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An Office of the
Department of Health and Human Services
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August 1, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: **Emergency Rule**: MaineCare Benefits Manual, Chapter II, Section 97, Private Non-Medical Institutions

This letter gives notice of rules that the Department has determined immediate adoption of is necessary to assure that initiatives directed by the Maine State Legislature are immediately implemented to achieve required savings in the approved budget. The Legislature, in Public Law chapter 213, authorizes emergency rulemaking on or before 12/31/09 for provisions over which the Department has subject matter jurisdiction without demonstrating that emergency rule implementation of this rule is necessary to avoid a threat to public health, safety or general welfare. These emergency rules specifically address budget initiatives for children's Private Non-Medical Institution (PNMI) services and for adults with mental illness.

In this rulemaking, the Department is adding language detailing eligibility criteria and requiring prior authorization for behavioral health PNMI services for both children and adults. These changes are necessary to assure that PNMI services are medically necessary and that more cost effective community based services are used to the fullest extent possible. Prior authorization will be required for all PNMI services provided under Appendix D, Child Care Facilities and Appendix E, Community Residence for Members with Mental Illness. In this Section, the Department is also defining models of PNMI services for which standard rates are being set in a separate rulemaking pertaining to reimbursement of children's PNMI services in Chapter III, Section 97.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm 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 Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter II, Section 97, Private Non-Medical Institutions

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department has determined that the immediate adoption of these rules is necessary to assure targeted budget savings are met.

In this rulemaking, the Department is adding language detailing eligibility criteria and requiring prior authorization for children's PNMI services. These changes are necessary to assure that PNMI services are medically necessary and that more cost effective community based services are used to the fullest extent possible. In this Section, the Department is also defining models of PNMI services for which standard rates are being set in a separate rulemaking pertaining to reimbursement of PNMI services in Chapter III, Section 97.

These rules will remain in effect for 90 days while the Department permanently adopts these changes in a proposed rulemaking. A public hearing will be held as part of that separate rulemaking. This rule has no impact on small businesses, counties or municipalities, other than those providers with twenty or fewer employees. These rule changes are expected to result in total savings of $8,538,368. The changes for children's PNMI services will result in cost savings per State Fiscal year of $6,838,368, $2,091,857 from general funds, $4,404,593 from federal funds and $341,819 from other special revenue. The changes for adult PNMI services are expected to result in an additional $1.7 million savings per State Fiscal year, $1,615,000 from general funds and $85,000 from other special revenue.

See http://www.maine.gov/bms/rules/provider_rules_policies.htm for rules and related rulemaking documents.

EFFECTIVE DATE: August 1, 2009

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97.01 **DEFINITIONS**
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97.01-1 Authorized Agent

Authorized Agent is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions for the Department pursuant to a signed contract or other approved signed agreement, including but not limited to conducting prior authorization, clinical review, and concurrent review of services.

97.01-~~1~~2 Family

Unless defined otherwise in the Principles of Reimbursement of Chapter III, Section 97, family means any of the following: spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

97.01-~~2~~3 Individual Service Plan

An Individual Service Plan (ISP) means the plan of service based on an individual assessment of a member's need for treatment or rehabilitation services made in accordance with the appropriate Principles of Reimbursement. Unless otherwise specified in the appropriate Principles of Reimbursement, this plan shall specify the service components to be provided, the frequency and duration of each service component, and the expected short and long range treatment and/or rehabilitative goals or outcome of services. Discharge planning must be addressed in the Individual Service Plan.

97.01-~~3~~4 Interim Per Diem

A per diem rate is the rate determined by the Department of Health and Human Services (DHHS) (per Chapter III, Principles of Reimbursement for PNMIs, Section 2400 and the applicable Appendix) that may be paid to a PNMI provider for the provision of covered services. The interim per diem rate will be adjusted at audit.

97.01-~~4~~5 Medical Supplies and Durable Medical Equipment

Unless defined otherwise in the Principles of Reimbursement, medical supplies and durable medical equipment means medically necessary supplies and equipment listed in Chapter II, Section 60, Medical Supplies and Durable Medical Equipment of the MaineCare Benefits Manual (MBM). All equipment must be directly related to member medical needs as documented in the individual service plan.

97.01 **DEFINITIONS** (cont.)

97.01-6 Per Diem Rate

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A per diem rate is the rate determined by the Department of Health and Human Services (DHHS) (per Chapter III, Principles of Reimbursement for PNMIs, Section 2400 and the applicable Appendix) paid to a PNMI provider for the provision of covered services.

97.01-7 Prior Authorization

Prior Authorization (PA) is the process of obtaining prior approval as to the medical necessity and eligibility for a service. Prior Authorization is also detailed in Chapter I of the MaineCare Benefits Manual (MBM). Crisis stabilization services do not require prior authorization, but providers must contact the Department within 48 hours to complete the prior authorization process for reimbursement of continued services.

97.01-8~~5~~ Private Non-Medical Institution

A Private Non-Medical Institution (PNMI) is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, personal care, and treatment services to four or more residents in single or multiple facilities or scattered site facilities. Private Non-Medical Institution services or facilities must be licensed by the Department of Health and Human Services, or must meet comparable licensure standards and/or requirements and staffing patterns as determined by the Department specified in Section 97.01 (A-F). For agencies serving persons with mental retardation in scattered site PNMIs, comparable licensure standards means those required by rule for community support services as described in Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug Treatment Services.

Services provided out-of-state must be medically necessary and unavailable in the State of Maine, and may be subject to approval by the Commissioner of the Department of Health and Human Services or designee, as well as prior authorization as described in this Section and Chapter I of the MaineCare Benefits Manual.

Appendix B. Substance Abuse Treatment Facility

A substance abuse treatment facility is a PNMI that is maintained and operated for the provision of residential substance abuse treatment and rehabilitation services, and is licensed and funded by the Department's Office of Substance Abuse. Substance abuse treatment facilities are also subject to rules in MBM, Chapter III, Section 97, and Appendix B.

97.01 **DEFINITIONS** (cont.)

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Appendix C. Medical and Remedial Services Facility

Medical and remedial services facilities are those facilities as defined in 22 MRSA §7801 that are maintained wholly or partly for the purpose of providing residents with medical and remedial treatment services and licensed by the Department of Health and Human Services under the "Regulations Governing the Licensing and Functioning of Assisted Living Facilities." These facilities must also be qualified to receive cost reimbursement for room and board costs not covered under this Section.

Medical and remedial facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix C.

Appendix D~~B~~. Child Care Facilities

A child care facility is any private or public agency or facility that is maintained and operated for the provision of child care services, as defined in 22 MRSA §8101, 8101(1), and 8101(4), is funded and licensed by the Department of Health and Human Services under the "Rules for Licensure of Residential Child Care Facilities," 10-148 CMR, Chapter 18; and/or is licensed and funded by the Department's Children's Behavioral Health Services pursuant to 34-B MRSA§3606.

Requests for exceptions to Department funding and licensure requirement may be made through written correspondence to the Office of MaineCare Services. Providers may make requests for exceptions to the Department of Health and Human Services funding and/or licensure requirement through written correspondence to the Office of MaineCare Services from the Office of Child and Family Services.

For the purpose of MaineCare reimbursement only, child care facility Private Non-Medical Institutions also include treatment foster homes, their staff and parents, licensed by the Department, and child placing agencies under contract with the Office of Child and Family Services. Child placing agencies must be licensed in accordance with the rules providing for the licensing of child placing agencies. Child care facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, and Appendix D.

Intensive Temporary ~~Out-of-Home~~Residential (ITRT) Treatment Services ~~(ITOOHTS)~~

97.01 **DEFINITIONS** (cont.)

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Intensive Temporary ~~Out-of-Home~~Residential Treatment Services ~~(ITOOHTS)~~(ITRT) are defined as child care facility private non-medical institution level of care services for children with mental retardation, autism, severe mental illness, and/or emotional disorders, who require twenty-four (24) hour supervision to be safely placed in their home and community. ITRT~~OOHTS~~ must be provided in the least restrictive environment possible, with the goal of placement as close to the child's home as possible. Families must remain as actively involved in their child's care and treatment as possible. The purposes of ITRT~~OOHTS~~ are to provide all services to both treat the mental illness/disorder and to return the child to his/her family, home and community as soon as possible.

ITRT~~OOHTS~~ provide twenty-four (24) hour per day, seven (7) days per week structure and supportive supervised living environment and active behavioral treatment, as developed in a treatment plan. This environment is integral to supporting the learning experiences necessary for the development of adaptive and functional behavior to allow the child to live outside of an inpatient setting.

ITRT~~OOHTS~~ are also subject to rules in MBM, Chapter III, Section 97, and Appendix D.

Appendix E~~C~~.Community Residences for Persons with Mental Illness

A community residence PNMI is a PNMI with integral mental health treatment and rehabilitative services, that is licensed by the Department, funded as a mental health residential treatment or supportive housing service by DHHS, Adult Mental Health , and operated in compliance with treatment standards established through these rules and the pertinent Principles of Reimbursement.

Community residences for persons with mental illness also include residential services for the integrated treatment of persons with dual disorders, which provide mental health and substance abuse treatment services to individuals with coexisting disorders of mental illness and substance abuse. These residences shall be licensed by the Department. Such residences must also be receiving funds from the Department for the treatment of persons with dual disorders. Community residences for persons with mental illness are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix E.

97.01 **DEFINITIONS** (cont.)

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~~D. Medical and Remedial Services Facility~~

~~Medical and remedial services facilities are those facilities as defined in 22 MRSA §7801 that are maintained wholly or partly for the purpose of providing residents with medical and remedial treatment services and licensed by the Department of Health and Human Services under the "Regulations Governing the Licensing and Functioning of Assisted Living Facilities." These facilities must also be qualified to receive cost-reimbursement for room and board costs not covered under this Section.~~

~~Medical and remedial facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix C.~~

Appendix F~~E~~. Non-Case Mixed Medical and Remedial Facilities

Non-case mixed facilities provide PNMI medical and remedial treatment services to members in specialized facilities or scattered site facilities not included in the case mix payment system described in Appendix C. These facilities specialize in solely treating members with specific diagnoses such as acquired brain injury, HIV/AIDS, mental retardation, or blindness. Services must be provided in compliance with these rules, the pertinent Chapter III, Principles of Reimbursement, and Chapter III, Appendix F, and any contractual provisions of the Department.

97.01-9~~6~~ Private Non-Medical Institution Services

Private Non-Medical Institution services are those services provided to a member at one of the above properly licensed and/or designated institutions, in accordance with these regulations, and in accordance with the pertinent Principles of Reimbursement established by the Department of Health and Human Services.

97.01-~~7~~10 Program Allowance

A program allowance, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400.1 and 2400.2 will be allowed in lieu of indirect and/or PNMI related cost.

97.01-11~~8~~ Provider Agreement

A provider agreement encompasses the MaineCare Provider/Supplier Agreement on file with the Office of MaineCare Services. Providers must also contract with the Department and satisfactorily meet all contract and provider agreement provisions.

97.01 **DEFINITIONS** (cont.)

97.01-12~~9~~ Rate Letter

A rate letter is an instrument used to inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Chapter III, Section 2400, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the industry price, program allowance, personal care services component, and average case mix index.

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97.01-13 Utilization Review

Utilization Review (UR) is a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent, or retrospective basis.

97.02 **ELIGIBILITY FOR CARE**

97.02-1 General Eligibility Criteria

The following individuals are eligible for medically necessary covered Private Non-Medical Institution services as set forth in this Manual:

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. ~~Some members may have~~There are restrictions on the type and amount of services that members ~~ey~~ are eligible to receive and they must meet specific eligibility criteria detailed below.

97.02-2 ~~Specific~~ Medical Necessity ~~Eligibility Criteria~~

Services in PNMIs must be medically necessary, as evidenced by meeting the eligibility criteria set forth in this section. A physician or primary care provider must also document in writing that this level of care is medically necessary for the member, and both the physician and the PNMI provider must keep this documentation in the member's file. For children's PNMI services, this documentation must be completed as part of the prior authorization process conducted by the Department and/or its Authorized Agent.

97.02 **ELIGIBILITY FOR CARE**

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97.02-3 Prior Authorization Requirements for Appendix D Child Care Facilities

All children's services under this Section with the exception of crisis services require prior authorization using eligibility criteria set forth in these rules.

Providers must submit all documentation required for prior authorization according to the guidelines of this Section and Chapter I of this Manual to the appropriate Department Regional Office of the Office of Child and Family Services.

All required assessment tools must be completed within the last ten(10) days prior to submission of the prior authorization request. The DHHS Intensive Temporary Residential Treatment Team (ITRT) in each Region will review the information submitted to determine whether the child meets the criteria set forth below. The Team will determine the child's level of severity and recommend an appropriate provider for the child.

Providers must obtain prior authorization for current residents using these same assessments at the next continuing stay review. Reassessment is required to assure that medical necessity criteria are met for continuing stay in either Level I or Level II programs. Each prior authorization letter sent to the provider and the child/guardian shall indicate the model level of care the child is eligible for.

Children must be assessed using the tools mentioned below and providers must submit all requested documentation to the appropriate Department Regional Office of Child and Family Services. Failure to submit requested information will result in disapproval of the prior authorization request. The Department will not reimburse for services that have not been prior approved.

Crisis service providers must contact the Department within 48 hours of initiation of service to begin the prior authorization process for continued provision of services.

Any change in a child's location or program within an agency or to another agency requires prior authorization.

97.02-4 **Assessment Tools for Appendix D Child Care Facilities**

The following assessment tools are used in assessing eligibility for Children's PNMI services, though none of the tools are used as the sole determinant of eligibility.

97.02 **ELIGIBILITY FOR CARE (cont)**

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Children's Habilitation Assessment Tool (CHAT)Assesses functioning in three domains: behavior, social skills and life skills using interviews for individuals 6 to 18 years of age diagnosed with mental retardation or a pervasive developmental disorders.

Child and Adolescent Functional Assessment Scale (CAFAS) Assesses the functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems in individuals 6 through 17 years of age. A trained rater completes the scale.

Global Assessment Functioning (GAF) is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate social, occupational and psychological functioning, e.g., how well or adaptively one is meeting various problems-in-living. Children and adolescents under the age of 18 may be evaluated on the Children's Global Assessment Scale, or C-GAS, and for infants, the Parent-Infant Relationship Global Assessment Scale (PIR-GAS) PIR-GAS version is utilized.

Preschool and Early Childhood Functional Assessment Scale (PECFAS) Assesses functioning related to behavioral, emotional, psychological, or psychiatric problems for children 3 to 7 years of age who are not enrolled in a full-day kindergarten or first grade. A trained rater completes the scale.

97.02-5 Medical Eligibility Criteria for Appendix D Child Care Facility Services

There are five models of PNMI services for Appendix D Child Care Facilities:

1. Mental Retardation and Pervasive Developmental Disorder (PDD) Conditions: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

   There are two levels of PNMI services for children withmental retardation and/or PDD and other symptoms requiring this intensity of service. A child is eligible for only one level of service at a time. Initial prior authorization will not be given for more than thirty days at a time and continuing stay will be assessed at aminimum of every ninety days thereafter.

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

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All of the following criteria set forth below must be met, in addition to criteria for either Level I or Level II services, as detailed below. The child must have:

- An Axis I or II diagnosis from the most current version of the DSM, and
- A disorder that has lasted for at least six (6) months or is expected to last for at least one (1) year in the future, and
- A current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- A disorder that is amenable to treatment in a residential setting, and
- even with intensive community intervention, including services and supports, there is significant potential that the child will be hospitalized, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher level of care than can be provided in the home and community.

In addition to the above criteria, the child must meet the following criteria for either Level I or Level II services:

Level I Criteria:

- Significant recent aggression across multiple environments or severe enough within one environment to have caused serious injury or there is significant potential of serious injury to self or others; or
- Recent homicidal ideation with risk of harm to others, or
- Recent suicidal ideation with risk of harm to self; or

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

EMG 8/1/09

- Symptoms of mental retardation or Pervasive Developmental Disorder so severe that it results in an inability to care for oneself to a developmentally appropriate level even with home and community supports and services; or

- Has not responded to less restrictive level of care or would have a significant risk of harm to self or others if a less restrictive setting were attempted; and

- An assessment using the Children's Habilitation Assessment Tool (CHAT) with a score of 30 or higher or Global Assessment Functioning (GAF) tool score of 50 or lower with description of specific symptoms justifying the score.

Level II Criteria

- The Child must meet all the level I service criteria and in addition:

- Frequency, intensity and duration of intervention required to address daily repeated aggression and potential for harm to self or others, or

- Frequency, intensity and duration of assistance required to address activities of daily living and potential for harm to self or others either directly or as a consequence of being unable to maintain ADL's and

- Children's Habilitation Assessment Tool (CHAT) score of 35 or higher, or a Global Assessment Functioning (GAF) score of 40 or lower with description of specific symptoms justifying the score.

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

EMG 8/1/09 2. Child Mental Health Conditions: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

There are two levels of PNMI services for children and adolescents with Mental Health Conditions.

The child must meet all of the criteria set forth below:

- The child must have either an Axis I or II diagnosis from the most current version of the DSM, and
- The child's disorder has lasted for at least six (6) months or is expected to last for at least one year in the future, and
- The child has a current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- The child's disorder is amenable to treatment in a residential setting, and
- Even with intensive community intervention, including services and supports, there is significant potential that the child will be hospitalized, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher level of care than can be provided in the home and community.

In addition, the child must meet the criteria below for Level I or Level II services:

Level I Criteria:

For Level I Treatment for Mental Health Conditions: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

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

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The child must have a mental health condition as follows:

- Significant recent aggression across multiple environments or severe enough within one environment to have caused injury or there is significant potential of injury to self or others; or
- Recent homicidal ideation with risk of harm to others, or
- Recent suicidal ideation with risk of harm to self; or
- Symptoms of mental illness so severe that it results in an inability to care for oneself in a developmentally appropriate manner, even with home and community supports or services; or
- Has not responded to less restrictive level of care or would have a significant risk of harm to self or others if a less restrictive setting were attempted; and
- A Child and Adolescent Functional Assessment Scale (CAFAS) score of 100 or higher or Global Assessment Functioning (GAF) score of 50 or lower with description of specific symptoms justifying the score.

Level II Criteria

Level II Mental Health Conditions: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

The child must meet all the Level I Criteria, and in addition meet the following criteria:

- Frequency, intensity and duration of intervention required to address daily repeated aggression and potential for harm to self or others, or
- Frequency, intensity and duration of assistance required to address Activities of Daily Living and potential for harm to self or others either directly or as a consequence of being unable to maintain ADL's and

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

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- A Child and Adolescent Functional Assessment Scale (CAFAS) 8 scale score of 120 or higher, or Global Assessment Functioning (GAF) score of 40 or lower with description of specific symptoms justifying the score.

3. Intensive Mental Health Service for Infants and/or Toddlers

The criteria set forth below are minimum standards for eligibility for treatment for this program that is only for infants or toddler birth through age five (5).

Infants/toddlers must exhibit:

- Failure to respond to less restrictive level of care or there would be a significant risk of harm if a less restrictive setting were attempted; and

- A Preschool and Early Childhood Functional Assessment Scale (PECFAS) 8 scale score of 100 completed within ten (10) days of submission for Prior Authorization, or DC 0-3R Parent-Infant Relationship Global Assessment Scale (PIR-GAS) Axis II of 60 or lower or other tools approved by the Department, and

- The infant/toddler must also meet all of the criteria set forth below:

- an Axis I or II diagnosis from the most current version of the DSM, or

- an Axis I diagnosis from the most current version of the DC 0-3R, and

- The disorder has lasted for at least six (6) months or is expected to last for at least one year in the future, and

- The infant/toddler must have a current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and

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

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- The disorder must be amenable to treatment in a residential setting, and

- Even with intensive community intervention, including services and supports, there is significant potential that the infant/toddler will be hospitalized, or there is a clear indication that the infant/toddler's condition would significantly deteriorate and would require a higher level of care than can be provided in the home and community.

4. Crisis Stabilization Residential Services

Crisis Stabilization services are individualized therapeutic interventions provided to a child 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. Psychiatric emergency is when the child is in imminent risk of serious harm to self or others and even with intensive community intervention, including services and supports, there is significant potential that the member will be hospitalized.

Components of crisis stabilization include assessment, monitoring behavior and the member's response to therapeutic interventions; participating and assisting in planning for and implementing crisis and post stabilization activities, and supervising the child to assure personal safety.

While crisis services do not require prior authorization, providers must contact the Department within forty eight (48) hours to get approval of continued reimbursement for this service using the prior approval process detailed in this Section.

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

EMG 8/1/09

5. Therapeutic Foster Care: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

Therapeutic Foster Care is a family based service delivery approach providing treatment to children with moderate to severe mental health, behavioral health and developmental needs. Treatment is delivered through services integrated with key interventions and supports provided by therapeutic foster parents who are trained supervised and supported by qualified therapeutic foster care program staff. The delivery of treatment is a shared responsibility between the independently licensed clinical staff, the independently licensed social work staff and the therapeutic foster parents. Therapeutic foster care is designed to allow children receiving treatment to reside in a family like setting as opposed to institutional settings, while receiving treatment.

To be eligible for these services, the child must be in DHHS custody and must require therapeutic intervention detailed above.

The child must meet the following criteria:

- A Child and Adolescent Functional Assessment Scale (CAFAS) 8 scale score of 50 higher, and
- 97 an Axis I or II diagnosis from the most current version of the DSM, and
- 1. The child's disorder must have lasted for at least six (6) months or is expected to last for at least one year in the future, and
- A current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- Even with intensive community intervention, including services and supports, significant potential that the child will be hospitalized, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher level of care than can be provided in the home and community.

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

EMG 8/1/09

97.02-6 Prior Authorization and Medical Eligibility for Appendix E: Community Residences For Persons With Mental Illness

Appendix E services require prior authorization and utilization review. Providers must contact the DHHS Office of Adult Mental Health Services for prior authorization. No PNMI provider may admit a member into an Appendix E facility without prior authorization. To be eligible, members must meet the following eligibility criteria, with documentation of all of the following information in the member's care plan:

a. Assessment Tools Used for Prior Authorization:

Providers must use the Department's approved assessment tool, the Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2010, of the American Association of Community Psychiatrists (LOCUS) as a tool in assessing eligibility.

b. Eligibility Criteria:

Members must meet the following eligibility criteria, with documentation of all of the following information in the member's plan:

The person is age eighteen (18) or older or is an emancipated minor;

AND

1. Has a primary diagnosis on Axis I or Axis II of the multiaxial assessment system of the current version of the *Diagnostic and Statistical Manual of Mental Disorders*, other than one of the following diagnoses: Delirium, dementia, amnesia, and other cognitive disorders; Mental disorders due to a general medical condition, including neurological conditions and brain injuries; Substance abuse or dependence; developmental disabilities; Adjustment disorders; V-codes; or Antisocial personality disorder;

AND

demonstrates a need for residential care as assessed by the LOCUS with a score on the LOCUS of at least 23 or greater and a Level V or more.

97.03 **DURATION OF CARE**

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Each MaineCare member is eligible for covered services that are medically necessary as determined by eligibility and continued eligibility requirements set forth in this Section. The Department reserves the right to request additional information to evaluate eligibility and ~~medical necessity~~ continued eligibility for services.

97.04 **COVERED SERVICES – DIRECT SERVICE STAFF**

A covered service is a service for which payment to a PNMI provider is permitted under the rules of this Section. Direct service staff is defined as staff who provide the services listed in this Section. MaineCare covers the following services when provided in an approved setting of a licensed Private Non-Medical Institution in accordance with Chapter III, Principles of Reimbursement for Private Non-Medical Institution Services, provided within the scope of licensure of the facility, and billed by that facility, and as identified in Section 97.08. Not all of the following services are included in the rate for every type of facility. Refer to the applicable Appendix in Chapter III for services that ~~may be~~are included in the rate for each type of PNMI. The Chapter III Principles of Reimbursement for each type of Private Non-Medical Institution define which staff services are allowable. The service must be listed in the Principles of Reimbursement in order for the service to be reimbursable. Covered services may include, but are not limited to:

97.04-1 Physician services
97.04-2 Psychiatrist services
97.04-3 Psychologist services
97.04-4 Psychological examiner services
97.04-5 Social worker services
97.04-6 Licensed clinical professional counselor services
97.04-7 Licensed professional counselor services
97.04-8 Dentist services
97.04-9 Registered nurse services
97.04-10 Licensed practical nurse services
97.04-11 Psychiatric nurse services
97.04-12 Speech pathologist services
97.04-13 Licensed alcohol and drug counselor services
97.04-14 Occupational therapy services
97.04-15 Other qualified mental health staff services
97.04-16 Other qualified medical and remedial staff services
97.04-17 Other qualified alcohol and drug treatment staff services
97.04-18 Personal care services
97.04-19 Other qualified child care facility services
97.04-20 Other qualified licensed treatment foster care provider services
97.04-21 Interpreter services
97.04-22 Nurse practitioner services
97.04-23 Physician assistant services
97.04-24 Clinical consultant services
97.04-25 Physical therapy services

97.05 LIMITATIONS

97.05-1 Collateral Contacts

Reimbursement shall be made for direct services, collateral contacts, and certain supportive services when there is not a direct encounter with the member, only as described in Chapter III, Principles of Reimbursement for PNMIs, Section 2400, and when provided by qualified staff members.

97.05-2 Non-Duplication of Services

It is the responsibility of the PNMI provider to coordinate PNMI services with other "in-home" services to address the full range of member needs. Other MaineCare covered services shall not duplicate PNMI services included in the facility's PNMI rate. Covered services, listed in the applicable Appendix, and/or in contracts with the Department, that are part of the PNMI rate are the responsibility of the PNMI to provide or arrange under contract as necessary with providers practicing within the scope of their licensure.

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Services that are part of the PNMI rate may not be billed to MaineCare separately by other providers. ~~For example, if the PNMI provides personal care services, and a member receives Home and Community-Based Waiver Services, the p~~Personal care services are included as part of the PNMI rate and shall be delivered by the PNMI provider and not by a MaineCare provider under any other Section of this Manual including PSS under Section 96, Private Duty Nursing and Personal Care Services provider or other Section of MaineCare policy. ~~certified nursing assistant (CNA), home health aide (HHA), or personal care assistant (PCA), as otherwise allowed.~~ Providers of Behavioral Health Services under Section 65 and PNMI services under Section 97 must not duplicate services and must obtain prior authorization for services under both Sections.

~~In order to avoid duplication of services, staff providing case management services as part of~~ PNMI providers must ~~treatment shall~~ coordinate their services with all other MaineCare services, including but not limited to case managers providing services outside the residential setting, in accordance with the provisions of Chapter II, Section 13, of the MaineCare Benefits Manual, Targeted Case Management Services.

97.05-3 Out-of-State Placement

Reimbursement shall not be made for Private Non-Medical Institution services provided out of state unless the services are medically necessary, and are not available within the State and prior authorization (as described in this Section and Chapter I, of the MaineCare Benefits Manual) has been granted.

97.04 **COVERED SERVICES – DIRECT SERVICE STAFF** (cont.)

97.05-4 Bed-Hold Days

Bed-hold days are not reimbursable.

For members receiving State S.S.I. and cost-reimbursement benefits, in order for benefits to continue for a member who is temporarily admitted to a State institution, a hospital, or a nursing facility when the residential care facility provider has agreed to hold the bed, the provider must do the following:
a) Notify the Social Security Administration that the member has been admitted to an institution, and b) Notify the Social Security Administration that the bed is being held for the resident.

97.06 **NON-COVERED SERVICES**

Please refer to Chapter I of the MaineCare Benefits Manual for additional non-covered services, including services that are for vocational, academic, socialization or recreational purposes.

97.06-1 Private Room and Other Non-Covered Services

The PNMI may permit payment by a relative of an additional amount to enable a member to obtain non-covered services such as a private room, telephone, television, or other non-covered services. However, the additional charge for non-covered services shall not exceed the charge to private pay residents. The supplement for a private room shall be no more than the difference between the private pay rate for a semi-private room and a private room rate. There shall be a signed statement by the member and/or relative making the additional payment that he/she was notified and agreed to the payment for non-covered services before those services were provided. This provision shall not apply where the standard of care in the PNMI is for a private room.

Private rooms, as are all PNMI room and board costs, are non-covered services under MaineCare, but if there is a medical necessity for a private room, the PNMI must make one available.

96.06-2 Personal Care Services Provided by a Family Member

Personal care services provided by a family member are not a covered service, and may not be billed by the family or by any other provider.

97.07 POLICIES AND PROCEDURES

97.07-1 Setting

Services shall be delivered in the Private Non-Medical Institution or other settings appropriate to individual service needs in accordance with an individual service plan.

97.07-2 Qualified Staff

A Private Non-Medical Institution may be reimbursed for services provided by the following staff and as set forth in the Chapter III, Principles of Reimbursement for that type of institution:

A. Professional Staff

All professional staff must be conditionally, temporarily, or fully licensed and approved to practice as documented by written evidence from the appropriate governing body.

MaineCare may reimburse a PNMI for covered services as defined in Section 97.04 if they are provided by the following professional staff members: dentist, licensed alcohol and drug counselor, licensed clinical professional counselor, licensed professional counselor, nurse practitioner, occupational therapist registered, physician, physician assistant, licensed practical nurse, psychiatrist, psychiatric nurse, psychologist, psychological examiner, registered nurse, social worker, or speech language pathologist. All providers must hold appropriate licensure in the state or Province in which services are provided and must practice within the scope of these licensing guidelines. See Appendix D of Section 97, Chapter III, for PNMI covered services.

B. Other Qualified Mental Health Staff

Other staff may be considered qualified for purposes of this Section if they meet the following requirements:

1. They have education, training, or experience that qualifies them to perform certain specified mental health functions;

2. They receive certification from the Department, or its designee, that they are qualified to perform such functions and such verification is recorded in writing and kept in the files of the Department, or its designee; and

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

3. They perform such functions under the supervision of a licensed, certified, or registered health professional with the supervisory relationship having been described to and approved by the Department in accordance with its licensing and certification regulations.

C. Other Qualified Medical and Remedial Services Staff

Medical and remedial services and personal care services staff members may be considered qualified for purposes of this Section if they meet the following requirements:

1. The services they provide are prescribed by a physician and are in accordance with the member's plan of care.

2. The facility has written documentation that each staff person has received orientation or is currently in orientation in keeping with the licensing regulations for medical and remedial services facilities cited in Section 97.01-1(D) and is adequately performing medical and remedial services according to minimum standards set by the Office of MaineCare Services identified in the regulations cited above.

3. The medical and remedial services staff person is not a member of the member's family as defined in the Chapter III, Principles of Reimbursement for Medical and Remedial Service Facilities.

D. Other Qualified Alcohol and Drug Treatment Staff

Other qualified alcohol and drug treatment staff are staff members, other than professional staff defined above, who have appropriate education, training and experience in substance abuse treatment services, related disciplines as approved by the Office of Substance Abuse (OSA), or behavioral sciences; who work under a substance abuse treatment professional, consisting of at least one (1) hour per week for each twenty (20) hours of covered services rendered; and who are approved by the State Board of Alcohol and Drug Counseling as documented by written evidence on file with that office pursuant to Section 4.19 of the Regulations for Licensing/Certifying Substance Abuse Treatment Facilities in the State of Maine. A Certified Alcohol and Drug Counselor is considered to be another qualified substance abuse staff member.

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

E. Personal Care Service Staff

Personal care service staff may be considered qualified for purposes of this Section if they meet the following requirements:

1. The personal care services provided by all PNMIs are prescribed by a physician upon or within thirty (30) days of admission, are in accordance with the member's plan of care, are supervised by a registered nurse at least every ninety (90) days, and are not provided by a member of the member's family as described in Section 97.01-6 or the pertinent Appendix of Chapter III, Principles of Reimbursement.

2. The following facilities shall have written documentation that each staff person has received orientation in keeping with the licensing regulations for: a) community residences for people with mental illness, cited in Section 97.01-1(C) or, b) as outlined in the residential services agreement required by the Department of Health and Human Services licensing requirements cited in Section 97.01-1 (E); or c) in accordance with licensing regulations for residential substance abuse treatment PNMIs as cited in Section 97.01-1(A).

   Alcohol and drug treatment PNMIs ~~that provide personal care services~~ shall maintain documentation that each staff member providing such services has received forty (40) hours of orientation and training in personal care procedures appropriate to residents.

   Areas of training must include introduction to chemical addictions, assistance in self administration of medication, infection control, bowel and bladder care, nutrition, methods of moving patients, and health oriented record keeping.

   Personal care service staff shall adequately perform personal care services according to minimum standards set by the Department when providing services in community residences for people with mental illness.

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

F. Other Qualified Child Care Facility Staff

Other qualified child care facility staff are those individuals who have appropriate education, training, attributes, and experience as approved by the Office of ~~Children's~~Child and Family Services (OCFS). The PNMI shall submit to the OCFS for approval, names and qualifications of personnel defined as other qualified child care staff in the format provided by that Office.

1. In order to qualify for reimbursement for other qualified child care facility staff, the PNMI shall provide written evidence on file with the provider that other qualified child care facility staff shall meet the standards outlined in the certification requirements established by the OCFS as documented by written evidence on file with that Office.

2. Other qualified child care staff, when performing PNMI reimbursable services, shall receive regular, documented supervision by appropriately licensed or certified staff in accordance with the Rules for Licensure of Residential Child Care Facilities, (or in the case of facilities also licensed by the Office of Substance Abuse, Licensed Alcohol and Drug Counselors).

G. Other Qualified Licensed Treatment Foster Care Providers

Other qualified licensed treatment foster care providers are licensed treatment foster care homes/parents who hold a contract to provide treatment foster care services to State agency clients.

H. Interpreter Services

See Chapter I for provider rules regarding Interpreter Services.

I. Clinical Consultant Services

Clinical consultant services must be provided by licensed or certified professionals as described in Chapter II, Section 97.07-2, of these rules, and working within all State and Federal regulations specific to the services provided.

For those facilities covered under Chapter II, Appendix B, substance abuse facilities, clinical consultants may include substance abuse services including methadone maintenance services.

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

97.07-3 Assessment and Individual Service Plan

Qualified staff must provide reimbursable services following a written individual service plan. The service plan must be developed and reviewed in accordance with these rules for either substance abuse treatment facilities, child care facilities, community residences for persons with mental illness, medical and remedial services facilities, non-case mixed medical and remedial facilities, or ~~ITOOHTS~~ ITRT facilities. PNMI staff must assess members for unmet physical and mental health needs, and complement the individual service plan with appropriate referrals for health care.

97.07-4 Member's Record

The provider must keep a record for each member that includes, as applicable, but is not necessarily limited to:

A. The member's name, address, and birthdate;

B. The member's medical and social history, as appropriate;

C. The member's diagnosis. The attending physician or psychiatrist, if applicable;

D. Long and short range medical and other goals, as appropriate;

E. A description of any tests ordered by the PNMI and performed and results;

F. A description of treatment, counseling, or follow-up care;

G. Notation of any medications and/or supplies dispensed or prescribed;

H. Plans for coordinating the services with other agencies, if applicable;

I. The discharge plan of the member;

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

J. Written progress notes as appropriate for each type of facility or PNMI, the minimum for each being a monthly note, which shall identify the services provided and progress toward achievement of goals.

97.07-5 Program Integrity

See Program Integrity (formerly Surveillance and Utilization Review) in the MBM Chapter I.

97.07-6 Review of the Individual Service Plan

A review of the individual service plan shall be conducted by the appropriate case review team and/or professional of the following facilities in accordance with the following:

A. for substance abuse treatment facilities, the rules and regulations cited in Section 97.01-1(~~A~~B);

B. for child care institutions, the rules and regulations cited in Section 97.01-1(~~B~~D); and

C. for community residences for persons with mental illness, the rules and regulations cited in Section 97.01-1(~~C~~E);

Reviews for community residences for persons with mental illness must be made at least every ninety (90) days;

D. for medical and remedial services facilities, the regulations cited in Section 97.01-1(~~D~~C); and

E. for non-case mixed medical and remedial facilities, the rules cited in Section 97.01-1(~~E~~F) and the Chapter III, Principles of Reimbursement for Non-Case Mixed Medical and Remedial Facilities.

F. for ~~ITOOHTS~~ITRT facilities, the rules cited in Section 97.01-1(F); and the Chapter III, Appendix D, Principles of Reimbursement for Child Care Facilities.

97.07-7 Discharge Summary

A discharge summary shall summarize the entire case in relationship to the plan of care.

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

97.07-8 Time Studies

A. The Department requires time studies for educational staff performing duties as described in Section 97.06 to determine if a percentage of the time can be applied to direct service staff and is an allowable cost under Chapter III, Principles of Reimbursement for Private Non-Medical Institutions, Section 2400. The percentage of time determined in the time study that is applicable to academic services listed in MBM Chapter I, Section 1.06-4, Non-Covered and Non-Reimbursable Services will not be allowable time (and the costs related to that time) under Chapter III, Section 2400.

B. The Department requires time studies of direct time for staff who perform both covered direct services and other non-covered services for facilities covered under Appendices B, D, and E. The percentage of time determined from the time study spent in duties as described in Section 97.04 is an allowable cost under Chapter III, Principles of Reimbursement for Private Non-Medical Institutions, Section 2400.

C. Facilities must complete time studies in accordance with procedures prescribed by the Office of MaineCare Services.

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97.07-9 Continuing Stay Requirements

Members must continue to meet the eligibility criteria set forth in each Section above for provider reimbursement in the PNMI setting.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES**

Requirements identified in this Section shall be the responsibility of direct care staff. Direct care services include supervisory and training activities necessary to accomplish the provisions described in this Section. It also includes personal supervision or being aware of members' general whereabouts, observing or monitoring members to ensure their health and safety, assisting with or reminding members to carry out activities of daily living, and assisting members in adjusting to the facility and community.

97.08-1 Substance Abuse Treatment PNMIs – Medical and Clinical Requirements

A. Medical and Clinical Responsibility

Clinical responsibility for implementation of each member's overall specific treatment plan shall rest with a treatment team, which shall be chosen from the qualified professional staff as defined in Section 2400 of the pertinent Chapter III, Principles of Reimbursement.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

All services must be provided pursuant to a written service plan based upon an individual assessment made in accordance with the Regulations for Licensing/Certifying Substance Abuse Treatment Programs in the State of Maine.

Service plans must be reviewed and signed by a physician, psychiatrist, psychologist, social worker, licensed clinical professional counselor, registered nurse or licensed alcohol and drug counselor as defined in Chapter II, Section 97.07-2.

Such qualified professional staff shall be responsible for the provision of direct services to members, and for direct supervision of all other staff in the implementation of the service plan through the various elements of the comprehensive treatment described in this Section. The qualified professional staff shall ensure that a full range of formal treatment services is provided to each member in conjunction with the structured set of activities routinely provided by the PNMI and in accordance with the individual member's needs. The range of formal treatment services provided to members by the PNMI shall aid the member, through detoxification, residential rehabilitation, halfway house services, extended care services, adolescent residential rehabilitation, or extended shelter services toward the primary goal of recovery for the chemically dependent person.

PNMI staff shall assess members for unmet mental health needs, and complement the substance abuse plan of care with appropriate referrals for mental health care.

B. Personal Care Services

PNMIs approved and funded by Adult Mental Health Services in licensed facilities ~~may~~must also provide necessary personal care services ~~necessary~~ for the promotion of ongoing treatment and recovery. MaineCare does not cover personal care services provided by a family member.

Personal care services shall be prescribed by a physician, provided by qualified staff, and will occur in the substance abuse treatment PNMI where the member receiving services resides.

Personal care services shall consist of, but are not limited to, the following:

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

- Assistance or supervision of activities of daily living that include bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the member's health and safety within the substance abuse treatment PNMI;

- Supervision of or assistance with administration of physician ordered medication;

- Personal supervision or being aware of the member's general whereabouts, observing or monitoring the member while on the premises to ensure their health and safety, reminding the member to carry out activities of daily living, and assisting the member to carry out activities of daily living, and assisting the member in adjusting to the group living facility;

- Arranging transportation and making phone calls for medical or treatment appointments as recommended by medical providers, or as indicated in the member's plan of care;

- Observing and monitoring member's behavior and reporting changes in the member's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate;

- Arranging or providing motivational, diversionary, and behavioral activities that focus on social interaction to reduce isolation or withdrawal and to enhance communication and social skills necessary for ongoing treatment and recovery, as described in the member's plan of care;

- Monitoring and supervising member's participation in the treatment; and

- Psychosocial treatment including assisting members to adjust to the substance abuse treatment PNMI, to live as independently as possible, to cope with personal problems during periods of stress, to accept and adjust to their personal life situations, to accept and cope with their chemical addictions and to decrease unhealthy behaviors leading to possible relapse into active addiction, in addition to providing services and a supportive environment which promotes feelings of safety and freedom from danger, fear or anxiety.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

C. Medical Detoxification

MaineCare limits detoxification services to seven (7) days for each admission episode, with no limit on the number of admissions or covered days on an annual basis. The facility may provide detoxification services for a longer period if medical necessity is substantiated and ordered by the medical director, and documented in the member's clinical file by the facility's designated medical staff.

Detoxification services provide immediate diagnosis and care to members having acute physical problems related to substance abuse. Providers of detoxification services shall make and maintain arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI.

Each member shall receive a complete physical examination by a physician within forty-eight (48) hours of admission and the results shall be entered in the member's record. Admissions resulting from a direct physician referral by telephone may be sufficient to meet this requirement so long as the orders are taken by an RN or an LPN who has been trained to take telephone orders. The referring physician shall sign these orders within forty-eight (48) hours.

PNMIs shall provide medical evaluation and diagnosis upon intake. Designated areas suitable (1) for the provision of general medical services, and (2) to control and administer drugs prescribed by the PNMI's legally qualified staff, shall be maintained by the PNMI so as to assure the appropriate treatment of physical illness and maintenance of good general health among members. The member shall receive continuing medical supervision under the direction of a physician while in the PNMI that shall be documented in the member's case record. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals and physical examinations.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to good health and enabling the member to sustain a substance free life style. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall maintain a medical staffing pattern, which enables it to meet the physical care requirements delineated above. The PNMI shall provide for twenty-four (24) hour, on-premises medical coverage by a registered nurse or licensed practical nurse who is experienced in the disease process of chemical dependency. Physician back up and on-call staff shall be provided to deal with medical emergencies.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

D. Residential Rehabilitation

MaineCare limits residential rehabilitation to thirty (30) days for any single admission, with a limit of two (2) admissions and thirty (30) covered days on an annual basis per member. These limits allow some clinical flexibility should additional treatment be required or should a member drop out very early in treatment and are admitted at a later date.

Any continuous stay in excess of twenty-eight (28) days requires documented need in the member's treatment plan.

Residential rehabilitation shall provide scheduled therapeutic treatment consisting of diagnostic and counseling services designed to enable the member to develop a substance free life style.

Each member shall receive a complete physical examination by a physician within seventy-two (72) hours of admission and the results shall be entered in the member's record. Admissions resulting from a direct physician referral by telephone may be sufficient to meet this requirement so long as the orders are taken by an RN or an LPN who has been trained to take telephone orders. The referring physician shall sign these orders within forty-eight (48) hours.

PNMIs shall provide medical evaluation upon intake and laboratory examinations as deemed appropriate by the physician as soon as practicable after admission. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals, and physical examinations. Arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI shall be made and maintained by the PNMI.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to good health and the maintenance of a substance free life style. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling at a minimum of ten (10) hours per week.

The PNMI shall maintain a medical staffing pattern, which enables it to meet the physical care requirements delineated above. The PNMI shall provide for twenty-four (24)-hour staff coverage. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section. For the purposes of this Section, physician consultant services are not considered subcontracting.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

E. Adolescent Residential Rehabilitation Services

Adolescent residential rehabilitation PNMIs provide the opportunity for recovery through modalities, which emphasize personal growth through family and group support and interaction. The PNMI's qualified staff shall teach attitudes, skills, and habits, conducive to facilitating the member's transition back to the family and community. Adolescent residential rehabilitation PNMIs are designed to last at least three (3) months and are limited to twelve (12) months per single admission.

MaineCare does not cover in-house, accredited, individualized schooling, weekly vocational exploration groups, and structured recreational activities.

Services must include but are not limited to:

- Medical evaluation;
- Physical examination within seventy-two (72) hours following admission or no more than thirty (30) days prior to admission, and laboratory examinations as appropriate and as soon as practicable after the member's admission;
- Individual and group counseling at a minimum of ten (10) hours per week for each member;
- Arrangements for needed health care services; and
- Planning for and referral to further treatment.

The PNMI shall document that all persons providing services are legally qualified through licensure, certification, and/or registration as required to provide the service. PNMIs shall have qualified (as described in Section 2400 of these principles) staff coverage twenty-four (24) hours a day, including weekend coverage and shall include weekly clinical supervision to the staff to ensure the well-being of the members and to provide for the growth and development of the staff.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section. For the purposes of this Section, physician consultant services are not considered subcontracting.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

F. Halfway House Services

MaineCare limits halfway house services to a single admission of one hundred eighty (180) covered days on an annual basis per member. Any stay in excess of one hundred eighty (180) days requires documented need in the member's service plan.

A halfway house shall provide scheduled therapeutic and rehabilitative treatment consisting of transitional services designed to enable the member to sustain a substance free life style in an unsupervised community living situation.

Counseling staff of the PNMI shall perform an assessment of the member's medical and social/psychological needs, as required by the Office of Substance Abuse, within five (5) days of admission unless the member can show evidence of such examination within the last thirty (30) days. Such assessment may be completed prior to admission by the substance abuse treatment facility referring the member. This assessment may additionally include, but not be limited to an examination for contagious or infectious disease, determination of the status of chronic physical disease and examination of nutritional deficiencies. Arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI shall be made and maintained by the PNMI.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to facilitating the member's transition back to the community. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall have a written agreement with an ambulance service to assure twenty-four (24)-hour access to transportation to emergency medical care facilities for members requiring such transport. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section, with the exception of physician consultant services.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

G. Extended Care Services

MaineCare limits extended care services to a single admission of two hundred seventy (270) covered days on an annual basis per member. Any stay in excess of two hundred seventy (270) days requires documented need in the member's treatment plan.

Extended care services shall provide scheduled therapeutic plan consisting of treatment services designed to enable the member to sustain a substance free life style within a supportive environment.

Each member shall receive a complete physical examination by a physician within seventy-two (72) hours of admission and the results shall be entered in the member's record. Physical examinations performed more than thirty (30) days before admission are not acceptable. If the member's admission was based on the results of a physical examination performed thirty (30) or fewer days before admission, the PNMI's physician must approve the prior examination or re-examine the member within forty-eight (48) hours after admission.

PNMIs shall provide medical evaluation upon intake and laboratory examinations as deemed appropriate by the physician as soon as practicable after admission. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals, and physical examinations. The PNMI is responsible for referring the member to external clinicians and facilities for specialized services beyond the capability of the PNMI.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to facilitating the member's transition back to the community. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall have a written agreement with an ambulance service to assure twenty-four (24)-hour access to transportation to emergency medical care facilities for members requiring such transport. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section, with the exception of physician consultant services.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

H. Extended Shelter

The extended shelter will provide a structured therapeutic environment for members who are on a waiting list for treatment, or who have either completed detoxification treatment, or are otherwise not in need of detoxification services. The primary objectives of extended shelters are to stabilize the substance abuser in order to provide continuity of treatment to enable the member to develop an appropriate supportive environment to remain substance free and develop linkages with community services.

The term of residency shall not exceed forty-five (45) days. The PNMI shall provide a daily structured sequence of individual and/or group counseling for the treatment of substance abuse provided by qualified staff members (listed in Section 2400 of the pertinent Chapter III, Principles). MaineCare does not cover other educational and vocational counseling required by the Office of Substance Abuse Regulations for Extended Care Shelters.

Services provided will depend upon the therapeutic needs of individual members and must include but are not limited to:

- Evaluation of the member's medical and psychosocial needs;
- A medical examination by a physician within five (5) days of admission unless the member can show evidence of such examination within the last thirty (30) days;
- Opportunities for learning basic living skills, such as personal hygiene skills, knowledge of proper diet and meal preparation, constructive use of leisure time, money management and interpersonal relationship skills, all of which are considered non-covered services by MaineCare;
- Clinical services, including individual and group counseling; and
- Opportunity for family involvement.

The PNMI shall have twenty-four (24)-hour coverage by on-site trained staff (as required by Adult Mental Health Services) and include weekend coverage.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

Each PNMI shall provide at least one (1) hour per week of professional consultation to the clinical staff to ensure the well being of the members and to provide for the growth and development of the staff. This consultation may be either on a group or individual basis.

The PNMI shall assure the availability of a transportation support system twenty-four (24)-hours a day, and shall maintain a written agreement for the provision of transportation between the facility and emergency care facilities.

97.08-2 Child Care Facilities

A. General Description

Responsibility for implementation of each member's individual service plan shall rest with a licensed or certified clinical personnel or staff person operating within the scope of his/her license or certification under Maine law. Such clinical personnel or staff is responsible for the provision of direct services and for documented supervision of other qualified staff involved in implementing the service plan. Supervisory arrangements must be made in accordance with licensing and certification regulations. The health professional may be employed by the facility or engaged through a consultant contract or agreement.

PNMIs must provide all services pursuant to a written service plan based on an individualized assessment of the member made in accordance with the Rules for the Licensure of Residential Child Care Facilities or the Rules for Licensure of Child Placing Agencies, whichever is applicable.

Service plans must be developed, approved and signed in accordance with the Rules for Licensure of Residential Child Care Facilities or Rules for Licensure of Child Placing Agencies. The plan shall specify the treatment and rehabilitative services to be provided. The plan shall be reviewed and documented according to the applicable licensing requirements.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

Providers must maintain records in accordance with Chapter I and Chapter II, Sections 97.07-4, and 5 of the MaineCare Benefits Manual. Discharge summaries shall be consistent with the Rules for the Licensure of Residential Child Care Facilities and Rules for Licensure of Child Placing Agencies.

Rehabilitative services are designed to improve member's instrumental functioning in daily living, emotional and physical capability in areas of daily living, community integration and interpersonal functioning. These services include, but are not limited to:

- Group therapy aimed at improving a member's emotional integration, self-awareness, and environment;

- Emotional development skills training aimed at promoting behaviors that affect a member's relations with other people and the member's attitudes, interest, values, and emotional expression;

- Daily living skills training, aimed at addressing member dysfunction in areas necessary to maintain independent living;

- Interpersonal skills training, such as structured learning therapy, which are aimed at addressing member dysfunction in areas of social appropriateness and social integration;

- Community skill training, such as modeling therapy that is aimed at ameliorating member dysfunction in the awareness and appropriate use of community resources; and

- Collateral contacts, which mean a face-to-face contact on behalf of the member by clinical personnel or qualified staff to seek information, or discuss the member's case with other professionals, caregivers, or others included in the treatment plan in order to achieve continuity; of care, coordination of services, and the most appropriate mix of services for the member. Discussions or meetings with staff of the PNMI provider on behalf of the same member are not considered to be collateral contacts.

B. Physical Care

The population served by child-care facilities tends to manifest a wide variety of physical problems in addition to those mental health or behavioral disorders that are the primary presenting problems. For this reason, it is imperative that the provider provides physical care for members that is integral rather than adjunctive. In this sense, the provider shall assure that physical care exists that meets the primary care needs of

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

members. The provider shall coordinate and collaborate with other physical health care providers ~~arrange for the provision of general medical and dental services~~ so as to assure the appropriate treatment of physical illness and the maintenance of good general health among members. The provider shall also maintain arrangements with external clinicians and facilities for the provision of specialized medical, surgical, and dental services to members.

97.08-3 Community Residences for Persons with Mental Illness

Direct member services performed by clinical personnel refers to mental health treatment, substance abuse treatment, rehabilitative services and/or personal care services performed as deemed medically necessary and described in an authorized plan of care with the member present and participating. These services are provided within the scope of their licensure or certification by physicians, psychiatrists, psychologists, social workers, psychiatric nurses, psychological examiners, occupational therapists, other qualified mental health staff, personal care service staff, licensed substance abuse staff, licensed clinical professional counselors, licensed professional counselors or other qualified alcohol and drug treatment staff as defined in Chapter II, Section 97.07-2.

Mental health treatment and rehabilitative services refer to direct member services provided for reduction of a mental illness and restoration of a member to his/her best possible functional level. These services focus on the establishing or regaining of functional skills; the increase of self-understanding, crisis prevention and self management; socialization and leisure skill development; the development and enhancement of social roles within the context of natural supports, the consumer's community, and others within the residential treatment facility; and other activities connected with the rehabilitation goals and objectives identified in the plan of care.

These services are deemed medically necessary and described in an authorized plan of care and are provided with the member present and participating. The individualized rehabilitation plan shall include sequential steps developed with the consumer. Treatment planning will include, when possible, community staff providing services outside the facility as well as residential treatment facility staff. Planning will also include any other individuals that the member chooses. The plan will reflect individualized goals and objectives identifying the tailored services to be provided. Services provided are based on a well defined, time-limited plan that focuses on the member's particular strengths, needs, and choices and which is developed through a regularly scheduled, individualized planning process on a quarterly basis. One of the key elements reflected in the services provided by the facility is that of the expectation of growth and recovery. Mental health treatment and rehabilitative services are provided by physicians, psychiatrists, psychologists, social workers, licensed clinical professional

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

counselors, licensed professional counselors, certified interpreters, psychiatric nurses, psychological examiners, occupational therapists, and other qualified mental health staff, as defined in Chapter II, Section 97.07-2, operating within their competence in accordance with state law.

MaineCare does not cover personal care services provided by a family member. Personal care services must be prescribed by a physician, are provided by other qualified mental health staff, in accordance with their respective plans of care, as defined in Section 97.07-2 (E) and include, but are not limited to, the following:

- Assistance or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the member's health and safety;

- Supervision of or assistance with administration of physician ordered medication;

- Personal supervision or being aware of the member's general whereabouts, observing or monitoring the member to ensure their health and safety, reminding the member to carry out activities of daily living, and assisting the member in adjusting to the facility and the community;

- Arranging transportation and making phone calls for appointments as recommended by medical providers or as indicated in the member's plan of care; and

- Observing and monitoring member's behavior and reporting changes in the member's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate.

Integrated treatment services for persons with coexisting disorders (chronic mental illness and substance abuse) shall include mental health and substance abuse rehabilitative services. These services assist members in confronting their addiction history (alcohol and drug abuse) and develop motivation for long-term compliance and plans for ongoing recovery and treatment. Such rehabilitation services include individual counseling, family therapy, group therapy, and other services necessary to enhance a member's successful transition to housing and services in the community and promote the ability to function as independently as possible in the community.

Integrated treatment services shall also include independent living skills and social skills services, necessary to promote ongoing recovery and treatment. Specific treatment goals and objectives of such services shall be documented in each member's individual service plan.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

MaineCare does not reimburse for services that are primarily academic, vocational, socialization or recreational in nature, as described in Chapter I of the MaineCare Benefits Manual. MaineCare does not reimburse self-help supportive meetings.

A. Description of the Facility's Clinical Services

Clinical responsibility for implementation of each member's individual service plan shall rest with a licensed or certified mental health professional operating within the scope of his/her license or certification under Maine law. Such mental health professional shall be responsible for the provision of direct services and for documented supervision of other qualified mental health staff involved in implementing the service plan. The Department, in accordance with its licensing and certification regulations, must approve supervisory arrangements. The mental health professional may be employed by the facility or engaged through a consultant contract or agreement.

Within thirty (30) days of the entry of the member in the facility, all services must be provided pursuant to a written service plan based on an individualized assessment of the member made by a psychiatrist**,** psychologist, physician, licensed clinical social worker, psychiatric nurse, licensed master social worker conditional I, licensed master social worker conditional II, licensed clinical professional counselor or licensed clinical professional counselor conditional. The plan shall specify the treatment and rehabilitative services to be provided at the facility site. The plan shall be reviewed and documented every ninety (90) days.

Records must be maintained and reviewed in accordance with Sections 97.07-4, 5, and 7.

Only services provided at the facility for the diagnosis, assessment, treatment, rehabilitation, or provision of personal care services are reimbursable. It is recognized that many elements of a comprehensive plan of services to mentally ill members are not reimbursable by MaineCare. Services reimbursable under Section 97, Chapter III may complement, but must not duplicate, services provided outside of the facility, regardless of the actual provider of services. Each member's comprehensive individual service plan shall assure the most appropriate non-duplicative mix of services.

B. Personal care services

PNMIs approved and funded by Adult Mental Health Services in licensed facilities ~~may~~must also provide personal care services necessary for the promotion of ongoing treatment and recovery.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

97.08-4 Medical and Remedial Facilities

Medical and remedial facilities, whether they are case-mix reimbursed or non-case mix reimbursed facilities, include services provided at the facility for the diagnosis, assessment, treatment, rehabilitation, or provision of personal care services. These services must be provided within the scope of licensure or certification by staff as defined in Section 97.07-2.

MaineCare does not cover personal care services provided by a family member. A physician must prescribe personal care services. Other qualified personal care staff must provide services in accordance with respective plans of care, which include, but are not limited to, the following:

- Provision of personal care and nursing services;

- Assistance with or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks such as food preparation, laundry, and housekeeping essential to the activities of daily living and to the maintenance of the member's health and safety;

- Supervision of or assistance with the administration of physician ordered medication;

- Personally supervising or being aware of the member's general whereabouts, observing or monitoring the member to ensure his or her health and safety, reminding the member to carry out activities of daily living, and assisting the member in adjusting to the facility and the community; and

- Arranging transportation for appointments as recommended by medical providers or as indicated in the member's plan of care.

97.08-5 Intensive Temporary ~~Out-of-Home~~Residential Treatment Services (~~ITOOHTS~~ITRT)

Providers must include at least four family meetings per month as part of the treatment process unless documentation in the treatment plan indicates that such meetings are counterproductive to the child's progress. Each child must have an initial plan developed within the first seventy-two (72) hours of admission, and a comprehensive treatment plan developed within twenty (20) working days after admission.

Providers must meet all of the following requirements:

A. The comprehensive treatment plan shall include, but not be limited to:

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

1. A comprehensive assessment including all of the following dimensions:

   a. Psychiatric, including a diagnostic formulation, to include Axis I –V and specific DSM-IV criteria met;

   b. Psychological;

   c. History and physical;

   d. Neurological, if indicated;

   e. Educational;

   f. Recent psychological assessment (including I.Q. and Learning Disability (LD) assessment);

   g. Medication, including target symptoms and risk and benefit statement;

   h. Any other assessment warranted by the child's condition and/or illness.

2. Description of the child's strengths and service needs;

   a) A description of the short-term and long-term treatment goals, focusing on specific benchmarks for the child to return home. These must be specific, measurable, achievable, realistic, and time limited;

   b) The rationale for utilizing a particular method or modality of treatment;

   c) The family's responsibilities (i.e. visitation, family therapy sessions, contacting school, etc.;

   d) A specification of treatment goals in the service plan describing responsibility for staff, child, and parent/guardian involvement to attain treatment goals;

   e) An assessment at each clinical review, of whether the child may be safely discharged, to include specific barriers preventing discharge; and

3. Documentation of current discharge planning.

97.08 **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES** (cont.)

B. Progress notes must be entered into the record at least weekly, at a minimum addressing specific goals indicated in the individual treatment plan. These notes must include, but are not limited to the following:

a) A description of the services rendered to the child since the last note was entered, including a description of the specific interventions used;

b) A description of the child's response to these interventions;

c) The child's progress toward the identified goals, as indicated by objective measures whenever possible;

d) A description of the service rendered to the family since the last note was entered, including specific interventions used;

e) A description of the family's response to these interventions; and

f) The family's progress toward these goals, as indicated by objective measures whenever possible.

C. Physician notes, when appropriate, must be kept for:

1) General progress, with notes entered and updated in the record; and
~~1.~~ changes or additions of medications: Notes must document:

~~1.~~a. Reasons for using the specified medication;

~~2.~~b. Risks and benefits for using the specified medication, including possible medication interactions;

~~3.~~c. Documentation that informed consent including indication, risk benefit has been received prior to administration; and

~~4.~~d. Documentation of therapeutic response to any new or changed medications, including review of side effects.

97.09 **REIMBURSEMENT**

For each MaineCare provider enrolled as a participating Private Non-Medical Institution, the Department will determine an interim per diem rate, as determined under Chapter III, Section 97, Principles of Reimbursement for Private Non-Medical Institution Services and the applicable Appendix.

97.09 **REIMBURSEMENT** (cont)

Providers are required to obtain separate MaineCare provider number(s) for each PNMI provider type as described in Section 97.01-1. Upon completion of the provider's fiscal year, the providers shall submit to the Department, a cost report for each PNMI that has been assigned a provider number(s) in accordance with Chapter III of the Principles of Reimbursement.

Agencies that obtain public funds from another source to use as either a portion or as the entire State share of the PNMI rate must complete a Rider A as part of their Provider/Supplier Agreement to certify the State share of MaineCare funding. If certified public funds support only a portion of the PNMI rate, the full rate must be paid to the provider, with an adjustment made at settlement to reimburse the Department the amount certified in Rider A. This amount will be reported to the Department using Chapter III, Section 97 rules for the submission of cost reports.

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 MaineCare.

97.10 **BILLING INFORMATION**

Providers must bill in accordance with the Department's billing Instructions for the UB-~~92~~04 Claim Form. Billing instructions are available at:
http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html