MaineCare Services
An Office of the
Department of Health and Human Services
John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-2674; Fax: (207) 287-2675
TTY: 1-800-423-4331

July 15, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: Proposed Rule: Chapter 101 MaineCare Benefits Manual, Chapter II and III, Section 40, Home Health Services

This letter gives notice of a proposed rule: Chapter 101, MaineCare Benefits Manual, Chapter II and III, Section 40, Home Health Services.

The Department proposes changes to the above named section of policy that are major substantive rules. Specifically, in Chapter II, the Department is proposing to change §40.05-E, Medical Supplies, to no longer allow for routine supplies to be separately billable at acquisition cost. These costs will now be considered as part of the service rates listed in Chapter III. Furthermore, this section also clarifies language for non-routine supplies to state that these supplies are not billable under section 40 and must be billed under section 60. In addition, the Department is simultaneously proposing Chapter III and proposes new HIPAA compliant codes for the reimbursable services under this section. These coding changes are required in order to comply with Federal statute. All changes must be approved by the legislature as these are major substantive rules and are planned to go in effect upon implementation of the Maine Integrated Health Management Solution (MIHMS). A public hearing is scheduled for August 5, 2009.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services

RULE TITLE OR SUBJECT: Chapter 101 MaineCare Benefits Manual, Chapter II and III, Section 40, Home Health Services

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The Department proposes changes to the above named section of policy. Specifically, in Chapter II, the Department is proposing to change §40.05-E, Medical Supplies, which will eliminate routine supplies as a separately coverable service. The costs associated with these supplies will be included in the service rates listed in Chapter III. Furthermore, this section also clarifies language for non-routine supplies to state that these supplies are not billable under section 40 and must be billed under section 60. In addition, the Department is simultaneously proposing Chapter III and proposes new HIPAA compliant codes for the reimbursable services under this section. These coding changes are required in order to comply with Federal statute. All changes must be approved by the legislature as these are major substantive rules and are planned to go in effect upon implementation of MIHMS.

SEE http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html **for rules and related rulemaking documents.**

THIS RULE WILL __ WILL NOT _X__ HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 M.R.S.A. §§ 42 and 3173
45 C.F.R. part 162

PUBLIC HEARING:

Date: August 5, 2009, 1 PM
Location: Conference Room # 3
Department of Health and Human Services
Office of MaineCare Services
442 Civic Center Drive
Augusta, ME

Any interested party requiring special arrangements to attend the hearing must contact the agency person listed below before July 29, 2009.

DEADLINE FOR COMMENTS: Comments must be received by midnight August 15, 2009.

AGENCY CONTACT PERSON: Alyssa Morrison, Health Planner
AGENCY NAME: Office of MaineCare Services
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: 207-287-9368 FAX: (207) 287-9369 TTY: 1-800-423-4331 or 207-287-1828 (Deaf or Hard of Hearing)

SECTION 40 **HOME HEALTH SERVICES** **ESTABLISHED 10/1/79**
LAST UPDATED 01/20/06

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SECTION 40 **HOME HEALTH SERVICES** **ESTABLISHED 10/1/79**
LAST UPDATED 01/20/06

Major Substantive Rule

40.01 DEFINITIONS

40.01-1 **Authorized Agent** shall mean the organization authorized by the Department to perform functions pursuant to a contract or which are specified in a written agreement. The Authorized Agent will perform medical eligibility determinations and prior authorizations of services as required.

40.01-2 **Certification Period** shall mean the months, days, years, which identify the period covered by the physician's plan of care. The "From" date for the initial certification must match the start of care date. The "To" date can be up to, but never exceed, two (2) calendar months and mathematically never exceed sixty-two (62) days. Recertifications shall follow the same length of time requirements.

40.01-3 **Classification Period** shall mean the period of time, designated by a start and end date established by the Department or its Authorized Agent, approved for coverage of home health services, in accordance with Section 40.08.

40.01-4 **Contraindicated** shall mean the member's condition renders some particular line of treatment improper or undesirable.

40.01-5 **Duration** shall mean the length of time the services are to be rendered and may be expressed in days, weeks, or months. This must be specified on the physician certified plan of care.

40.01-6 **Extensive Assistance** means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or
- Full staff performance during part (but not all) of the last seven (7) days.

40.01-7 **Frequency** shall mean the number of visits per discipline to be rendered, stated in days, weeks, or months. This must be specified on the physician certified plan of care.

40.01-8 **Functionally Significant Improvement** is the demonstrable, measurable increase in the individual's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

40.01-9 **Home Health Agency (HHA**) means a voluntary, public or private organization, or a part of such organization, that is certified under Title XVIII of the Social Security Act for reimbursement for the delivery of home health services.

40.01-10 **Home Health Aide Services** are those in-home services that are provided by a certified home health aide and which are delegated and supervised by a registered nurse. A certified home health aide must have satisfactorily completed a training program for certified nurse assistants, consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health

40.01 **DEFINITIONS** (cont.)

agency must also have completed an agency orientation as defined by the Regulations Governing the Licensing and Functioning of Home Health Care Services.

40.01-11 **Home Health Services** are those skilled nursing and home health aide services, physical and occupational therapy services, speech-language pathology services, medical social services, and the provision of certain medical supplies, needed on a "part-time" or "intermittent" basis. Services are delivered by a Medicare certified home health agency to a member in his or her home or in other particular settings with limitations as described in Section 40.06. Services are delivered according to the orders of a licensed physician and an authorized plan of care.

In a nursing facility (NF) setting, only physical therapy, occupational therapy and/or speech-language pathology services may be delivered by a home health agency if the NF's MaineCare reimbursement rate does not include these services.

40.01-12 **Intermittent**, in general, shall mean skilled nursing care needed on fewer than seven (7) days each week or less than eight (8) hours each day for periods of up to twenty-one (21) days (or longer in exceptional circumstances when the need for care is finite and predictable); but as defined in CMS Publication 11 "Medicare Home Health Agency Manual," and the regulations issued pursuant thereto as are most currently in effect. This manual is available on line at http://www.cms.hhs.gov/manuals/11_hha/HH00.asp

40.01-13 **Medical Social Services** are assessment, counseling, and assistance services that are needed by a member to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the member's medical condition or to affect his or her rate of recovery. Services are provided by a social worker who is functioning within the scope of the license granted by the state or province in which the services are performed and who has had at least one (1) year of social work experience in a health care setting. Medical social services must be required in conjunction with a skilled nursing service, physical therapy, occupational therapy or speech-language pathology services.

A licensed social worker shall receive consultation in accordance with State of Maine Board of Social Work Registration and the Rules and Regulations of the Board of Social Work.

The licensed social worker with more than two (2) years experience shall receive consultation from a licensed master social worker, a licensed clinical social worker, or a certified social worker on a quarterly basis.

40.01-14 **Nursing Services** are those services that are provided by a registered nurse (RN) and/or a licensed practical nurse, which holds a current license issued by the state or province in which services are performed.

40.01 **DEFINITIONS** (cont.)

40.01-15 **Occupational Therapy Services** are those restorative services provided in accordance with physician orders, by an Occupational Therapist Registered (OTR) or by a Certified Occupational Therapist Assistant (COTA) under the direct supervision of an OTR, licensed by the state or province in which services are provided and acting within the scope of that license.

40.01-16 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

40.01-17 **Part-time**, in general, shall mean less than eight (8) hours a day or twenty-eight (28) hours a week; but as defined in CMS Publication 11 "Medicare Home Health Agency Manual," and the regulations issued pursuant thereto as are most currently in effect. This manual is available on line at http://www.cms.hhs.gov/manuals/11_hha/HH00.asp

40.01-18 **Physical Therapy Services** are those restorative services provided in accordance with physician orders, by a physical therapist or by a physical therapist assistant working under the direct supervision of a licensed physical therapist, licensed by the state or province in which services are provided and acting within the scope of that license.

40.01-19 **Psychiatric Nursing Services** are services provided by a registered professional nurse that is licensed by the state or province in which services are provided and has met requirements for approval to practice as an advanced practice psychiatric nurse or is certified as a psychiatric and mental health nurse by the appropriate national accrediting body.

40.01-20 **Rehabilitation Potential** is the documented expectation by a physician of measurable, "functionally significant improvement" (defined in Section 40.01-8) in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician documentation of rehabilitation potential must include the reasons used to support the physician expectation and must follow guidelines detailed in MaineCare Benefits Manual (MBM), Chapter II, Section 90, Physician Services.

40.01-21 **Speech-Language Pathology Services** are those restorative services which are furnished in accordance with physician orders by a speech-language pathologist or speech language pathology assistant licensed by the state or province in which services are provided, who is acting within the scope of that license, and services meet the conditions described in Chapter II, Section 109 of the MBM. Services may be delivered by a speech-language pathology assistant who is registered and supervised by a Board licensed speech-language pathologist, as provided by 32 M.R.S.A., Section 6003 (7-A).

40.01 **DEFINITIONS** (cont.)

40.01-22 **Start of Care Date (SOC**) shall mean the first billable visit. This date remains the same on subsequent plans of care until the member is discharged.

40.01-23 **The Unit of Home Health Service** is a visit. A visit means personal contact in the member's place of residence made for the purpose of providing a covered service by a health worker on the staff of a home health agency or by others under contract or arrangement with the home health agency. When two (2) or more persons simultaneously provide separate and distinct types of services, each provider's service is recorded as a separate visit.

40.01-24 **Unstable Medical Condition** exists when the member's condition is fluctuating in an irregular way and/or is deteriorating and affects the member's ability to function independently. The fluctuations occur to such a degree that medical treatment and professional nursing observation, assessment and management are required at least three (3) times per week. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record.

40.02 **ELIGIBILITY FOR CARE**

40.02-1 **General and Specific Requirements**

An individual may be found eligible to receive services as set forth in this Section, if he or she meets both the General MaineCare Eligibility Requirements and the Home Health Services Medical Eligibility Requirements.

40.02-2 **General MaineCare Eligibility Requirements.** Individuals must meet the financial 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.

40.02-3 **Home Health Services Medical Eligibility Requirements.** A member must meet the following requirements:

A. The medical condition of the member must be such that it can be safely and appropriately treated by the home health agency under a plan of care reviewed and signed by a physician every certification period; AND

B. The member must be in a place of residence and NOT in an institution that meets the definition of a hospital, nursing facility or ICF-MR except as allowed under Section 40.01-11 and Section 40.06; AND

C. Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis. The plan of treatment signed by both the physician and the home health agency must include a statement of the

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

medical necessity for receiving services at home citing the specific reasons outpatient care is contraindicated (defined in 40.01-4) or not possible. The reasons must be listed and the likelihood of a bad outcome must be probable or definite as opposed to possible or rarely; AND

D. Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness/injury where these indications are part of a longstanding pattern of the member's condition and there is no significant change in health status; AND

E. The condition of the member must require skilled nursing care on a "part-time" (as defined in Section 40.01-17) or "intermittent" (as defined in Section 40.01-12) basis or otherwise no less than twice per month, or physical therapy services, or speech-language pathology services, or occupational therapy services as described below.

1. intraarterial, intravenous, intramuscular or subcutaneous injection, or intravenous feeding, all for treatment of unstable conditions requiring medical or nursing intervention. Daily insulin injections for an individual whose diabetes is under control do not meet the requirements of this Section; or

2. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition; or

3. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the past thirty (30) days) or unstable condition; or

4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites and tumor erosions); or

5. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observation for a new or recent (within past thirty (30) days) condition; or

6. professional nursing assessment, observation and management of an unstable medical condition (see Section 40.01-24); or

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

7. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record; or

8. care to manage conditions requiring a ventilator/ respirator (Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) system or wearing an airway clearance system vest does not meet the requirements of this Section); or

9. direct assistance from a professional nurse is required for the safe management of an uncontrolled seizure disorder (i.e.: grandmal); or

10. assessment and management for a new or recent medical condition (within the past thirty (30) days); or

11. professional nursing care and monitoring for administration of treatments, procedures, or dressing changes, which involve prescription medications, according to physician orders, at least twice per month. Treatments include:

    a. administration of medication via a tube;
    b. tracheostomy care;
    c. urinary catheter change;
    d. urinary catheter irrigation;
    e. barrier dressings for Stage 1 or 2 ulcers;
    f. chest PT by RN;
    g. oxygen therapy by RN;
    h. other physician ordered treatments; or
    i. teaching and training activities for patient and family;

or

12. professional nursing care for members receiving:

    a. radiation therapy;
    b. chemotherapy given intravenously or by injection; or
    c. hemodialysis or peritoneal dialysis;

or

13.a. physical therapy or occupational therapy services as part of a planned program that is designed, established and provided by, and requires the professional skills of a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve

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

specific goals within a given time frame. The need for maintenance or preventative therapy does not meet the requirements of this Section.

b. in addition to the requirements in Section 40.02-3(E)(13)(a), members aged twenty-one (21) or older, seeking occupational or physical therapy services must have rehabilitation potential (defined in Section 40.01-20) documented by a physician;

or

14. speech-language pathology services as part of a planned program that is designed, established, and provided by and requires the professional skills of a licensed speech-language pathologist or speech-language pathology assistant supervised by a Board licensed speech-language pathologist.

Members age twenty-one (21) and over must be assessed by a physician. The physician must provide documentation that the member has experienced a significant decline in his or her ability to communicate orally, safely swallow, or masticate and has rehabilitation potential (defined in Section 40.01-20). The documentation of the physician's assessment must be signed by the physician and be part of the member's record.

For continued eligibility beyond the initial certification period for members age twenty-one (21) and over, the home health agency must obtain a report completed by the speech-language pathologist documenting the member's progress and prognosis for improved speech, mastication, or swallowing functioning. The report must be forwarded to the member's physician for confirmation that rehabilitation potential still exists for the member. The report must be amended and signed by the physician to document the rehabilitation potential of the member. This report must be maintained in the member's medical record.

40.02-4 **Medical Eligibility Requirements for Psychotropic Medication Services**. A member may receive in-home psychotropic medications if he or she meets ALL of the following requirements:

A. The member has a severe and disabling mental illness that meets the eligibility requirements set forth in Section 17.02, Community Support Services for

Major Substantive Rule

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

Persons with Severe and Disabling Mental Illness. A copy of the Department's approved Section 17 assessment tool shall be completed pursuant to the requirements in Section 17.

The signed assessment shall be maintained in the member's medical record. A copy of the signed assessment must be submitted to the Department along with the start of care form; AND

B. The member requires psychotropic medication administration or monitoring for psychotropic medication; AND

C. The member is not receiving psychotropic medication services under any other Sections of the MBM (except physician services are allowed); AND

D. Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis. The plan of treatment signed by both the physician and the home health agency must include a statement of the medical necessity for receiving services at home citing the specific reasons outpatient care is contraindicated (defined in 40.01-4) or not possible. The reasons must be listed and the likelihood of a bad outcome must be probable or definite as opposed to possible or rarely.

40.02-5. **Prior authorization (PA) requirements.** The HHA must obtain prior authorization from the Department or its Authorized Agent for all members age twenty-one (21) and older in the following circumstances:

A. Home health nursing and aide services and medical social services must be prior authorized after the first two (2) consecutive certification periods (defined in 40.01-2). This subsection pertains to these particular home health services received after the enactment of legislation in 2004, which changed the prior authorization requirement from sixty (60) to one hundred-twenty (120) days. This subsection is no longer in effect after the implementation of Section 40.02-5 (B) below.

B. Effective January 20, 2006, all home health services must be prior authorized after the first two (2) consecutive certification periods (defined in 40.01-2) or

C. A member who qualifies under 40.02-4 and requires psychotropic medication administration or psychotropic medication monitoring as his/her only services, shall be exempt from prior authorization for these services. If the member requires any additional home health services, these shall require prior

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

authorization prior to providing services. In this circumstance, the home health agency cannot authorize services for the first two (2) consecutive certification periods.

The Department or its Authorized Agent must determine if the member continues to meet the eligibility for care requirements in Section 40.02. Members receiving services under Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities are not eligible for reimbursement for services under this Section because these services are also covered under Section 19.

40.03 **DURATION OF CARE**

Each MaineCare member is eligible to receive as many covered services as are medically necessary as long as the member meets the eligibility requirements as set forth in Section 40.02, and services are provided in accordance with a valid, authorized certification period as required in Section 40.08-2, and there is a valid prior authorization when PA is required (see 40.02-5). The Department reserves the right to request additional information to evaluate medical necessity. Coverage will be denied if the services provided are not specified in the authorized plan of care.

Home health services shall be reduced, denied, or terminated by the Authorized Agent or the Department, as appropriate, if any of the following situations occur:

A. The member declines home health services;

B. A significant change occurs in the member's medical or functional status such that a plan of care can no longer be developed and implemented safely;

C. The member does not meet the medical eligibility criteria for home health services as set forth in Section 40.02-3, as determined by the Authorized Agent or the Department;

D. The member is not financially eligible to receive MaineCare benefits;

E. When the member's most recent assessment, and the clinical judgment of the Authorized Agent, determine that the authorized plan of care must be changed or reduced to match the member's needs as identified in the assessment, the plan of care shall be modified by the Authorized Agent, or the Department, to reflect the change in needs;

F. The member has provided fraudulent information in connection with obtaining services;

G. The Department, or the Authorized Agent, documents that the member, or other person living or visiting the member's residence, harasses, threatens or endangers the safety of individuals delivering services;

40.04 STANDARDS OF CARE

General Regulatory Compliance

All home health agencies must meet the following standards to qualify for MaineCare reimbursement:

A. In order to qualify for reimbursement under this Section, a home health agency must have in effect a license pursuant to the Department's Regulations Governing the Licensing and Functioning of Home Health Care Services, as are currently in effect. A home health agency must also comply with all requirements of Title XIX of the Social Security Act and the regulations issued pursuant thereto, as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein. The home health agency must have in effect a current MaineCare provider agreement with the MaineCare program.

B. In order to qualify for reimbursement under this Section a home health agency must have in effect a current Medicare certification to participate pursuant to §1861(o) and 1891 of the Social Security Act and the regulations found at 42 CFR, Part 484, and regulations issued pursuant thereto as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

40.05 COVERED SERVICES

A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual. In order to be reimbursed under this Section, covered services must be delivered under a timely and complete plan of care, signed and certified by a qualified physician. The plan of care must meet the requirements of Section 40.08. The CMS-485 must be completed for each member under this Section.

A. **Skilled Nursing Services**. To be covered as skilled nursing services, the services must meet the following conditions:

1) require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the member and accepted standards of medical and nursing practice; and

2) be medically necessary to the treatment of the member's illness or injury. Medical necessity of services is based on the condition of the member at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period; and

3) be required on an intermittent or part-time basis (as defined in Section 40.01-12 and 40.01-17). To meet the requirement for intermittent skilled nursing care, a member must have a medically predictable recurring need for skilled nursing service; and

40.05 **COVERED SERVICES** (cont.)

4) be ordered by the physician for the member and are included in the physician's plan of care.

B. **Home Health Aide Services**. The services must be required in conjunction with a skilled nursing service as described in 40.05(A) or physical therapy or occupational therapy as described in 40.05(C). Home health aide services must be ordered by the physician and specified as to frequency and duration in the physician's plan of care for the member. The services must be medically necessary to provide personal care to the member, to maintain health, or to facilitate treatment of the member's illness. Covered services include, but are not limited to:

1) personal care services;

2) simple dressing changes that do not require the skills of a registered or licensed nurse;

3) assisting the member with self-administering medications that do not require the skills of a registered or licensed nurse; home health aides cannot administer medications;

4) assistance with activities that directly support skilled therapy services and are listed on the Maine State Board of Nursing approved nursing assistant skills checklist;

5) routine care of prosthetic and orthotic devices;

6) incidental services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the above definition (for example, light cleaning, preparing a meal, removing trash, or shopping). However, the purpose of the home health aide visit must not be solely to provide these incidental services.

C. **Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services**. The Department may review at any time a member's plan of care and other records to determine if therapy services are medically necessary and in accordance with the requirements of this Section. If the Department, or its Authorized Agent, determines that the therapy services are no longer medically necessary, the Department will not reimburse the HHA for continuing services. Therapy services are otherwise reimbursable only if all of the conditions set forth in this Section are met.

Physical therapy, occupational therapy and speech-language pathology services must meet the following criteria:

1) prescribed by a physician;

2) directly and specifically related to an active treatment regimen;

3) of such a level, complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required;

40.05 **COVERED SERVICES** (cont.)

4) performed by a licensed therapist or by a licensed therapist assistant under the supervision of a licensed or registered therapist, each operating within the scope of his or her license;

5) provided based on the physician's assessment that the member has rehabilitation potential (defined in Section 40.01-20) and will improve significantly in a predictable period.

   a. Once rehabilitation potential has been established for members aged twenty-one (21) or older, they are specifically eligible only for physical and occupational therapy in the following circumstances:

      i. treatment following an acute hospital stay for a condition affecting range of motion, muscle strength, and physical functional abilities. Services must be initiated within sixty (60) days from the date of the physician's certification of the member's rehabilitation potential; and/or

      ii. treatment after a surgical procedure performed for the purpose of improving physical function. Services must be initiated within sixty (60) days from the date of the physician's certification of the member's rehabilitation potential; and/or

      iii. treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-6) with at least one-person physical assist (defined in Section 40.01-16) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility;

      iv. palliative care is limited to one (1) visit per year to design a plan of care and train the member or caretaker of the member to implement the plan or to reassess the plan of care;

6) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;

   and

7) certified by the physician in a current certification period.

40.05 **COVERED SERVICES** (cont.)

D. **Medical Social Services**. Medical social services that are provided by a qualified medical social worker may be covered as home health services when medical social services are required in conjunction with a skilled nursing service as described in 40.05(A) or physical therapy or occupational therapy as described in 40.05(C); AND when:

1) the services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the member's medical condition or to affect his or her rate of recovery; and

2) the plan of care indicates how the services that are required necessitate the skills of a qualified medical social worker.

3) services may include: assessments of the social and emotional factors related to the member's illness, need for care, response to treatment and adjustment to care; assessment of the relationship of the member's medical and nursing requirements to the member's home situation, financial resources, and availability of community resources; appropriate action to obtain available community resources to assist in resolving the member's problem; and counseling services which are required by the member. Medical social services to address general problems that do not clearly and directly impede treatment or recovery, as well as long-term social services, such as ongoing alcohol counseling, are not covered.

4) certified by the physician in a current certification period.

E. **Medical Supplies.** To be considered a medical supply, items must meet the following criteria:

1) Routine medical supplies are consumable items, which are essential to the home health agency to carry out the physician's plan of care. These items ~~must be billed at acquisition cost~~ are not separately billable. The costs associated with these items are included within the rates of other reimbursable services listed in Chapter III of this Section.

2) Non-routine supplies are not covered items under this section. All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require the use of the specific supplies. Non-routine supplies and durable medical equipment shall be covered and reimbursed under Chapters II and III, Section 60, Medical Supplies and Durable Medical Equipment.

40.06 **LIMITATIONS**

Services delivered under this Section shall not duplicate any other services delivered to the member. Duplication includes, but is not limited to:

A. Services under this Section shall not be reimbursed for members who are receiving services under Section 19, Home and Community Benefits for the Elderly and for Adults with

40.06 **LIMITATIONS** (cont.)

Disabilities, because nursing services and personal care services are provided under this Section.

B. Home health aide services shall not be reimbursed for members who are receiving services under Section 2, Adult Family Care Services, or Section 12, Consumer Directed Attendant Care Services, or Section 21 Home and Community-Based Waiver Services for the Mentally Retarded or Section 22, Home and Community-Based Waiver Services for the Physically Disabled. Personal care services are covered services under these Sections.

C. If the member resides in a Section 50, ICF-MR, a home health agency may provide services only if the facility's MaineCare reimbursement rate, or the facility's contract with the seeding state agency, does not include these services. Home health aide services shall not be reimbursed in Section 97 (PNMI) and Section 50 (ICF-MR) settings because personal care services are a covered service under these Sections.

D. Nursing and home health aide services delivered to a member who is receiving Section 96, Private Duty Nursing (PDN) Services & Personal Care Services, shall count towards the member's authorized PDN cap. Occupational therapy, physical therapy, and speech-language pathology services may be provided and do not count toward the member's PDN cap.

E. Excluding members whose medical condition is "unstable" (as defined in Section 40.01-24), assessment and management services, as well as teaching and training services, are limited to two (2) certification periods or a maximum of one hundred twenty (120) days, per admission.

40.07 **NON-COVERED SERVICES**

The following services are not reimbursable by the MaineCare Program under this Section:

A. Parenting skills training.

B. Nursing services, physical therapy, and occupational therapy exercises that may be carried out by the member, or family member or friend who is trained, willing and able to safely perform the service after receiving instruction from the appropriate home health care professional.

C. Services provided by a personal care attendant.

D. Laboratory services as defined in Section 55 of this Manual.

E. Blood glucose monitoring, i.e. glucometer, if the member is stable and does not need teaching of diabetic management.

40.07 **NON-COVERED SERVICES** (cont.)

F. Routine foot care, unless the member suffers severe circulatory impairment, or metabolic, neurological, or systemic diseases where nonprofessional care may pose a threat to the member's condition.

G. Homemaking services (for example; vacuuming, laundry) and chore services, except when delivered as “incidental” services, as described in Section 40.05 (B).

H. RN supervisory visits made for the purpose of supervising home health aide services to the member.

I. Nursing evaluation visits, unless skilled observation and assessment by a licensed nurse would result in a change of the treatment of the member.

J. Visits made solely to remind the member to follow instructions.

K. Services that can be appropriately provided by other community resources, e.g., homemaker services, adult protective services, "Meals on Wheels".

L. Respite services.

M. Venipuncture if this is the sole skilled service provided during the visit.

N. Custodial care.

O. A monthly injection if this is the sole skilled nursing service provided during the visit.

P. Monthly catheter change, beyond the acute phase.

Q. Non-routine supplies

40.08 **POLICIES AND PROCEDURES**

40.08-1 **Prior Authorization Requirement**

For all services under this Section that require prior authorization (see Section 40.02-5), the Department or its Authorized Agent shall conduct the eligibility assessment and reassessment as required in order to approve a prior authorization request. Home health services will be authorized only if all requirements set forth in this Section are met. Prior authorization determines only medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or coverage by other third party payor.

A. Submission of request. In order to receive reimbursement, a HHA must request an assessment and receive approval from the Authorized Agent before providing services after the first two (2) consecutive certification periods (defined in Section 40.01-2).

40.08 **POLICIES AND PROCEDURES** (cont)

The HHA shall submit prior authorization requests in accordance with procedures set forth by the Department.

B. Notice of Approval. For all approved prior authorization requests for home health services, the Authorized Agent will provide written notice to the HHA.

C. Notice of Denial or Modification and Right to Appeal. For all denied or reduced prior authorization requests, the Authorized Agent will notify both the member and the HHA of the denial or modification, reason, right to appeal, and appeal procedures (see Section 40.08-5).

D. The home health agency must notify the Department of a member's start of care date for the initial certification period. The admit/discharge form must be submitted to the Department within fourteen (14) days of admission. If services continue into a consecutive certification period, the HHA must notify the Department with an updated CMS 485 no later than five (5) days after the start of this second certification period, and with any subsequent consecutive certification period. The home health agency must also submit documentation of rehabilitation potential as described in Section 40.02-3(E)(13b) and (14) for physical therapy, occupational therapy, and speech-language pathology services for initial and consecutive certification periods for members receiving these services.

E. When prior authorization is required, all home health services shall be prior authorized and covered for an approved classification period. It is the responsibility of the home health agency to submit a request for prior authorization when prior authorization is required. When prior authorization is required, the home health agency must submit the referral form, the CMS 485, the documentation of rehabilitation potential for any physical therapy, occupational therapy and speech-language pathology services being received by the member and documentation of why the member cannot receive home health services in an outpatient hospital setting.

The beginning and end dates of the individual's classification period correspond to the beginning and end dates for MaineCare coverage. In order for home health services coverage to continue uninterrupted, the home health agency must submit the Department's authorized request form to the Authorized Agent five (5) calendar days prior to the end date of the current classification period

40.08-2 **Plan of Care Requirements**

In accordance with licensing requirements, all home health services must be provided under a plan of care established by the HHA, individually for each member.

A. Providers Qualified to Establish a Plan of Care.

40.08 **POLICIES AND PROCEDURES** (cont)

1. The member's physician must establish a written plan of care.

   The physician must recertify and sign the plan of care for each certification period (Section 40.01-2).

2. A HHA nurse or skilled therapist or social worker may establish an additional, discipline oriented plan of care, when appropriate. These plans of care may be incorporated into the physician's plan of care or prepared separately, but do not substitute for the physician's plan of care.

B. Content of the Plan of Care. The orders on the plan of care must specify the nature, frequency and duration of each service to be provided to the member and the type of professional who must provide it. The physician must sign the plan of care before the HHA submits its claim for those services to the Department for payment. The plan of care must contain:

1. all pertinent diagnoses, including the member's mental status;

2. the types of services, supplies, and equipment ordered;

3. the frequency and duration of the visits for each discipline to be made. A discipline may be one (1) or more of the following: skilled nursing, physical therapy, speech-language pathology services, occupational therapy, medical social services, or home health aide;

4. the prognosis, rehabilitation potential, goals, functional limitations, permitted activities, nutritional requirements, medications, and treatments;

5. any safety measures to prevent injury;

6. the discharge plans;

7. any additional items the home health agency or physician chooses to include;

8. the member's address and type of residence, whether private home or residential care facility, etc; and

9. identify any other community resources and services, as well as care management, care coordination, targeted case management or social work services.

C. Certification Period. Both the plan of care, required under Section 40.08-2

40.08 **POLICIES AND PROCEDURES** (cont)

(A)(1), and the discipline-oriented plan of care, as provided for in 40.08-2 (A)(2), must be reviewed and signed by a physician for each certification period as defined in Section 40.01-2.

D. Verbal Orders.

1. Services that are provided from the beginning of the certification period and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician if:

   a. the clinical record contains a documented verbal order for the care before the services are furnished; and

   b. the services are included in a signed plan of care.

2. Any increase in the frequency of services or any addition of new services during a certification period must be authorized in advance by a physician with verbal or written orders. The Department will pay for care provided based on verbal orders only if they are followed by a written order signed by the physician before the Department is billed.

40.08-3 **Awaiting Placement**

A member who is currently receiving home health services under this Section and who no longer meets the eligibility criteria under this Section, but has been determined eligible, by the Department or its Authorized Agent, for any of the following in-home long term care services, Section 96, Private Duty Nursing & Personal Care Services, any Home and Community Benefit program, Section 43 Hospice Services, or Section 12, Consumer Directed Attendant Services, may be classified as “awaiting placement”. “Awaiting placement” status may be used, if necessary, until an appropriate service provider begins delivering services. Under awaiting placement status, members will be covered for services under this Section.

“Awaiting placement” classification is for a specified period of time approved by the Department or its Authorized Agent. For coverage to continue beyond the approved period, the HHA must submit a completed request form along with a current CMS 485, to the Authorized Agent at least five (5) calendar days prior to the end date of the member’s approved period. If upon review, the Department or its Authorized Agent determines the member is no longer eligible for any of the other in-home programs, continued coverage for home health services shall be denied.

40.08-4 **Member's Record**

40.08 **POLICIES AND PROCEDURES** (cont)

Content of Records

There shall be a specific record for each member, which shall include, but not necessarily be limited to:

1. The member's name, address, and birth date;

2. The name of the attending physician;

3. The member's social and medical history and diagnosis;

4. The member's need for teaching and the member's ability to learn;

5. Community resources available to meet the needs of the member;

6. A personalized plan of care, which meets the requirements in Section 40.08-2;

7. Plans for coordination with other health care agencies for the delivery of services. For psychiatric nursing services, plans will include coordination with other mental health and social services agencies;

8. Discharge plan for the member;

9. Written progress notes and/or flow sheets including (at a minimum):

   a. Identification of the service provided, the date, and the provider;
   b. Progress toward the achievement of long and short-range goals;
   c. Signature of the service provider; and
   d. Date and full description of any unusual condition or unexpected event.

10. Entries are required for each date of service billed;

11. The plan of care signed and reviewed as necessary by the supervising physician;

12. Documentation of skilled nursing and home health aide hours. The HHA must maintain records, which show the entrance and exit times of each skilled nurse's and each aide's visits and total time spent in the home by each. Exclude travel time;

13. The signed CMS-485 must be retained and available upon request. Complete the form in its entirety. Do not leave any blank items. However, there are items where "not applicable" (N/A) is acceptable;

14. Documentation of rehabilitation potential as defined in this Section for members receiving physical therapy, occupational therapy and speech-language pathology services.

40.08 **POLICIES AND PROCEDURES** (cont)

40.08-5 **Member Appeals**

See Chapter I of the MaineCare Benefits Manual for information regarding appeals. Members under age twenty-one (21) years shall submit a request for an appeal in accordance with Chapter I. An appeal by members who are age twenty-one (21) years and over regarding services under this Section must be requested in writing and mailed to:

Director
Office of Elder Services
c/o Hearings
11 State House Station
442 Civic Center Dr.
Augusta, Maine 04333-0011

40.08-6 **Program Integrity**

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

40.09 **REIMBURSEMENT**

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

1. The amount listed in Chapter III, Section 40, "Allowances for Home Health Services" of the MaineCare Benefits Manual; or

2. The lowest amount allowed by the Medicare carrier; or

3. The provider's usual and customary charge.

B. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from every other source that is available for payment of a rendered service prior to billing MaineCare.

C. The eligibility requirements and limits on home health services under this Section do not apply to members with Medicare coverage or other third party health insurance until the coverage for these home health services, (including occupational therapy, physical therapy and speech-language pathology services) by the other third party payor has been exhausted. MaineCare will cover the co-insurance and deductible in these cases.

Major Substantive Rule

40.10 COPAYMENT

A. A copayment will be charged to each MaineCare member for each day home health services are provided. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

B. The member shall be responsible for copayments up to $30.00 per month whether the copayment has been paid or not. After the $30.00 cap has been reached the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.

D. Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

Providers are subject to the Department’s copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

40.11 CONFIDENTIALITY

The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431 et seq. and other applicable sections of state and federal law and regulation.

40.12 BILLING INSTRUCTIONS

A. Billing must be accomplished in accordance with the Department's billing requirements in "Billing Instructions for Home Health Agencies" that are available by contacting the Office of MaineCare Services, 11 State House Station, Augusta, ME.

B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, refer to the billing instructions distributed by the Department and to Chapter I, General Administrative Policies and Procedures.

40.12 **BILLING INSTRUCTIONS** (cont.)

C. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement. In 2010, the Department will implement a new claims information system, Maine Integrated Health Management Solution (MIHMS). The billing codes listed in Chapter III of this section will change when that system is implemented. Approximately thirty (30) days before implementing the MIHMS system, the Department will notify providers in writing of the date on which new billing procedures must begin.

40.13 **BILLING APPEALS FOR DUAL MAINECARE/MEDICARE MEMBERS**

A. An agency document must be on file signed by the MaineCare member or guardian noting that services are denied Medicare coverage and all claims will be submitted to MaineCare.

B. The agency will obtain and keep on file a signed departmental "Authorization to Represent" form on all MaineCare members. This form will be provided by the Department. The agency will present this form to the Department or its designee when an Initial Determination and/or Reconsideration or Administrative Law Judge is requested.

C. The Department will find the home health agency liable for the cost of services following an adverse decision by Medicare in response to a Department appeal detailing a technical denial. Examples of a technical denial shall include but not be limited to:

1) Plan of Care not authorized by a physician.
2) Information not received.
3) No documentation for services billed.
4) Time Limit Reject.

SECTION 40 **HOME HEALTH SERVICES** 10/1/79

Major Substantive Rules

PROC CODE	DESCRIPTION	MAXIMUM ALLOWANCE	UNIT
~~HHS11~~	~~Registered Nurse Services~~	~~By Report~~	~~Per visit~~
~~HHS12~~	~~Licensed Practical Nurse Services~~	~~By Report~~	~~Per visit~~
~~HHS13~~	~~Home Health Aide Services~~	~~By Report~~	~~Per visit~~
~~HHS14~~	~~Licensed Occupational Therapist (OTR) Services~~	~~By Report~~	~~Per visit~~
~~HHS15~~	~~Certified Occupational Therapist Assistant (COTA) Services~~	~~By Report~~	~~Per visit~~
~~HHS16~~	~~Licensed Physical Therapist Services~~	~~By Report~~	~~Per visit~~
~~HHS17~~	~~Licensed Physical Therapist Assistant Services~~	~~By Report~~	~~Per visit~~
~~HHS18~~	~~Licensed Speech-Language Pathologist Services~~	~~By Report~~	~~Per visit~~
~~HHS19~~	~~Licensed Speech Pathologist Assistant Services~~	~~By Report~~	~~Per visit~~
~~HHS20~~	~~Medical Social Services~~	~~By Report~~	~~Per visit~~
~~HHS21~~	~~Routine Supplies Identify Supply in "Remarks"~~	~~By Report~~	~~Per visit~~
~~HHS22~~	~~RN – Psychotropic Medication Administration and Monitoring~~	~~By Report~~	~~Per visit~~

~~THE REIMBURSEMENT CODES BELOW WILL BE ACTIVATED UPON NOTICE TO PROVIDERS FROM THE DEPARTMENT.~~

~~THESE CODES WILL REPLACE THE LOCAL CODES INDICATED ABOVE.~~

~~PROC CODE~~	~~DESCRIPTION~~	~~MAXIMUM ALLOWANCE~~	~~UNIT~~
~~U551~~	~~Registered Nurse Services~~	~~By Report~~	~~Per visit~~
~~U551~~	~~Licensed Practical Nurse Services~~	~~By Report~~	~~Per visit~~
~~U571~~	~~Home Health Aide Services~~	~~By Report~~	~~Per visit~~
~~U431~~	~~Licensed Occupational Therapist (OTR) Services~~	~~By Report~~	~~Per visit~~
~~U431~~	~~Certified Occupational Therapist Assistant (COTA) Services~~	~~By Report~~	~~Per visit~~
~~U421~~	~~Licensed Physical Therapist Services~~	~~By Report~~	~~Per visit~~
~~U421~~	~~Licensed Physical Therapist Assistant Services~~	~~By Report~~	~~Per visit~~
~~U441~~	~~Licensed Speech-Language Pathologist Services~~	~~By Report~~	~~Per visit~~
~~U441~~	~~Licensed Speech Pathologist Assistant Services~~	~~By Report~~	~~Per visit~~
~~U561~~	~~Medical Social Services~~	~~By Report~~	~~Per visit~~
~~U270~~	~~Routine Supplies Identify Supply in "Remarks"~~	~~By Report~~	
~~U551~~	~~RN – Psychotropic Medication Administration and Monitoring~~	~~By Report~~	~~Per visit~~
G0154TD	Services of skilled nurse in home health setting, each 15 minutes	By Report	Per Visit
0551	Skilled nursing visit		

G0154TE	Services of skilled nurse in home health setting, each 15 minutes	By Report	Per Visit
0559	Other skilled nursing		
G0156	Services of home health aide in home health setting, each 15 minutes	By Report	Per Visit
0571	Home health aide visit charge		
G0152	Services of occupational therapist, in home health setting, each 15 minutes	By Report	Per Visit
0431	Occupational therapy visit charge		
G0152TF	Services of occupational therapist, in home health setting, each 15 minutes	By Report	Per Visit
0431	Occupational therapy visit charge		
G0151	Services of physical therapist in home health setting, each 15 minutes	By Report	Per Visit
0421	Physical therapy visit charge		
G0151TF	Services of physical therapist in home health setting, each 15 minutes	By Report	Per Visit
0421	Physical therapy visit charge		
G0153	Services of speech and language pathologist in home health setting, each 15 minutes	By Report	Per Visit
0441	Speech-language pathology visit charge		
G0153TF	Services of speech and language pathologist in home health setting, each 15 minutes	By Report	Per Visit
0441	Speech-language pathology visit charge		
G0155	Services of clinical social worker in home health setting, each 15 minutes	By Report	Per Visit
0561	Medical social services visit charge		
T1502	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit	By Report	Per Visit
0551	Skilled nursing visit		

Modifiers	Description
TD	Registered Nurse (RN)
TE	LPN/LVN
TF	Intermediate Level of Care (Certified OT, PT, ST Assistant)
UF	Services provided in the morning
UG	Services provided in the afternoon
UH	Services provided in the evening
UJ	Services provided at night

NOTE: These changes will become effective upon implementation of MIHMS. Providers will be notified at least thirty (30) days prior to the effective date.