpatient Services**

Outpatient Services are professional assessment, counseling and therapeutic medically necessary services provided to members, to improve functioning, address symptoms, relieve excess stress and promote positive orientation and growth that facilitate increased integrated and independent levels of functioning. Services are delivered through planned interaction involving the use of physiological, psychological, and sociological concepts, techniques and processes of evaluation and intervention.

Services include a Comprehensive Assessment, diagnosis, including co-occurring mental health and substance abuse diagnoses, individual, family and group therapy, and may include Affected Others and similar professional therapeutic services as part of an integrated Individualized Treatment Plan. Services must focus on the developmental, emotional needs and problems of members and their families, as identified in the Individual Treatment Plan.

These services may be delivered during a regularly scheduled appointment or on an emergency after hours basis either in an agency, home, or other community-based setting, such as a school, street or emergency shelter.

Coordination of treatment with all included parties (as appropriate to the outpatient role), including PCP's, or other medical practitioners, and state or other community agencies, is well documented.

Children's Outpatient Services offer ways to improve or to stabilize the member's family living environment in order to minimize the necessity for out-of-home placement of the member, to assist parents, guardians and family

65.06 COVERED SERVICES (cont.)

members to understand the effects of the member's disabilities on the member's growth and development and on the family's ability to function, and to assist parents and family members to positively affect their member's development.

For children's Outpatient Services determination of the appropriate level of care shall be based on clinical assessment information obtained from the member and family.

These services may be provided by a clinician or substance abuse qualified staff practicing within the scope of their licensure.

There is a limit on Children's Mental Health Outpatient Services of seventy-two (72) quarter-hour units of service per year. For a member to receive services beyond seventy-two (72) quarter-hour units of service in a service year for Children's Mental Health Outpatient Services, the following conditions must be satisfied:

1. Any member receiving Children's Mental Health Outpatient Services must be diagnosed with an Axis I diagnosis of a serious emotional disturbance or an Axis II diagnosis as described in the most recent Diagnostic and Statistical Manual of Mental Disorders or in the DC 0-3 National Center for Clinical Infant Programs Diagnostic Classifications of Mental Health and Developmental Disabilities of Infancy and Early Childhood Manual.

2. Evidence that continued treatment that is necessary to correct or ameliorate a mental health condition must be documented in the member's file. Documentation must include prior treatment, progress, if any, and clinical justification that additional treatment is medically necessary.

   AND

3 The member must be participating in treatment and making progress toward goals or, if the member is not making progress, there must be an active strategy in place to improve progress toward goals. Family

   Participation is required in treatment services to the greatest degree possible, given the individual needs as well as family circumstances.

There is a limit on Adult's Mental Health Outpatient Services of seventy-two (72) quarter-hour units of service per year. For a member to receive services beyond seventy-two (72) quarter-hour units of service in a service year for

65.06 COVERED SERVICES (cont.)

Adult's Mental Health Outpatient Services, the following conditions must be satisfied:

1. Any member receiving Adult Mental Health Outpatient Services must be diagnosed with an Axis I or Axis II psychiatric disorder;

2. There must be documented evidence that continued outpatient treatment:

   a. Is reasonably expected to bring about significant improvement in symptoms and functioning; and

   b. is medically necessary to prevent the mental health condition from worsening, such that the member would likely need continued outpatient treatment;

AND

3. The member must be participating in treatment and making progress toward goals supporting his or her ongoing recovery, or, if the member is not making progress, there must be an active strategy in place to improve progress toward goals.

65.06-4 **Family Psychoeducational Treatment**

Family Psychoeducational Treatment is an Evidenced Based Practice provided to eligible members in multi-family groups and single family sessions. Clinical elements include engagement sessions, psychoeducational workshops and on-going treatment sessions focused on solving problems that interfere with treatment and rehabilitation, including co-occurring mental health and substance abuse diagnoses.

Providers must have a contract to provide this service as described in 65.03-2.

For children's Family Psychoeducational Treatment Services determination of the appropriate level of care shall be based on the Child/ Adolescent's Level of Functional Assessment Score (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), other tools approved by DHHS and clinical assessment information obtained from the member and family.

65.06 COVERED SERVICES (cont.)

65.06-5 **Intensive Outpatient Services (IOP)**

Intensive Outpatient Services (IOP) are those services certified as such by the Office of Substance Abuse, DHHS under the Regulations for Licensing/Certifying Substance Abuse Programs, 14-118 CMR chapter 5, section 11, in the State of Maine. Covered services must be provided under the direction of a physician (MD or DO) or psychologist, and delivered by qualified staff to an eligible member.

The provider shall provide an intensive and structured service of alcohol and drug assessment, diagnosis, including co-occurring mental health and substance abuse diagnoses, and treatment services in a non-residential setting aimed at members who meet ASAM placement criteria level II.1 or level II.5. IOP may include individual, group, or family counseling as part of a comprehensive treatment plan. The provider will make provisions for the utilization of community resources to supply client services when the program is unable to deliver them. Each program shall have a written agreement with, or, shall employ, a physician and other professional personnel to assure appropriate supervision and medical review and approval of services provided.

65.06-6 **Medication Management Services**

Medication Management Services are services that are directly related to the psychiatric evaluation, prescription, administration, education and/or monitoring of medications intended for the treatment and management of mental health disorders, substance abuse disorders and/or Co-occurring Disorders.

65.06-7 **Neurobehavioral Status Exam, Neuropsychological Testing and Psychological Testing**

Neurobehavioral Status Exam (Procedure Code 96116) and Psychological Testing (Procedure Code 96101)

Neurobehavioral Status Exam and Psychological Testing services include clinical assessment of thinking, reasoning and judgment, meeting face-to-face with the member, time interpreting test results and preparing the report of test results. Services also may include testing for diagnostic purposes to determine the level of intellectual function, personality characteristics, and psychopathology, through the use of standardized test instruments or projective tests.

65.06 COVERED SERVICES (cont.)

Neuropsychological Testing by a Psychologist or Physician (Procedure Code 96118) e.g., Halstead-Reitan Neuropsychological Battery Wechsler Memory Scales and Wisconsin Card Sorting

When performed by a Psychologist or Physician, Neuropsychological Testing services includes both face-to-face time administering tests to the member and time interpreting these test results and preparing the report. In addition to the administration, scoring, interpretation and report writing, this code also allows reimbursement for additional time necessary to integrate other sources of clinical data, including previously completed and reported technician and computer administered tests.

Neuropsychological Testing by a Psychological Examiner (Procedure Code 96119) e.g., Halstead-Reitan Neuropsychological Battery Wechsler Memory Scales and Wisconsin Card Sorting)

When provided by a Psychological Examiner, Neuropsychological Testing services includes interpretation, report preparation, and interpretation. The test is administered by a Psychological Examiner (i.e. technician), and includes any reportable amount of time the technician spent with the client to assist them in completing the assessment.

Neurobehavioral Status Exam, Neuropsychological Testing, and Psychological testing do not require prior authorization nor do they require the completion of a Comprehensive Assessment or Treatment Plan. However, if the services are provided in a school the need for the evaluation must be documented in the member's written notice and maintained in the member's record.

Please see Appendix I for a list of qualified professionals.

Providers may bill for Neuropsychological Testing by a Psychologist or Physician (96118) and Neuropsychological Testing by a Psychological Examiner (96119) retroactively to September 1, 2010. The prescribed time limits for the submission of claims (timely filing) standards still apply, per the MaineCare Benefits Manual, Chapter 1-General Administrative Policies and Procedures, Section 1, 1.10-2-Time Limits for Submission of Claims.

65.06-8 **Children's Assertive Community Treatment (ACT) Service**

Children's Assertive Community Treatment (ACT) service is a twenty-four (24) hour, seven (7) days a week intensive service provided in the home, community and office, designed to facilitate discharge from inpatient

65.06 COVERED SERVICES (cont)

psychiatric hospitalization or to prevent imminent admission to a psychiatric hospital. It may also be utilized to facilitate discharge from a psychiatric residential facility, or prevent the need for admission to a crisis stabilization unit.

Children's ACT services shall include all of the following:

- Individual treatment planning;
- Development and implementation of a comprehensive crisis management plan and providing follow-up services to assure services are delivered and the crisis is resolved;
- Follow-along service, defined as a medically necessary service that assures flexibility in providing services on an as needed basis in accordance with a member's ITP;
- Contacts with the member's parent, guardian, other family members, providers of services or supports to ensure continuity of care and coordination of services within and between inpatient and community settings;
- Family involvement, education and consultation in order to help family members develop support systems and manage the member's mental illness and co-occurring substance abuse;
- Individual and family outpatient therapy, supportive counseling or problem-solving activities, including interactions with the member and his/her immediate family support system in order to maintain and support the member's development and provide the support necessary to help the member and family manage the member's mental illness and co-occurring substance abuse;
- Linking, monitoring, and evaluating services and supports; and
- Medication services, which minimally includes one face-to-face contact per month with the psychiatrist or the advanced practice registered nurse (APRN), nurse practitioner or clinical nurse specialist with advanced training in children's psychiatric mental health.

65.06 COVERED SERVICES (cont)

65.06-8.A. **Specific Eligibility Requirements for Members Ages Zero (0) Through Twenty (20) for Children's Assertive Community Treatment (ACT) Service**

1. Eligible members must need treatment that is more intensive and frequent than what they would get in Outpatient or Children's Home and Community Based Treatment.

2. Members receiving Children's ACT Services must be diagnosed with an Axis I diagnosis of a serious emotional disturbance as described in the most recent Diagnostic and Statistical Manual of Mental Disorders or in the 0-3 National Center for Clinical Infant Programs Diagnostic Classifications of Mental Health and Developmental Disabilities of Infancy and Early Childhood Manual. For children's ACT services determination of the appropriate level of care shall be based on the Child/ Adolescent's Level of Functional Assessment Score (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), other tools approved by DHHS and clinical assessment information obtained from the member and family.

3. In addition, the member must meet at least one of the following criteria:

   Be at clear risk for psychiatric hospitalization or residential treatment or admission to a crisis stabilization unit;

   OR

   Has been discharged from a psychiatric hospital, residential treatment facility or crisis stabilization unit within the past month, with documented evidence that he or she is highly likely to experience clinical decompensation resulting in readmission to the hospital, crisis unit or residential treatment in the absence of Children's ACT Service.

65.06-8.B. **Provider Requirements**

Children's ACT services are provided by a multidisciplinary team on a twenty-four (24) hour per day, seven days a week basis.

65.06 COVERED SERVICES (cont)

1) The multidisciplinary team must include;

   a) a psychiatrist, or an advanced practice registered nurse (APRN), nurse practitioner or clinical nurse specialist with advanced training in children's psychiatric mental health and with the approval of the Children's Behavioral Health Medical Director, and

   b) a licensed clinical social worker (LCSW), licensed clinical professional counselor (LCPC), or a licensed marriage and family therapist (LMFT).

2) The Multidisciplinary team may also include any of the following;

   a) a psychologist,

   b) a physician assistant with advanced training in children's psychiatric mental health,

   c) an advance practice registered nurse (APRN), nurse practitioner or clinical nurse specialist with advanced training in children's psychiatric mental health, if the team includes a psychiatrist,

   d) a registered nurse with advanced training in children's psychiatric mental health,

   e) a licensed masters social worker- conditional clinical (LMSW-CC),

   f) a licensed clinical professional counselor- conditional clinical (LCPC-CC),

   g) a licensed alcohol and drug counselor (LADC),

   h) a certified alcohol and drug counselor (CADC),

   i) a vocational counselor and/or an educational counselor, or

   j) a bachelor level other qualified mental health professional (OQMHP).

65.06 COVERED SERVICES (cont)

These teams operate under the direction of an independently licensed mental health professional. The team will assume comprehensive clinical responsibility for the eligible member.

65.06-8.C **Duration/Prior Authorization/Utilization Review**

Children's ACT Service may be provided to an eligible member for up to six (6) continuous months with prior approval. Services beyond the initial six (6) months must be reauthorized by DHHS or its authorized agent. Requests for reauthorization must be submitted in writing at least fourteen (14) days prior to the six (6) month anniversary date and documented in the member's record. This service may be utilized concurrently with MaineCare Benefits Manual Section 28, Rehabilitation and Community Support Services for Children with Cognitive Impairments and Functional Limitations, or other services under this Section for a period not to exceed thirty (30) days. The specific purpose of this thirty (30) day interval must be for transition to a less intensive or restrictive modality of treatment. Any concurrent services must be prior approved by DHHS or its authorized agent. Concurrent services will only be approved when the Children's ACT team provider is able to clearly demonstrate that the member would not be able to be discharged from this level of care without concurrent services.

Providers must submit request for prior authorization and reauthorization using DHHS approved forms for this service to DHHS or its authorized agent, who will use information in the member's record and clinical judgment to consider the need for this service. The DHHS staff or its authorized agent will consider prior approval for any admission of a member into the Children's ACT service considering diagnosis, functioning level, clinical information, and DHHS approved tools to verify need for this level of care. The setting in which the Children's ACT service is to be provided must also be approved.

Documentation of this approval must appear in the member's record. See also Chapter I for prior authorization timelines.

65.06 COVERED SERVICES (cont)

65.06-9 **Children's Home and Community Based Treatment**

This treatment is for members in need of mental health treatment based in the Home and Community who need a higher intensity service than Outpatient but a lower intensity than Children's ACT.

Services include providing treatment to members living with their families. Services also may include members who are not currently living with a parent or guardian. Services include providing individual and/or family therapy or counseling, as written in the ITP. The services assist the member and parent or caregiver to understand the member's behavior and developmental level including co-occurring mental health and substance abuse, teaching the member and family or caregiver how to appropriately and therapeutically respond to the member's identified treatment needs, supporting and improving effective communication between the parent or caregiver and the member, facilitating appropriate collaboration between the parent or caregiver and the member, and developing plans and strategies with the member and parent or caregiver to improve and manage the member's and/or family's future functioning in the home and community.

Services include therapy, counseling or problem-solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her mental health treatment needs, learning the social skills and behaviors necessary to live with and interact with the community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self-awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.

The goals of the treatment are to develop the member's emotional and physical capability in the areas of daily living, community inclusion and interpersonal functioning, to support inclusion of the member into the community, and to sustain the member in his or her current living situation or another living situation of his or her choice.

65.06 COVERED SERVICES (cont)

65.06-9.A. **General Eligibility Requirements for Children's Home and Community Based Treatment**

The member must meet all of the following criteria:

Have a medically necessary need for the service, defined as follows:

Have completed a multi-axial evaluation with an Axis I or Axis II mental health diagnosis using the most recent Diagnostic and Statistical Manual of Mental Disorders or an Axis I diagnosis from the most recent Diagnostic Classification of Mental Health and Development

Disorders of Infancy and Early Childhood Manual (DC-03) within thirty (30) days of the start of service. Axis I mental health diagnoses do not include the following: Learning Disabilities (LD) in reading, mathematics, written expression, Motor Skills Disorder, and LD NOS (Learning Disabilities Not Otherwise Specified); Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder NOS); and

Have a significant functional impairment (defined as a substantial interference with or limitation of a member's achievement or maintenance of one or more developmentally appropriate, social, behavioral, cognitive, or adaptive skills), and

Have a diagnosis of a serious emotional disturbance for one (1) year or likely to last more than one (1) year; and

Determination of the appropriate level of care based on the Child/ Adolescent's Level of Functional Assessment Score (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), other tools approved by DHHS and other clinical assessment information obtained from the member and family; and

Need treatment that is more intensive and frequent than what he or she would get in Outpatient and a lower intensity than Children's ACT; and

65.06 COVERED SERVICES (cont)

If the member is living with the parent or guardian the parent/guardian must participate in the member's treatment, consistent with the ITP.

65.06-9.B. **Specific Imminent Risk Eligibility Requirements to waive Central Enrollment and Prior Authorization for Children's Home and Community Based Treatment**

To receive services due to Imminent Risk the member must meet the following criteria:

Behavioral Health: Where there has been a risk assessment and determination by a crisis provider or other licensed clinician that the member is at risk for impending admission, within forty eight (48) hours, to a Psychiatric Hospital, Crisis Stabilization Unit or Homeless Shelter, or other out of home behavioral health treatment facility, unless services are initiated, or

Child Welfare: Where Child Welfare Services (CWS) of DHHS is involved with the family, imminent risk of removal is the stage at which CWS has completed its assessment, and has determined that the family must participate in a safety plan requiring that services start immediately or the member will be removed from the home or foster care setting (not including a Treatment Foster Care setting), or

Corrections: Where the Juvenile Community Corrections Officer, law enforcement officer or court recommends or determines that the member will be detained or committed within forty eight (48) hours unless services are initiated, and

The parent/guardian must participate in the member's treatment, consistent with the ITP.

65.06-9.C. **Waiver of Central Enrollment and Prior Authorization for services provided due to Imminent Risk is valid only under the following conditions:**

Eligibility criteria as stated in Children's Home and Community Based Treatment must be clearly documented,

Providers must fax a referral form to the offices of DHHS or its Authorized Agent the same day of the start of service,

65.06 COVERED SERVICES (cont)

Providers must forward documentation of the risk of removal from crisis provider, licensed clinician, child welfare worker, juvenile community corrections officer, law enforcement officer or court to DHHS within thirty (30) days of the start of service, and

Providers must ensure that the one of the criteria for imminent risk is met, to include Behavioral Health, Child Welfare, or Corrections,

Providers must begin the Comprehensive Assessment process with the member immediately and initiate treatment with the family and child within forty eight (48) hours, and

Providers must contact DHHS or its Authorized Agent for Prior authorization to be entered into the computer system within forty eight (48) hours.

65.06-9.D. **Provider Requirements for Children's Home and Community Based Treatment**

Staff allowed to provide this treatment include a clinician and a bachelor's level staff certified as a Behavioral Health Professional.

To provide Home and Community Based Treatment the employee must meet the educational requirement and complete the required Behavioral Health Professional (BHP) training within the prescribed time frames, as described in 65.06-9(E).

Educational requirement to deliver the Home and Community Based Treatment services can be one (1) of the following:

1) Bachelor's degree in related field: social services, human services, health or education

2) Bachelor's degree in a unrelated field with the provider required to have a specific plan for supervision and training documented in the personnel file of the employee.

65.06 COVERED SERVICES (cont.)

65.06-9.E. **Provisional Approval of Providers of Children's Home and Community Based Treatment:**

A bachelor's level staff must begin receiving the Behavioral Health Professional training within thirty (30) days from the date of hire. The provisional candidate must complete the training and obtain certification within one (1) year from the date of hire.

Approvals must be maintained in the agency's personnel file and the length of provisional status documented in the employee's file. Provisional candidates who have not completed certification requirements within one (1) year from the date of hire are not eligible to perform reimbursable services with any provider until certification is complete.

DHHS or its Authorized Agent may approve exceptions for staff to be qualified as clinicians under this section beyond the effective date of these rules. DHHS or its Authorized Agent will consider information such as attempts at recruiting qualified clinicians, availability of qualified clinicians in geographic areas, supervision to be provided, clinical competency of the individual, and wage/salary offered by the agency.

65.06-9.F. **The provider of Children's Home and Community Based Treatment must:**

Understand the member's diagnosis and the particular challenges it presents to the member's family;

Be knowledgeable about and capable of delivering the appropriate treatment for the diagnosis and symptoms;

Coordinate with DHHS or its Authorized Agent to ensure each member who gets the service has a medical need for the service and that the member's parent(s) or caregiver is involved.

65.06 COVERED SERVICES (cont.)

Members of the treatment team will provide information, support and/or intervention, whenever possible and clinically appropriate to the members and families they serve appropriate to ensuring continuity and consistency of treatment. The treatment team will coordinate and communicate with the local crisis agency when necessary.

Providers must refer the member for psychiatric consultation when necessary.

65.06-9.G. **Provider Requirements: Treatment Teams**

The treatment team must include:

1) A clinician who will provide therapy or counseling directly to the member and/or family in the home; and

2) A behavioral health professional who will provide intervention services to the member and family under the direct supervision of a clinician as defined in Section 65.02-9.

The Children's Behavioral Health Services Medical Director may approve exceptions to the number of staff required for treatment teams to provide service for this Section. The Medical Director will consider information including but not limited to whether the provider is using an approved evidence-based practice or whether the alternative treatment model has been tested with randomized or controlled outcome studies.

65.06-9.H. **The treatment team shall:**

Provide individual and family, if appropriate, treatment in the home and community, as written in the ITP;

Teach the member how to appropriately and therapeutically manage his or her mental health treatment and particular mental health challenges;

Support development of effective communication between the member and significant others in their lives (family, employers, teachers, friends, etc.);

65.06 COVERED SERVICES (cont.)

Facilitate appropriate collaboration between the member and significant others;

Support the member in utilizing the new skills in his or her living situation and community that have been described in the ITP;

Develop plans and strategies with the member to improve his or her ability to function in his or her living situation and community after treatment is complete;

Meet with other service providers to plan and coordinate treatment to ensure the integration of the treatment across the member's home, school, and community and to achieve the desired outcomes and goals identified in the ITP (see collateral contacts, Section 65.06-10); and

Review the ITP at least every ninety (90) days to determine whether or not the ITP will be continued, revised or discontinued. The clinician, and parent or caregiver, and member, if appropriate must sign and date the ITP.

Children's Home and Community Based Treatment shall be consistent with existing evidence-based, promising and acceptable or best practice parameters in type, staffing, frequency, duration, and service provider setting. Where evidence based practices do not exist, the treatment shall be consistent with promising and acceptable or best practice treatment parameters.

65.06-9.I. **Duration of Care/Prior Authorization/Utilization Review**

Children's Home and Community Based Treatment services must meet requirements for central enrollment and will be subject to prior authorization and ongoing utilization review.

Children's Home and Community Based Treatment requires prior authorization and utilization review every ninety (90) days of treatment. DHHS will evaluate effectiveness before authorizing continuation of treatment. The duration of care will typically be up to six (6) months, subject to prior authorization and DHHS utilization review. Subject to medical necessity and

65.06 COVERED SERVICES (cont)

utilization review, treatment may be approved beyond six (6) months on a case-by-case basis.

Utilization Review must ensure that:

The ITP is reviewed every ninety (90) days;

Each member has a medical need for the service;

The member's parent/caregiver is participating in the treatment planning process and in the treatment, if appropriate;

Measurable progress is being made on the goals and objectives identified in the ITP and that this progress is expected to continue; and

A discharge plan addresses the natural supports and treatment needs that will be necessary for the member and family to sustain their progress at the end of this treatment.

The purpose of the treatment and measure of effectiveness will be demonstrated improvement for the member and family in one or more of the following areas:

Functioning and skill development;

Adaptive behavior;

Member's ability to live within the family and larger community.

65.06-10 **Collateral Contacts for Children's Home and Community Based Treatment**

Collateral Contact is a face-to-face contact on behalf of a member by a mental health professional to seek or share information about the member in order to achieve continuity of care, coordination of services, and the most appropriate mix of services for the member.

Discussions or meetings between staff of the same agency (or contracted agency) are considered to be collateral contacts only if such discussions are face-to-face and are part of a team meeting that includes

65.06 COVERED SERVICES (cont)

professionals and caregivers from other agencies who are included in the development of the Individual Treatment Plan (ITP).

For the purposes of Collateral Contacts for Children's Home and Community Based Treatment, MaineCare reimburses only up to ten (10) hours (forty (40) units) of billable face-to-face collateral contacts per member per year of service. DHHS or its Authorized Agent may approve, in writing, additional collateral contact hours and/or non face-to-face collateral contacts for Multi-Systemic Therapy (MST) services and Functional Family Therapy (FFT) consistent with the requirements of the MST and FFT models of service, as defined in 65.02-24 and 65.02-19.

65.06-11 **Opioid Treatment**

Opioid Treatment is defined as outpatient services licensed to provide opiate replacement therapy through medication delivered under the direction of a physician (MD or DO) and supervised by a Certified Clinical Supervisor (CCS). Opioid Treatment provides the medication and treatment services including individual and group counseling.

Opioid Treatment coverage will be administered in accordance with Federal and State laws and regulations that govern Opioid treatment, including the Maine Office of Substance Abuse, DHHS, the Center for Substance Abuse Treatment (Division of the Substance Abuse and Mental Health Services Administration), the US Drug Enforcement Agency, the US Food and Drug Administration and the State Pharmacy Board, and provided as part of a package of services including the cost of providing the medication and the necessary individual and group counseling.

65.06-12 **Interpreter Services**

Interpreter Services are described in Chapter I, Section 1.06-3 of the MaineCare Benefits Manual.

65.06-13 **Children's Behavioral Health Day Treatment**

A covered service is a specific service determined to be medically necessary by Qualified Staff licensed to make such a determination and subsequently specified in the Individual Treatment Plan (ITP) and for which payment to a provider is permitted under the rules of this Section. This Qualified Staff must assume clinical responsibility for medical necessity and the ITP development. The Behavioral Health Day Services described below are covered when (1) provided in an appropriate setting as specified in the ITP, (2) supervised by an appropriate professional as specified in the ITP, (3) performed by a qualified provider, and (4) billed by that provider. Behavioral Health Day Treatment Services must be

65.06 COVERED SERVICES (cont)

delivered in conjunction with an educational program in a School as defined in 65.03-4.

Behavioral Health Day Treatment Services are structured therapeutic services designed to improve a member's functioning in daily living and community living. Programs may include a mixture of individual, group, and activities therapy, and also include therapeutic treatment oriented toward developing a child's emotional and physical capability in area of interpersonal functioning. This may include behavioral strategies and interventions. Services will be provided as prescribed in the ITP.

Involvement of the member's family will occur in treatment planning and provision. Behavioral Health Day Treatment Services may be provided in conjunction with a residential treatment program. Services are provided based on time designated in the ITP but may not exceed six (6) hours per day, Monday through Friday, up to five days per week. Medically Necessary Services must be identified in the ITP.

65.06-13-A. Eligibility for Behavioral Health Day Treatment

The member must be aged twenty (20) or under, and must be referred by the Qualified Staff, as defined below. Additionally, the member must need treatment that is more intensive and frequent than Outpatient but less intense than hospitalization.

Within thirty (30) days of the start of service, the member must have received a multi-axial evaluation and must have been diagnosed either with an Axis I or Axis II behavioral health diagnosis based on the most recent Diagnostic and Statistical Manual of Mental Disorders or with an Axis I diagnosis based on the most recent Diagnostic Classification of Mental Health or Development Disorders of Infancy and Early Childhood Manual (DC-03); and

In addition, based on an evaluation using the Battelle, Bayley, Vineland or other tools approved by DHHS, as well as other clinical assessment information obtained from the member and family, the member must either have a significant functional impairment (defined as a substantial interference with or limitation of a member's achievement or maintenance of one or more developmentally appropriate, social, behavioral, cognitive, or adaptive skills); or

Have a competed evaluation establishing that the member has 2 standard deviations below the mean in one domain of development or 1.5 standard deviations below the mean in at least two areas of

65.06 COVERED SERVICES (cont)

development on the Battelle, Bayley, Vineland, or other tools approved by DHHS and other clinical assessment information obtained from the member and family.

65.06-13.B. Provider Requirements for Behavioral Health Day Treatment

Staff qualified to provide this treatment include the following clinicians (Psychiatrist, Psychologist, LCSW, LMSW, LCPC, LMFT) and staff certified as a Behavioral Health Professional (BHP) who has completed ninety (90) documented college credit hours or Continuing Education Units (CEU's). Staff qualified to determine medical necessity to develop the ITP are Psychologists, LCSWs, LMSWs, LCPCs, or LMFTs. Board Certified Behavioral Analysts (BCBAs) are allowed to provide supervision to BHP staff.

To provide Behavioral Health Day Treatment as a BHP, the employee must meet the education requirement and complete the required BHP training within the prescribed time frames, as described in 65.06-13.C.

65.06-13.C. Provisional Approval of Providers of Behavioral Health Day Treatment:

All staff must begin receiving the Behavioral Health Professional training within thirty (30) days from the date of hire. The provisional candidate must complete the training and obtain certification within one (1) year from the date of hire.

Approvals must be maintained in the agency's personnel file and the length of provisional status documented in the employee's file. Provisional candidates who have not completed certification requirements within one (1) year from the date of hire are not eligible to perform reimbursable services with any provider until certification is complete.

65.07 NON-COVERED SERVICES

Please refer to the MaineCare Benefits Manual, Chapter I, General Administrative Policies and Procedures, for a general listing of non-covered services including academic, vocational, socialization or recreational services and custodial services and associated definitions that are applicable to all Sections of the MaineCare Benefits Manual.

65.07 NON-COVERED SERVICES (cont.)

Additional non-covered services related to the delivery of mental health services are as follows:

65.07-1 Homemaking or Individual Convenience Services: Any services or components of services of which the basic nature is to maintain or supplement the housekeeping, homemaking or basic services for the convenience of the member are not reimbursable under this policy. These non-covered services include, but are not limited to, housekeeping, shopping, child day care, or respite and laundry service.

65.07-2 Transportation Services: Costs related to transportation services are built into the rates for all services by allocation of non-personnel costs. Therefore, separate billings to the MaineCare Program for travel time are not reimbursable.

65.07-3 Case Management Services: Any services, or components of services of which the basic nature is to provide case management services are not reimbursable under these Mental Health Services rules unless otherwise indicated. Please refer to Chapter II, Section 13, Case Management Services and Chapter II, Section 17, Community Support Services, of the MaineCare Benefits Manual for a description of the coverage of such services.

65.07-4 Adult Community Support/Adult Day Treatment Services: Any services, or components of services of which the basic nature is to provide Adult Community Support Services, or Adult Day Treatment Services are not reimbursable under this Section. Please refer to Chapter II, Section 17, Community Support Services, of the MaineCare Benefits Manual for a description of the coverage of such services.

65.07-5 Financial Services: Any services, or components of services of which the basic nature is to provide economic services to the member, such as financial or credit counseling are not covered under this Section.

65.07-6 Driver Education and Evaluation Program (DEEP) Evaluations: Any program, services or components of services of which the basic nature is to provide DEEP evaluations are not reimbursable under this Section.

65.07-7 Comparable or Duplicative Services: Services as defined under this Section are not covered if the member is receiving comparable or duplicative services under this or another Section of the MaineCare Benefits Manual.

65.07 NON-COVERED SERVICES (cont.)

1. Any Services provided as a Covered Service under Section 65 are not covered and are not reimbursable if the member is receiving another service under Section 65, except as set forth in the specific Covered Services and as follows:

   a. Such concurrent services are prior authorized for a specified duration and amount by DHHS or its authorized agent, and

   b. Such exceptions are documented in the member's ITP, and

   c. Concurrent services are consistent with the provisions in the MaineCare services described in this Section and other MaineCare Benefits Manual Sections, and

   d. There is a clear documented clinical justification as to why concurrent treatment under this service is needed, as follows:

      i. During the course of provision of a service the clinician uncovers an issue requiring referral to specialized treatment (e.g. trauma, sexual abuse issue, substance abuse), or

      ii. The service is necessary for a successful transition of the member to a different level of care.

2. Other such comparable or duplicative services include, but are not limited to services covered under MaineCare Benefits Manual, Section 40, Home Health Services, and Section 96, Private Duty Nursing Services; services that are duplicated by a Private Non-Medical Institution providing services under Section 97, and other services described in this Section. Refer to Appendix II for further detail on comparable or duplicative services.

65.08 LIMITATIONS

65.08-1 **Services in Individual Treatment Plan (ITP)**

Only services included in the ITP will be reimbursed. Reimbursement will be allowed for covered services prior to the approval of the initial ITP, when the provider obtains subsequent approval of those services within thirty (30) days of the date the member begins treatment.

65.08 LIMITATIONS (cont.)

65.08-2 **Prior Authorization and Utilization Review**

Some services in this section require prior authorization, including Crisis Residential, Children's Assertive Community Treatment, Children's Home and Community Based Treatment and Collateral Contacts for Children's Home and

Community Based Treatment. After submitting a Prior Authorization request the provider will receive prior authorization with a description of the type, duration and costs of the services authorized.

The provider is responsible for providing services in accordance with the prior authorization letter. The prior authorization number is required on the CMS 1500 claim form. All extensions of services beyond the original authorization must be prior authorized by this same procedure.

All other services in this section require notification of initiation of services for utilization review purposes.

65.08-3 **Crisis Resolution**

A treatment episode is limited to six (6) face-to-face visits over a thirty (30) day period. DHHS Children's Behavioral Health Services (CBHS) or Office of Adult Mental Health Services (OAMHS) Medical Director or Designee may approve more than six (6) face to face visits, if medically necessary and clinical documentation supports the need for the service. Crisis resolution services will cover the time necessary to accomplish appropriate crisis intervention, collateral contact, stabilization and follow-up. When increased staffing is necessary to ensure that a member receives necessary services while the safety of that member is maintained, MaineCare reimbursement for these services will be made to more than one (1) clinician and/or other qualified staff at a time. Providers must maintain documentation of the necessity of this treatment.

More than one agency may be reimbursed for crisis contacts and respective face-to-face follow-up contacts for children and adult crisis resolution services only when the two agencies have a formal agreement or sub-contract stipulating one (1) or more agencies deliver phone services and the other agency (or agencies) provide follow-up, and face-to-face services.

65.08-4 **Crisis Residential**

Prior authorization for up to 7 (seven) consecutive days, beginning with the date of admission must be obtained for all medically necessary Crisis Residential Services. Providers may not provide Crisis Residential Services for longer than the 7 (seven)

65.08 LIMITATIONS (cont.)

day period, unless DHHS or its authorized agent has prior authorized an extension of the 7 (seven) day period of service and the extension is medically necessary.

65.08-5 **Outpatient Services**

65.08-5.A. **Comprehensive Assessment**

Comprehensive Assessments are limited two (2) hours or eight (8) units annually and to only those needed to determine appropriate treatment, such as whether or not to treat, how to treat and when to stop treating. Reimbursement for a Comprehensive Assessments does not include psychological testing. Reimbursement for Comprehensive Assessments shall not exceed two (2) hours or eight (8) units annually, except when a member requires a change in the level of care or a new provider, an additional one (1) hour or four (4) units will be authorized for the provider of the new service to do an addendum to the original Comprehensive Assessment.

Additional Comprehensive Assessments of two (2) hours or eight (8) units may be authorized during the same year if a copy of the existing annual assessment cannot be obtained after reasonable efforts or if the member chooses not to authorize access to the existing assessment.

65.08-5.B. **Individual Outpatient therapy**

For members, individual and family mental health or co-occurring individual outpatient is limited to two (2) hours per week except when a member requires services for an emergency or crisis situation or when a service is medically necessary to prevent hospitalization. For members, individual and family outpatient for those needing interpreter services will be limited to three (3) hours per week. For members, substance abuse individual and family outpatient is limited to three (3) hours per week, for thirty (30) weeks in a forty (40) week period.

MaineCare reimbursement for individual outpatient will be made to only one (1) provider at any given time unless temporary coverage is provided in the absence of the usual provider. A member may receive mental health individual outpatient and substance abuse individual outpatient concurrently from two (2) separate providers in accordance with the individual service limits. If a member is receiving integrated co-occurring services with one (1) provider for a mental health and a substance abuse diagnosed condition; the member may not also receive separate mental health or substance abuse individual outpatient therapy services under Section 65 Behavioral Health Services.

65.08 LIMITATIONS (cont)

65.08-5.C. **Group Outpatient therapy**

1. Members receiving group outpatient therapy must be eight (8) years of age or older, unless members less than eight (8) years of age receive family therapy or receive outpatient therapy in a group to specifically address a severe childhood trauma that may include, but is not limited to, a serious threat to one's life or physical integrity, a serious threat or harm to a parent, or sudden destruction of one's home or community.

2. Reimbursement for group outpatient therapy is limited to ninety (90) minutes per week except for:

   a. Members in an inpatient psychiatric facility for whom services shall be provided in accordance with the plan of care; or

   b. Members who are in group outpatient therapy that is designated for the purpose of trauma treatment; or

   c. Members who are sex offenders or victims of sexual abuse, and are in group outpatient therapy designated for treatment of sex offenders or victims of sexual abuse; or

   d. Members aged twenty (20) years or less, whose ITP documents the need for weekly outpatient therapy in excess of ninety (90) minutes per week.

   e. Members who receive Dialectical Behavior Therapy (DBT) meet for two (2) to two and a half (2 ½) hours per week for up to one (1) year but may meet more frequently for a shorter duration than one (1) year.

   f. Members who receive Differential Substance Abuse Treatment (DSAT) meet for two (2) three (3) hour groups per week for up to eight (8) weeks during the intensive phase of this Evidence Based Practice. The DSAT maintenance phase follows the intensive DSAT treatment and members attend one (1) two (2) hour group per week for up to twenty three (23) weeks.

65.08 LIMITATIONS (cont)

3. Group outpatient therapy for mental health and co-occurring services requires a minimum of four (4) members and is limited to no more than ten (10) members in a group. No more than two (2) members of the same family shall receive services in the same group, unless it is a family outpatient therapy group. When group outpatient therapy is provided to a group of more than four (4) members, it can be provided by up to two (2) therapists at one time. Substance Abuse Group Outpatient Therapy may include more than ten (10) members. If more than ten (10) members attend, two (2) clinicians must conduct the group. DSAT outpatient therapy groups may have less than the minimum of four (4) members.

   Reimbursement for group outpatient therapy is allowed if more than four (4) members are scheduled for the session but only four (4) or fewer members attend due to unavoidable circumstances.

4. Both clinicians may not bill for providing the same services to the same members at the same time. When group outpatient therapy is provided by both professionals at the same time, they can bill as follows:

   a. One provider seeks reimbursement for the provision of services to the total number of members in the group; or

   b. Each therapist bills for services provided to a portion of the total number of members in the group. Each co-therapist may bill only for the portion of members for which the other co-therapist has not billed. The total amount submitted by both therapists for MaineCare reimbursement must not exceed the total number of members in the group. For example, if there are eight (8) members in group outpatient therapy, each provider may bill the group rate for the session, accounting for four (4) members each.

   The provider billing for the member is responsible for maintaining all clinical records relating to that member.

65.08 LIMITATIONS (cont)

65.08-6 **Intensive Outpatient Services (IOP)**

Intensive Outpatient Services must be delivered for a minimum of three (3) hours per diem three (3) days a week. A provider may not be reimbursed for delivering Intensive Outpatient Services and Outpatient Services, including Opioid Treatment Services to a member at the same time. In addition, a provider may not be reimbursed for delivering more than one Outpatient service, including Opioid Treatment Services to a member at the same time.

65.08-7 **Medication Management Services**

Medication management limits for reimbursement are as follows:

1) For adults, up to one (1) hour is allowed for the Comprehensive Assessment of medication management.

2) For children, up to two (2) hours is allowed for the Comprehensive Assessment of medication management.

All subsequent sessions for medication management and evaluation are limited to thirty (30) minutes. Any additional time beyond the thirty (30) minutes is considered outpatient counseling, and is only reimbursable if it is a covered outpatient service, as defined in this Section. Providers must have documentation in their records to support those billings. Providers may bill for only one encounter with a member per day.

65.08-8 **Psychological Testing**

Psychological testing includes the administration of the test, the interpretation of the test, and the preparation of test reports. Psychometric testing does not include preliminary diagnostic interviews or subsequent consultation visits. Reimbursement for psychological testing will be limited to testing administered at such intervals indicated by the testing instrument and as clinically indicated.

Psychological testing is limited to no more than four (4) hours for each test except for the tests listed below. Providers must maintain documentation that clearly supports the hours billed for administration and associated paperwork.

Each Halstead-Reitan Battery or any other comparable neuropsychological battery is limited to no more than seven (7) hours (including testing and assessment). This is to be used only when there is a question of a neuropsychological and cognitive deficit.

Testing for intellectual level is limited to no more than two (2) hours for each test.

65.08 LIMITATIONS (cont)

Each self-administered test is limited to thirty (30) minutes. Only the testing for the eligible member is reimbursable. This includes self- administered tests completed for the benefit of the member as indicated by the testing instrument. The following tests are considered self-administered, and include but are not limited to:

1. Achenbach Child Behavior Checklist;
2. Adult Adolescent Parenting Inventory;
3. Child Abuse Potential Survey;
4. Connor's Rating Scales;
5. Parenting Stress Index;
6. Piers-Harris Self Concept Scale;
7. Reynolds Children's Depression Scale;
8. Rotter Incomplete Sentences Blank;
9. Shipley Institutes of Living Scale; and
10. Fundamental Interpersonal Relations Orientation Scale-Behavior (FIROB).

65.08-9 **Collateral Contacts**

For the purposes of Collateral contacts for Children's Home and Community Based Treatment, MaineCare reimburses only up to forty (40) units or ten (10) hours of billable face-to-face collateral contacts per member per year of service. DHHS or its Authorized Agent may approve, in writing, additional collateral contact hours and/or non face-to-face collateral contacts for Multi-Systemic Therapy (MST) services consistent with the requirements of the MST model of service, as defined in 65.02-24, and for Functional Family Therapy (FFT) services consistent with the requirements of the FFT model of service, as defined in 65.02-19.

65.09 POLICIES AND PROCEDURES

65.08-10 Opioid Treatment

Eff. 1/1/13

Reimbursement for methadone treatment for addiction to opioids is limited to twenty-four (24) months per lifetime, except as permitted through prior authorization. Only treatment after the effective date of this rule (January 1, 2013) will count toward the limit.

Prior authorization criteria can be found at: https://mainecare.maine.gov/ProviderHomePage.aspx

65.09-1 Clinicians and Other Qualified Staff

Clinicians: There must be written evidence from the appropriate governing body that all clinicians are conditionally, temporarily, or fully licensed and approved to practice. All clinicians must provide services only to the extent permitted by licensure. Clinicians are required to follow professional licensing requirements, including documentation of clinical credentials.

Other Qualified Staff: consist of a certified Mental Health Rehabilitation Technician (MHRT), a certified Behavioral Health Professional (BHP), or a certified MST therapist for the purposes of providing 65.06-9 Children's Home and Community Based Treatment certified by DHHS at the level appropriate for the services being delivered.

A provider may be reimbursed for covered services only if they are provided by clinicians or other qualified staff.

65.09-2 Providers of Behavioral Health Services for Members Who are Deaf or are Hard of Hearing

Services for members who are deaf or hard of hearing must be delivered by a provider or an interpreter who is credentialed in the communication mode of the member, whether that is American Sign Language, Oral Interpreter, Cued Speech, or some other communication mode used by deaf, hard of hearing, or non-verbal member, as approved by the Office of Multicultural Services, DHHS.

65.09-3 Member Records

A member's record must contain written documentation of a Comprehensive Assessment, an Individual Treatment Plan and progress notes. The Comprehensive Assessment process determines the intensity and frequency of medically necessary services and includes utilization of instruments as may be approved or required by DHHS. Individual Treatment Plans are the plans of care

65.09 POLICIES AND PROCEDURES (cont)

developed by the clinician or the treatment team with the member and in consultation with the parent or guardian, if appropriate, based on a Comprehensive Assessment of the member. Individualized plans include the Individual Treatment Plan, the Crisis/Safety Plan (where indicated by the Covered Service), and the Discharge Plan.

A. **Comprehensive Assessment**

1. A clinician must complete a Comprehensive Assessment that integrates co-occurring mental health and substance abuse issues within thirty (30) days of the day the member begins services. The Comprehensive Assessment must be included in the member's record. The Comprehensive Assessment process must include a direct encounter with the member and if appropriate, family members, parents, friends and guardian. The Comprehensive Assessment must be updated at a minimum, when there is a change in level of care, or when major life events occur, and annually.

   The Comprehensive Assessment must contain documentation of the member's current status, history, strengths and needs in the following domains: personal, family, social, emotional, psychiatric, psychological, medical, drug and alcohol (including screening for co-occurring services), legal, housing, financial, vocational, educational, leisure/recreation, potential need for crisis intervention, physical/sexual and emotional abuse.

   The Comprehensive Assessment may also contain documentation of developmental history, sources of support that may assist the member to sustain treatment outcomes including natural and community resources and state and federal entitlement programs, physical and environmental barriers to treatment and current medications. Domains addressed must be clinically pertinent to the service being provided.

   Additionally, for a Comprehensive Assessment for a member with substance abuse, the documentation must also contain age of onset of alcohol and drug use, duration, patterns and consequences of use, family usage, types and response to previous treatment.

3. The Comprehensive Assessment must be summarized, and include a diagnosis using all Diagnostic and Statistical Manual of Mental Health Disorders (DSM) axes or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood

65.09 POLICIES AND PROCEDURES (cont)

(DC 0-3) diagnosis, as appropriate. The Comprehensive Assessment must be signed, credentialed and dated by the clinician conducting the

Comprehensive Assessment. A Comprehensive Assessment for a member with a substance abuse diagnosis must also contain ASAM level of care criteria. If the Comprehensive Assessments for a member receiving integrated treatment for co-occurring disorders, the Comprehensive Assessment must contain both the DSM and ASAM criteria.

4. If a provisional diagnosis is made by an MHRT or CADC providing the direct service, the diagnosis will be reviewed within five (5) working days by the supervising licensed clinician and documented in the record.

5. Historical data may be limited in crisis services. The Comprehensive Assessment must contain documentation if information is missing and the reason the information cannot be obtained or is not clinically applicable to the service being provided.

B. **Individual Treatment Plan (ITP)**

1. The clinician, member and other participants (service providers, parents or guardian) must develop an ITP, based on the Comprehensive Assessment that is appropriate to the developmental level of the member within thirty (30) days of the day the members begins services.

2. When an ITP is required it must contain the following unless there is an exception:

   a. The member's diagnosis and reason for receiving the service;

   b. Measurable long-term goals with target dates for achieving the goals;

   c. Measurable short-term goals with target dates for achieving the goals with objectives that allow for measurement of progress;

   d. Specific services to be provided with amount, frequency, duration and practice methods of services and designation of who will provide the service, including documentation of co-occurring services and natural supports, when applicable;

   e. Measurable Discharge criteria;

65.09 POLICIES AND PROCEDURES (cont)

f. Special accommodations needed to address physical or other disabilities to provide the service; and

e. All participants must sign, credential (if applicable) and date the ITP. The first ninety (90) day period begins with date of the initial, signed ITP. The ITP must be reviewed at all major decision points but no less frequently than ninety (90) days, or as described in 65.09-3.B.7. If clinically indicated, the member's needs may be reassessed and the ITP may be reviewed and amended more frequently than every ninety (90) days. Changes to the ITP are considered to be in effect as of the date it is signed by the clinician and member or, when appropriate, the parent or guardian.

All participants must sign, credential (if applicable) and date the reviewed ITP.

3. For members receiving Crisis Resolution Services a written plan of care is substituted for the ITP.

4. For members receiving Family psychoeducation, no Comprehensive Assessment is required. For members receiving Psychological testing no Comprehensive Assessment or ITP is required. For members receiving a Neurobehavioral Status Exam, no ITP is required.

5. If a member receives covered Case Management Services MaineCare Benefits Manual, Section 13 or services under MaineCare Benefits Manual Section 17, the member's mental health provider's ITP will coordinate with the appropriate portion of the member's ITP described in MaineCare Benefits Manual Section 13 or MaineCare Benefits Manual Section 17.

6. MaineCare will reimburse for covered services provided before the ITP is approved as long as the ITP is completed within prescribed time frames from the day the member begins treatment.

7. The ITP must be completed and reviewed within the following schedule:

a. Crisis Resolution- as clinically indicated.

65.09 POLICIES AND PROCEDURES (cont)

b. Crisis Residential- completed within twenty four (24) hours of admission and reviewed on the seventh (7th) day of service and every two (2) days thereafter if continued stay is approved by DHHS or its authorized agent.

c. Outpatient Services- Mental Health, Co-occurring, Family Psychoeducation and Medication Management Services completed within thirty (30) days of admission and reviewed every twelve (12) visits or annually whichever comes first.

d. Outpatient- Substance Abuse completed within three (3) outpatient sessions and reviewed every ninety (90) days.

e. Intensive Outpatient Services completed within three (3) outpatient sessions and reviewed every thirty (30) days.

f. Children's Assertive Community Treatment, Children's Home and Community Based Treatment completed within thirty (30) days of admission and reviewed every ninety (90) days.

g. Opioid Treatment completed within seven (7) days of admission and reviewed every ninety (90) days.

8. If a member is assessed by appropriate staff, but an ITP is not developed because there is at least a sixty (60) day waiting list to enter into treatment, reimbursement may be made for the assessment only.

   Comprehensive assessments must be updated before treatment begins if, in the opinion of the professional staff assigned to the case, this would result in more effective treatment. If an update is necessary, additional units for the Comprehensive Assessment may be authorized by DHHS or its Authorized Agent.

9. Crisis/Safety Plan

   The Crisis/Safety Plan for Children's Home and Community Based Treatment must address the safety of the member and others surrounding a member experiencing a crisis. The plan must:

   a. Identify the precursors to the crisis;

65.09 POLICIES AND PROCEDURES (cont)

b. Identify the strategies and techniques that may be utilized to stabilize the situation;

a. Identify the individuals responsible for the implementation of the plan including any individuals whom the member (or parents or guardian, as appropriate) identifies as significant to the member's stability and well-being; and

d. Be reviewed every ninety (90) days or as part of the required review of the ITP.

10. If the member is a Bates vs. DHHS class member (Bates v. DHHS, No. CV 89-88 (Maine Superior Court, Kennebec County, August 2, 1990)) and the mental health services reimbursed under Section 65 services are identified in the member's Individual Treatment Plan (Individual Support Plan for Community Integration Services), then the provider must follow the termination requirements as described in paragraph 69 of the Consent Decree compliance requirements which include:

a. Obtaining prior written approval from DHHS for discharge; and

b. Giving thirty (30) days written notice to the member being discharged.

C. **Documentation**

Providers must maintain written progress notes for all services, in chronological order.

All entries in the progress note must include the service provided, the provider's signature and credentials, 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.

For in-home services, the progress note must also contain the time the provider arrived and left. Additionally, the provider must ask the member or an adult responsible for the member to sign off on a time slip or other documentation documenting the date, time of arrival, and time of departure of the provider.

65.09 POLICIES AND PROCEDURES (cont)

In the case of co-therapists providing group psychotherapy, the provider who bills for the service for a specific member is responsible for maintaining records and signing entries for that member. Facsimile signatures will be considered valid by DHHS if in accordance with mental health licensing standards.

Separate clinical records must be maintained for all members receiving group psychotherapy services. The records must not identify any other member or confidential information of another member.

For crisis services, the progress note must describe the intervention, the nature of the problem requiring intervention,
and how the goal of stabilization will be attempted, in lieu of an ITP.

The clinical record shall also specifically include written information or reports on all medication reviews, medical consultations, psychometric testing, and collateral contacts made on behalf of the member (name, relationship to member, etc.).

Documentation of cases where a member requires more than two (2) hours of outpatient services per week to prevent hospitalization must be included in the file. This documentation must be signed by the supervising clinician.

D. **Discharge/Closing Summary**

A closing summary shall be signed, credentialed and dated and included in the clinical record at the time of discharge. This will include a summary of the treatment, to include any after care or support services recommended and outcome in relation to the ITP.

E. Quality Assurance

Periodic review of cases to assure quality and appropriateness of care will be conducted in accordance with the quality assurance (QA) protocols established by DHHS.

Reviews will be in writing, signed and dated by the reviewers, and included in the member's record, or kept in a separate and distinct file parallel to the member's record.

65.09 POLICIES AND PROCEDURES (cont)

65.09-4 Program Integrity (PI) Unit

Program Integrity Unit requirements apply as defined in the MaineCare Benefits Manual, Chapter I, General Administrative Policies and Procedures

65.10 APPEALS

In accordance with Chapter I of the MaineCare Benefits Manual, members have the right to appeal in writing or verbally any decision made by DHHS to reduce, deny or terminate services provided under this benefit.

65.11 REIMBURSEMENT

A. The amount of payment for services rendered by a provider shall be the lowest of the following:

1. The amount listed in Chapter III;
2. The lowest amount allowed by the Medicare Part B carrier; or
3. The provider's usual and customary charge.

B. The daily rate of delivering crisis services to a member by an agency in the member's home on a quarter hour basis must not exceed the per diem rate of crisis support services delivered by an agency to a member outside the home. Please see Section 65.08, Limitations, for provider eligibility for reimbursement.

C. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing the MaineCare Program. MaineCare is not liable for payment of services when denied or paid at a rate reduced by a liable third party payor, including Medicare, because the services were not authorized, or a non-participating provider provided services that were coverable under the plan.

65.11-1 Rate Determination for Providers

DHHS will contract with providers that meet all DHHS and MaineCare guidelines and contracting requirements to provide services under this Section and are currently in good standing with DHHS.

DHHS will use the following as factors affecting the determination of the rates:

- Reasonable, necessary and comparable costs;

65.11 REIMBURSEMENT (cont)

- Productivity levels;
- Cost caps; and
- Service design and delivery.

65.12 CO-PAYMENT

Co-payment exemptions and dispute resolution are described in Chapter 1 of the MaineCare Benefits Manual.

Services furnished to members under twenty-one (21) years of age are exempted from co-payments.

A co-payment will be charged to each MaineCare member twenty-one (21) and older for services. The amount of the co-payment shall not exceed $2.00 per day, per service or $2.00 per week for Opioid Treatment Services for services provided according to the following schedule

MaineCare Payment for Services	Member Co-payment
$10.00 or less	$.50
$10.01 - $25.00	$1.00
$25.01 or more	$2.00

The member shall be responsible for co-payments up to twenty dollars ($20) per month per service whether the co-payment has been paid or not. After the twenty dollar ($20) cap has been reached, the member shall not be required to make additional co-payments and the provider shall receive full MaineCare reimbursement for covered services.

The provider shall not deny services to a MaineCare member on account of the member's inability to pay a co-payment. Providers must rely upon the member's representation that he or she does not have the money available to pay the co-payment. However, the individual's inability to pay does not eliminate his or her liability for the co-payment.

65.13 BILLING 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 for 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.

65.14

APPENDIX I
PROFESSIONAL STAFF

CHILDREN'S BEHAVIORAL HEALTH SERVICE

Provider	Crisis Resolution Services	Crisis Residential Services	Outpatient Services	Family Psychoeducational	Medication Services	Neurobehavioral Status Exam/ Psychological Testing	Children's ACT	Children's Home and Community Based Treatment/Collateral Contacts	Children's Behavioral Health Day Treatment
Physician	X	X	X	X	X	X			
Psychiatrist	X	X	X	X	X	X	X		X
Psychologist	X	X	X	X		X			X
Physician's Assistant	X	X		X			X		
Psychological Examiner						X			
LCSW/LMFT /LCPC/ LMSW	X	X	X	X			X	X	X
LADC/CADC			X				X		
APRN-PMH-NP/CNS	X	X	X	X	X		X		
RNBC/RNC	X	X		X	X			X	
MHRT	X	X		X			X		
BHP							X	X	X
BCBA (supervision only)									X
Mental Health Agency	X	X	X	X	X	X	X	X	X
NTA/Psycho metrician						X			

65.14 APPENDIX I (cont)

APPENDIX I

PROFESSIONAL STAFF

ADULT BEHAVIORAL HEALTH SERVICE

Provider	Crisis Resolution Services	Crisis Residential Services	Outpatient Services	Family Psychoed ucation	Medication Services	Neurobehavioral Status Exam/ Psychological Testing
Physician	X	X	X	X	X	X
Physician's Assistant	X	X		X	X	
Psychiatrist	X	X	X	X	X	X
Psychologist	X	X	X	X		X
Psych Examiner						X
LCSW/LCPC /LMFT/ LMSW	X	X	X	X		
APRN-PMH-NP/CNS	X	X	X	X	X	
RNBC/RNC	X	X		X	X	
MHRT	X	X		X		

PROFESSIONAL STAFF

SUBSTANCE ABUSE SERVICES

Provider	Outpatient Services	Intensive Outpatient Services	Opioid Treatment
Physician (MD/DO)/Psychologist	X	X	X
APRN	X	X	X
LADC/CADC	X	X	X
LCSW/LCPC/LMFT	X	X	X

65.15 **APPENDIX II**

Service	Service not allowed Concurrently
Crisis Resolution	Children's Assertive Community Treatment (ACT)
Crisis Residential	Children's Assertive Community Treatment (ACT)
Outpatient-Comprehensive Assessment/Therapy	Children's Assertive Community Treatment (ACT) Children's Home and Community Based Treatment/ Collateral Contacts Opioid Treatment
Family Psychoeducation	Children's Assertive Community Treatment (ACT) Children's Home and Community Based Treatment/ Collateral Contacts
IOP	Children's Assertive Community Treatment (ACT) Children's Home and Community Based Treatment/ Collateral Contacts Outpatient Therapy- Substance Abuse Opioid Treatment
Medication Management	Children's Assertive Community Treatment (ACT)
Neurobehavioral Status Exam	N/A
Psychological Testing	N/A
Children's Assertive Community Treatment (ACT)	Crisis Resolution Crisis Residential Outpatient Therapy Family Psychoeducational Treatment Medication Management Children's Home and Community Based Treatment/ Collateral Contacts
Children's Home and Community Based Treatment/ Collateral Contacts	Outpatient Therapy Family Psychoeducational Treatment Children's Assertive Community Treatment (ACT)
Opioid Treatment	Outpatient- Comprehensive Assessment/Therapy Substance Abuse IOP
Children's Behavioral Health Day Treatment	N/A