MaineCare in Education

2020

A MaineCare School-Based Services
Billing Guide for Providers

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MaineCare Billing for School-based Services

The purpose of this guide is to provide information to school administrative units and equivalent providers billing for services under the policy sections outlined below in the MaineCare Benefits Manual (MBM). The guide should be viewed as a supporting document to the policy, rather than as a standalone policy. Providers of School-based MaineCare services are responsible for familiarizing themselves with all Medicaid regulations, policies, and procedures currently in effect and as they are issued. School-based providers can receive MaineCare provider updates by signing up for MaineCare's e-messages or RSS feed at here. Archived provider updates are available at here.

History

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), amended section 1903(c) of the Act, permits Medicaid payments for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) through a child's Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP).

In August 1997, the Centers for Medicare and Medicaid Services (CMS) issued a school-based guide entitled *Medicaid and School Health: A Technical Assistance Guide* (the Technical Guide). According to the Technical Guide, school health-related services included in the IEP may be covered by Medicaid if all relevant statutory and regulatory requirements are met. In addition, the technical guide provides that a State Medicaid Agency may cover medical services included in an IEP or IFSP as long as (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all federal and state regulations are followed, including those specifying provider qualifications; and (3) the services are included in the State plan or are available under the EPSDT benefit.

In Maine, the Office of MaineCare Services (OMS) is responsible for operating the state's Medicaid program. MaineCare collaborates with the Maine Department of Education (DOE) in the implementation and administration of the Medicaid school-based program.

MaineCare members may also access medical services at schools through enrolled School Health Clinics as defined in MBM Ch II, Section 3.04-1, or through MaineCare providers who contract with schools to provide additional medical services outside of this school-based policy. When appropriate, MaineCare providers may also make arrangements with members to provide medically necessary services to members at a school location. In these instances, the services are not covered through the school-based services program.

MaineCare Program Overview

MaineCare is a health benefit for eligible individuals and families with lower income and resources. MaineCare is a means-tested program that is jointly funded by the state and federal governments and administered by the state. Among the groups of people served by MaineCare are certain eligible U.S. citizens and resident aliens, including lower income adults and their children, and people with disabilities who meet the Social Security Administration's standard of disabled. Poverty alone does not necessarily qualify an individual for MaineCare. MaineCare is the largest source of funding for medical services for people with limited income. The program is designed to meet the medically necessary needs of our members.

This guide contains specific technical information about program requirements associated with seeking payment for covered services rendered in a school setting. The purpose of this guide is to inform schools on the appropriate methods for claiming reimbursement for the provision of the services.

This billing guide is designed to answer most questions; however, questions may arise that require a call to a specific group such as Provider Relations, or our Prior Authorization unit. The list of key contacts has important information you may need. Specific program policy information, MaineCare manual notices, replacement/updated policies, fee schedules, forms, and much more are available on the maine.gov website as well.

Key Contacts

Office for Family Independence

For questions regarding eligibility, to apply, or to report changes, members may call 1-855-797-4357. TTY users dial 711.

Office of MaineCare Services (OMS)

https://www.maine.gov/dhhs/oms or access here.

MaineCare Member Services

For questions about covered services or to select a Primary Care Provider (PCP) call 1-800-977-6740. TTY users dial 711. You can also email.

Provider Services

For MIHMS and Health PAS Online Portal questions, email Provider Services or call 1-866-690-5585. TTY users dial 711.

Provider Relations

See the Provider Relations Staff Assignments (PDF) for a list of specialists by policy.

For any other questions related to the provision of School-based services, please contact Trista Collins, State Medicaid Educational Liaison, at Trista.collins@maine.gov or 207-624-4094.

Joint Guidance

The Department of Health and Human Services and the Department of Education now issue joint guidance notices to support stakeholders.

- Two notices have been issued to date.
- The first notice was issued in February 2020 and clarifies IEP guidance.
- The second notice was issued in September 2020 and answers some early questions regarding challenges of MaineCare covered service provision during the COVID-19 pandemic.

Member Eligibility for Services

How Families Apply for MaineCare

To apply for MaineCare, individuals can:

1. Walk in to any of the Office for Family Independence (OFI) offices in person and ask for a paper application.
2. Call to request an application at 855-797-4357, Option 8. TTY users can call Maine Relay at 711.
3. Use the online chat feature available on the My MaineCare Connection site, which can be found here.
4. Emails can be sent to mmchelp.dhhs@maine.gov.
5. Apply here.

There is also an online pre-screening tool at the website above that will allow families to find out what they could potentially be eligible for if they are not ready to complete an application

What Factors Impact Eligibility for Different MaineCare Programs

There are a number of different MaineCare programs for which OFI determines eligibility. From a very basic level, the following things are used to determine eligibility (and not necessarily in this order):

- Family Household Size
- Income
- Assets
- Citizenship
- Disability

MaineCare Member Responsibilities

MaineCare members do have a responsibility to report changes to their household within ten days, which includes changes of address, and changes to income, assets, and household composition.

Katie Beckett Program

When families do not qualify for MaineCare due to being over the income and/or asset limit, and there is a child in the home who is disabled, the Katie Beckett program offers the opportunity for the disabled child to be considered for MaineCare coverage, separate from their household size. This allows the parental income and assets to be excluded so that a child has potential eligibility.

After this piece is determined, the child then has to be determined disabled by the Social Security Administration or by the Department's Medical Review Team. Both entities use the same standards to determine disability. The teams review medical documentation from the child's providers to see if they meet the criteria for disability. If the child meets the standard, an additional assessment is done to see if the child meets an institutional level of need. This assessment is done by a nurse through an outside contracted agency. If a child is determined disabled and meets the nursing home level of care requirement, then a premium is determined based on parental income, and MaineCare coverage is granted.

Katie Beckett Premiums

This is a premium-based program so families do have to pay a monthly fee for this benefit. Fees are based on the total amount of income which comes into a household on a monthly basis. Even though there is a premium, MaineCare benefits are the same for these children as they are for any other child receiving MaineCare. There is no difference in member benefits.

In addition, members who have MaineCare through the Katie Beckett program are subject to an annual limit. They need to be informed that the costs for school-based services will be included in their calculation of utilized benefits any time consent is provided for school-based service reimbursement.

Services Provided to MaineCare Members-
Minimum Requirements

All School-based Services must meet the following minimum requirements:

1. **Be medically necessary;**
2. **Be ordered, prescribed, or recommended by a physician or other licensed practitioner of the healing arts;**
3. **Be included in the member's Individualized Education Plan or Individualized Family Service Plan; and,**
4. **Be medical in nature (as opposed to academic).**

It is the provider's responsibility to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I, Section 1 of the MaineCare Benefits Manual.

Consent to Bill MaineCare

Federal Medicaid regulations at 42 CFR 431.51 and section 1902(a)(23) of the Act require Medicaid beneficiaries to have the freedom to choose from all qualified providers. Therefore, Medicaid-eligible children cannot be limited to school health providers for Medicaid covered services.

Federal law requires that for Medicaid to be billed, a public agency:

(A) Must obtain parental consent, consistent with 300.9; and (B) Notify parents that the parents' refusal to allow access to their public benefits or insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent (IDEA 300.154, (2) (iv) (A), (B)).

School districts cannot:

- Require parents to sign up for or enroll in public insurance programs in order for their child to receive a free appropriate public education (FAPE) under Part B of the Individuals with Disabilities Act (IDEA):
- Require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount after receiving services, but may pay the cost that the parent otherwise would be required to pay; and
- Use a child's benefits under a public insurance program if that use would decrease available lifetime coverage or any other insured benefit;
- Result in the family paying for services that would otherwise be covered by the public insurance program and that are required for the child outside of the time the child is in school;
- Increase premiums or lead to the discontinuation of insurance; or risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

The use of Medicaid funds to provide or pay for MaineCare's school-based services program **will not**:

- Require a parent/guardian to incur an out-of-pocket expense;
- Decrease a child's Medicaid benefits; or
- Increase premiums or lead to the discontinuation of insurance or a student's eligibility for home and community-based waivers.

Special Note: In addition, parents must be informed that refusal to permit the school district to access public health benefits or insurance does not relieve the school district of its responsibility to ensure that all required services are provided to students at no cost to parents.

- Each consent form for school-based service reimbursement from MaineCare should include the following components:
    1. Student and parent/guardian names
    2. Student DOB
    3. Student's Medicaid A# (if applicable)
    4. Name of district requesting reimbursement
    5. Dates of consent start and end (this should coincide with IEP expiration date).
    6. For summer Extended School Year (ESY) transportation requests, specific start and end dates for those ESY services must be included.
    7. List of specific services for which claims will be submitted, including:
       Frequency and duration of all services - these need to be individually listed §300.9(a), (b); CMS Medicaid School-Based Administrative Claiming Guide, p54(1); Explanation regarding parental consent pursuant to 34 CFR. §300.154, §300.9(a), (b); and an explanation that if a child has MaineCare through the Katie Beckett program, the cost of services provided by the School Administrative Unit will count against the student's annual cap.

Signature for Consent to Provide Treatment- Clarification

The signature for consent to treat a member, provided on an Individual Treatment Plan (ITP) must be provided by the legal parent or guardian. In the case of a child in custody of the State of Maine, the signature must be from the authorized state representative. An Educational Surrogate does not meet the requirements for MaineCare.

504 Plans

MaineCare reimbursement is not available for students receiving services from an Accommodation Plan in accordance with Section 504 of the Rehabilitation Act. Section 504 plans do not meet federal or state requirements for Medicaid reimbursement through the school-based services program.

Homeschooled Students & Parentally-Placed Private School Students

School units are obligated to follow all federal laws during the identification process for providing services to students.

IDEA 2004 states there is "no individual right to special education and related services. No parentally-placed private school child with a disability has an individual right to receive some or all of the special education and related services that the child would receive if enrolled in a public school." (IDEA Part 300, B, 300.137).

If a district chooses to implement an IEP or an IFSP for a student who is homeschooled or parentally-placed, MaineCare will reimburse for school-based services listed on the IEP or IFSP.

Superintendent Agreements

For MaineCare purposes, superintendent agreements have no bearing on any school-based provider seeking reimbursement for services. If a service is listed on a student's IFSP or IEP, and it is medically necessary, there is the potential for Medicaid reimbursement. It does not make a difference from MaineCare's perspective where the child is living, or the terms of any agreement in place by superintendents.

Child Development Service (CDS) Contracted Providers

When a provider delivers services to MaineCare enrolled children, and those services are listed on the an IFSP or IEP as managed by CDS, the provider is providing a school-based service for those members. It is vital that providers ensure the correct use of modifiers when billing for services listed on an IEP. Services requiring these modifiers include Section 65 services, as well as Occupational Therapy (OT), Physical Therapy (PT), and Speech and Hearing (ST) services.

If a member receives services from a non-school-based provider in addition to school-based claims, documentation would need to be kept indicating that two separate services were provided on the same day. One claim could be submitted for the service provided (with script from PCP), and another claim could be submitted for the school-based service provided.

Please make sure the correct Place of Service of "03" is used for the service provided in a school.

There are no modifiers at this time that can be used for Section 28 services. (Please see section in this guide entitled "Modifiers" for further explanation.)

Often, some services, such as evaluation, are not listed on a member's IEP. In those cases, the service should not be billed as a school-based service.

Provider Guidelines

Billing and Rendering Providers

The following may bill MaineCare for school-based services:

A program that has been approved by the Department of Education, as either

- A Special Purpose Private School or a regular education public school program under 05-071 C.M.R. ch 101 §XII and 20-A MRSA §7204 (4), 7252-A and 7253, and 05-071 C.M.R. ch 101, §12, or

- A program operated by the Child Development Services system 20-A MRSA §7001(1-A).
- An enrolled MaineCare provider who has contracted with a school to provide services.

It is important to note that billing providers are different from rendering providers. Rendering providers are the professionals who actually provide the service. Please see Chapter I, Section 1.02 of the MaineCare Benefits Manual for further clarification. There are several ways that a school may establish relationships with these professionals:

1. **Direct reimbursement of health professionals**: The school (or school district) **employs** health professionals. When the school employs staff who will provide the health services, the school can enter a provider agreement with MaineCare and receive payments for the covered services provided.

2. **Contracting with health professionals**: The school (or school district) **contracts** with health practitioners to furnish services. Under this type of arrangement, the health practitioner (not the school) is the provider of services, and payments are made to the practitioner, unless the practitioner assigns its right to payment to the school district.

3. **Combination of direct employment and contracting**: The school (or school district) uses a combination of employed health professionals and contracted health professionals to furnish services; or the school provides some services directly, but contracts out entire service types without directly employing any practitioner in a particular service category.

How does MaineCare Define "School?"

As relates to Section 28 services:

28.01-13 **School** is a program that has been approved by the Department of Education, as either a Special Purpose Private School or a Regular Education Public School Program under 05-071 C.M.R. ch 101 §XII and 20-A MRSA §7204 (4), 7252-A and 7253, and 05-071 C.M.R. ch 101, §12, or a program operated by the Child Development Services System 20-A MRSA §7001(1-A).

As relates to Section 65 services:

65.03-4 **School** is a program that has been approved by the Department of Education, as either a Special Purpose Private School or a Regular Education Public School Program under 05-071 C.M.R., Chapter 101, § XII and 20-A MRSA §7204 (4), 7252-A and 7253, and 05-071 C.M.R., Chapter 101, §12, or a program operated or contracted by the Child Development Services System 20-A MRSA § 7001(1-A) that has enrolled as a provider and entered into a provider agreement, as required by MaineCare. For the purposes of this rule, a school may provide the following services:

(1) Neurobehavioral Status Exam, Neuropsychological Testing and Psychological Testing, as described in Section 65.06-7, and (2) Children's Behavioral Health Day Treatment, as described in Section 65.06-13.

Rate Setting Guidance

Chapter 65.11 states that payment for services will be made at the lowest of the following:

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

The usual and customary charge is not a set rate, but rather is determined by the provider. If the usual rate for a service is lower than the MaineCare rate, this is the rate that should be billed. MaineCare does not dictate this calculation, but it is determined by the provider's cost of service delivery.

Rounding Rule

The rounding rule provides instruction as to how services must be billed if they are unexpectedly delivered in an increment that is different than what is listed in the rate schedule.

Chapter I, Section 1.03J of the MaineCare Benefits Manual (MBM) outlines the conditions of use of the rounding rule as follows:

"Bill only for covered services and supplies delivered. In cases where services provided include less than a whole unit of a service, the unit shall be rounded up only if equal or greater than fifty per cent (50%) of the unit of service, e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service.

The procedure code for the smallest unit of service must be used. Specific provisions in any other Chapters or Sections of this Manual will supersede this rounding requirement."

For example, if a Day Treatment provider delivered 5.5 units of Behavioral Health Professional (BHP) service on a given day, the proper way to report billing would be to report 6 units of H2012 HN, billed at the lesser of provider's Usual and Customary Rate or the MaineCare rate.

If a provider delivered 4.5 units of BHP services and 1 unit of Master's Level Clinician services, the BHP units would be rounded up to 5 units and added to the 1 Master's level unit for a total of 6 units billed that day (5 units H2012 HN, 1 unit H2012 HO).

Use of the rounding rule should be limited to exceptions, and not a regular practice. MaineCare expects providers to schedule one-hour sessions consistently for services billed in hourly increments.

MaineCare Seed Payments

School districts and Child Development Services have an obligation to pay seed to the Department of Education for the reimbursement of all MaineCare school-based services provided through IDEA.

All services provided in accordance with an IEP or IFSP will be assessed seed, regardless of whether a claim for the services is submitted from a school directly or by a contracted provider. To aid in proper allocation of seed and following correct coding standards, providers must use the appropriate "TL" or "TM" modifier, as applicable, on their claims for services delivered in accordance with an IEP or IFSP. See the "Modifiers" section below for further detail.

If you are aware of any instances in which seed is not being currently assessed, please contact the Department of Education.

All questions regarding MaineCare seed/match procedures should be directed to the Department of Education.
You can also find information on the 2012 MaineCare seed/match procedures for School Administrative Units at the following link: https://mainedoenews.net/2012/08/16/mainecare-seed-match-procedures/

Information regarding MaineCare seed payment reports and adjustments can be found here:
http://www.maine.gov/education/data/mainecareseed.htm.

Provider Enrollment and Revalidation

Enrollment Instructions for Schools That Are Providers of School-Based Services

In order to provide consistency in the MIHMS enrollment process, providers must follow the guidelines below when enrolling schools or when revalidating enrollment. **Municipal School Units that do not operate schools but instead pay tuition to other schools should not enroll as MaineCare providers.** The school where the student receives the MaineCare medical service needs to be the enrolled provider who bills for the services.

Please be guided by what the Maine Department of Education refers to as your entity's legal name. During revalidation, each provider will need to provide a copy of IRS documentation to verify the entity's legal name.

Naming Requirement For All Public Schools

Pay To Provider/Bill to Name:	**City of Summerville (Legal name according to IRS documentation)**
Service Location Names:	Summerville High School
	Summerville Middle School
	Summerville Elementary School

If your service location name does NOT include "Elementary, Middle, or High" in in, you will be asked to choose the appropriate term to add at the end.

For example:	Summerville Lake School-High
	Summerville Lake School-Elementary
	Summerville Lake School-Middle
	Summerville Community School- Elementary Middle (if combination)

Naming Requirement For All Special Purpose Private Schools (SPPS)

Pay-To Provider/Bill to Name:	**Park Avenue, Inc. (Legal name according to IRS documentation)**
Service Location Names:	Park Avenue School, Inc.
	Park Avenue School, Inc. Parentally-Placed Services**

If your service location name does NOT include "Elementary, Middle, or High" in in, you will be asked to choose the most appropriate term to add at the end.

For example:	Summerville Lake School-High
	Summerville Lake School-Elementary
	Summerville Lake School-Middle
	Summerville Community School- Elementary Middle (if combination)

Naming Early Childhood Services Site Locations

In accordance with *Maine Unified Special Education Regulations* (MUSER), Chapter 101, Section XI, to account for services provided to children ages three through five who access education prior to entering kindergarten, each school district will need to add one new service location.

Following the above example, the name for location would be "Summerville – Early Childhood Services."

For billing purposes only, the physical address listed for the site being set up is the main office location, not where the actual service takes place.

It is imperative that districts set up these new locations so that seed can be appropriately assessed on all claims provided through IDEA. Place of service on these claims will be "03" to indicate they were provided at a school. If the service is provided at any other location, appropriate Place of Service Codes must be utilized to indicate location. Please contact your MaineCare Provider Relations Specialist for additional guidance.

New Regional Service Center Site Location Enrollments

Regional Service Center Site Locations- Providing Services to Members

To facilitate an efficient process for Regional Service Centers, MaineCare will enroll any Regional Service Center as a Provider Type 89, Public School, when the entity provides services to MaineCare members. Rendering providers will need to be set up for claims to be submitted.

Regional Service Center Site Locations- Acting Only as Billing Agent for other Districts

In cases where a Regional Service Center is created to streamline administrative duties, the Regional Service Center will be enrolled as a third-party billing agent for the participating schools and/or districts. This will allow the service locations to continue as they have already been set up, and also provide access to the billing resources through the portal for claims submission.

Department of Education Verification

It is important to understand that all enrollment requests from schools, including Special Purpose Private Schools, will be verified with the Department of Education.

Requests for enrollment as Early Childhood Providers will require a copy of the provider's program approval letter issued annually by Child Development Services (CDS).

Enrollment Instructions for School-Based Providers Who Are Not Schools

This enrollment and claims submission guidance change is being made to ensure that all school-based service claims are correctly paid in accordance with MaineCare Member Benefits Manual 65.06-13, 65.03-4 and that appropriate seed is assessed for these claims.

At this time, only providers who meet MaineCare's definition of "school" as defined in MBM 28.01-13 and MBM 65.03-4 are eligible to enroll as a school provider type. This includes Provider Types 87-Public School, 88-Special Purpose Private School, 89-Intermediate Education Unit, and 92-Early Childhood Provider.

If a provider does not meet the definition of a "school" at the time of the scheduled provider revalidation with MaineCare, the provider will need to complete a maintenance case on the MIHMS Health PAS Online Portal to terminate any site currently listed as a school.

When submitting a school-based service claim, all providers must make sure that the place of service code on the claim is "03" if that is where the service was delivered. This accurately reflects a service being provided in a school. If the service was provided at an office or other location, providers must use the appropriate place of service codes.

Providers who perform services in a school when the services are not directed by an IFSP or an IEP as described above remain eligible to bill for services and also must use also the Place of Service Code "03" for "school."

Enrollment and Revalidation Provider Fees

Schools, and most school-based providers are exempt from provider paying enrollment fees during enrollment and revalidation.

Third Party Reimbursement

State and federal rules and regulations determine the Department's liability for payment of claims submitted to MaineCare for services provided to individuals enrolled in a health maintenance organization or managed care plan or those who have other available third-party resources. MaineCare is the payer of last resort. The only exception is for services involving Indian Health Services (IHS) claims. IHS is the payer of last resort for Native Americans enrolled in MaineCare. For more information regarding Maine's third-party liability, please access the MaineCare Benefits Manual here: http://www.maine.gov/sos/cec/rules/10/ch101.htm.

Provider Types and Specialty Code Descriptions for School-Based Services

Provider Type	Specialty	MaineCare Benefits Manual Specific Policies, By Service
87- Public School	164- Therapy Services	***Based on Rendering Providers:*** Section 65: Behavioral Health Services Section 68: Occupational Therapy Services Section 85: Physical Therapy Services Section 109: Speech and Hearing Services
87- Public School	020- Community Support Services 142- Private Duty Nursing 163- Children's Community Rehabilitation	Section 65 Behavioral Health Services Section 96: Private Duty Nursing and Personal Care Services Section 28: Rehabilitative and Community Support Services for Children with Limited Cognitive Impairments and Functional Limitations
88- Special Purpose Private School	164- Therapy Services	***Based on Rendering Providers:*** Section 65: Behavioral Health Services Section 68: Occupational Therapy Services Section 85: Physical Therapy Services Section 109: Speech and Hearing Services
88- Special Purpose Private School	020- Community Support Services 142- Private Duty Nursing 163- Children's Community Rehabilitation	Section 65: Behavioral Health Services Section 96: Private Duty Nursing and Personal Care Services Section 28: Rehabilitative and Community Support for Children with Limited Cognitive Impairments and Functional Limitations
89- Intermediate Education Unit	164- Therapy Services	***Based on Rendering Providers:*** Section 65: Behavioral Health Services Section 85: Physical Therapy Services Section 109: Speech and Hearing Services
92- Early Childhood Provider	163- Children's Community Rehabilitation	Section 28: Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Confidentiality

Standards of Confidentiality

Federal Medicaid regulations regarding confidentiality require that those receiving released recipient information must (From CMS, "Medicaid and School Health Guide: A Technical Assistance Manual, 1997"):

Federal Medicaid regulations regarding confidentiality require that those receiving released recipient information must have standards of confidentiality comparable to the state Medicaid agency itself. This requirement is an additional condition for the release of information. However, a provider is not entitled to additional information simply because it is bound by contract and administrative regulations to protect confidentiality.

Release of Information

Every exchange of information outside a discrete organization entity or agency is considered a release. To permit release of additional information to providers, there must be some basis to ensure that the release meets the statutory and regulatory requirement of serving a purpose directly related to State Plan administration. The member's consent is not necessary for releases that are not in response to outside requests but are, instead, essential to plan administration or service delivery. The requirement for recipient consent applies to requests for information from an outside source, not releases which are essential to ordinary program operations provided to members at the time of application for Medicaid.

Accessing Data

Providers may access the Medicaid eligibility information only by entering the member's MaineCare identification number or two or more of the following data elements: (1) member's full name, including middle initial; (2) member's date of birth, and (3) member's social security number; and by entering date or dates of service(s).

Privacy and Security of Health Information - HIPAA

The Maine Department of Health and Human Services (the "Department") takes the protection of health information very seriously. DHHS has a Director of Healthcare Privacy who serves as the Department's Privacy Officer, and each office has Privacy and Security Officials or Privacy Liaisons who work to follow state and federal healthcare privacy laws, including the Health Insurance Portability and Accountability Act of 1996, or HIPAA. HIPAA has many purposes, but in part, it tells us how we can use and share protected health information, and the safeguards that are required to keep that information secure. HIPAA does not apply to all of our offices or programs, but when it does, we are required to follow it. There are steep penalties for failing to comply with the law. Even if an office does not fall under HIPAA, the Department still promises to use reasonable safeguards to protect the information of the individuals we serve.

The Department implements and updates confidentiality policies, procedures, training, and forms that the law requires for us to keep health information protected, whether that information is part of a conversation, in a paper chart, or part of an electronic record. Only the minimum health information necessary to conduct business is to be used or shared. Additionally, we only enter into agreements with other organizations to help us with our business processes if they agree to safeguard the information as the law requires.

We will also investigate any possible breach of patient or client data that happens at a Department office or with one of our vendors or business associates. If an actual breach occurs, the Department will contact individuals whose information is at risk and report the breach to government regulators. If you have questions, you may contact our Director of Healthcare Privacy at DHHS.Privacy@maine.gov.

The Family Educational Rights and Privacy Act - FERPA

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

For additional information, you may call 1-800-USA-LEARN (1-800-872-5327) (voice). Individuals who use TDD may use the Federal Relay Service or you may contact us at the following address: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Avenue, SW, Washington, D.C. 20202-8520.

School-Based Service Details

Covered Service Descriptions

The following services are covered as School-based services under MaineCare when the medical service is specifically listed on a MaineCare member's IFSP or IEP because it is medically necessary so that a MaineCare member can access his or her education through IDEA.

- Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (Section 28, MBM);
- Behavioral Health, including Day Treatment, neuropsychological testing, psychological testing (Section 65, MBM);
- Occupational Therapy Services (Section 68, MBM);
- Physical Therapy Services (Section 85, MBM);
- EPSDT (Section 94, MBM);
- Private Duty Nursing and Personal Care Services (Section 96, MBM);
- Speech and Hearing Services (Section 109, MBM); and
- Non-Emergency Transportation (Section 113, MBM).

The MaineCare Benefits Manual may be accessed online here.

Medical Necessity

- **Medical Necessity or Medically Necessary** services are those reasonably necessary medical and remedial services that are:

1. Provided in an appropriate setting;
2. Recognized as standard medical care, based on national standards for best practices and safe, effective, quality care;
3. Required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health and well-being;
4. MaineCare covered services (subject to age, eligibility, and coverage restrictions as specified in other Sections of this manual as well as Early and Periodic Screening, Diagnosis and Treatment Services requirements as detailed in Chapter II, Section 94 of the MaineCare Benefits Manual);
5. Performed by enrolled providers within their scope of licensure and/or certification; and
6. Provided within the regulations of the MaineCare Benefits Manual. (1.02E MBM)

Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Service Descriptions:

28.04-1 **Treatment Services for Children with Cognitive Impairments and Functional Limitations** are medically necessary treatment services for members under the age of twenty-one (21). Treatment services are designed to retain or improve functional abilities which have been negatively impacted by the effects of cognitive or functional impairment and are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills. Services include problem solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs, learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self-awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.

28.04-2 **Specialized Services for Children with Cognitive Impairments and Functional Limitations** are medically necessary, evidence-based treatment services for members under the age of twenty-one (21), that utilize behavioral interventions designed to improve socially significant behaviors and developmentally appropriate skills to a measurable degree. Services include problem solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs, learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self-awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Comprehensive assessment (completed within thirty days of initiation of services)
- ✓ Individual Treatment Plan (ITP)
- ✓ Prior Authorization
- ✓ Progress Notes

Provider Staff Requirements:

- ✓ Direct Care staff must meet be at least 18 years of age, have a high school diploma or equivalent, and must obtain a Behavioral Health Professional (BHP) certification within one (1) year of hire. Supervisors of direct care staff must meet qualifications as listed in 28.08-2 MBM.
- ✓ Staff providing specialized services must meet additional qualifications in 28.08-2- MBM.

For more information, please see:
MaineCare Benefits Manual, Section 28, Chapter II Policy (Description of Services and Requirements)
MaineCare Benefits Manual, Section 28, Chapter III Allowances (Reimbursement Rates)

Section 65 Behavioral Health Services

Service Description:

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

A covered service is a specific service determined to be medically necessary by Qualified Staff licensed to make such a determination and subsequently specified in the Individual Treatment Plan (ITP) and for which payment to a provider is permitted under the rules of this Section. This Qualified Staff must assume clinical responsibility for medical necessity and the ITP development. The Behavioral Health Day Services described below are covered when (1) provided in an appropriate setting as specified in the ITP, (2) supervised by an appropriate professional as specified in the ITP, (3) performed by a qualified provider, and (4) billed by that provider. Behavioral Health Day Treatment Services must be delivered in conjunction with an educational program in a School as defined in 65.03-4.

Behavioral Health Day Treatment Services are structured therapeutic services designed to improve a member's functioning in daily living and community living. Programs may include a mixture of individual, group, and activities therapy, and also include therapeutic treatment oriented toward developing a child's emotional and physical capability in area of interpersonal functioning. This may include behavioral strategies and interventions. Services will be provided as prescribed in the ITP. Involvement of the member's family will occur in treatment planning and provision. Behavioral Health Day Treatment Services may be provided in conjunction with a residential treatment program. Services are provided based on time designated in the ITP but may not exceed six (6) hours per day, Monday through Friday, up to five days per week. Medically Necessary Services must be identified in the ITP.

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Comprehensive assessment (completed within thirty days of initiation of services)
- ✓ Individual Treatment Plan (ITP) with crisis/safety and discharge plan
- ✓ Prior authorization
- ✓ Progress notes

Provider Staff Requirements:

- ✓ Staff qualified to provide this treatment include the following clinicians: psychiatrist, psychologist, LCSW, LMSW, LCPC, LMFT. It also includes staff certified as a Behavioral Health Professional (BHP) who has completed ninety documented college credit hours or Continuing Education Units (CEUs).
- ✓ Staff qualified to determine medical necessity to develop the ITP are psychologists, LCSWs, LMSWs, LCPCs, or LMFTs. Board Certified Behavioral Analysts (BCBAs) are allowed to provide supervision to BHP staff.
- ✓ To provide Behavioral Health Day Treatment as a BHP, the employee must meet the education requirement and complete the required BHP training within the prescribed time frames, as described in 65.06-13.C (MBM).

For more information, please see:
MaineCare Benefits Manual, Section 65, Chapter II Policy (Description of Services and Requirements)
MaineCare Benefits Manual, Section 65, Chapter III Allowances (Reimbursement Rates)

Section 68 Occupational Therapy Services

Service Descriptions:

MaineCare reimburses providers for the following occupational therapy services:

68.06-1 **Evaluations or re-evaluations**: For adults, one evaluation or re-evaluation per member per condition or event is a covered service. For children, additional evaluations or reevaluations are allowed as medically necessary.

68.06-2 **Modalities**: Modalities are any physical agents applied to produce therapeutic changes to biologic tissues; including but not limited to thermal, acoustic, light, mechanical, or electric energy. Except when performing supervised modalities, the therapist is required to have direct (one-on-one) continuous patient contact.

68.06-3 **Therapeutic Procedures**: Therapeutic procedures effect change through the application of clinical skills and/or services that attempt to improve function.

68.06-4 **Tests and measurements**: The therapist is required to have direct (one-on-one) continuous patient contact in performing testing and measurement

68.06-5 **Splinting**: Providers may bill for splinting supplies necessary for the provision of occupational therapy services. Covered supplies under this Section must be billed and reimbursed at the lesser of acquisition cost or the maximum allowed cost set by the Department. The acquisition cost must be documented by an invoice in the member's file.

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Personalized plan of service/plan of care
- ✓ Progress notes

Provider Staff Requirements:

- Qualified staff include the following: Occupational Therapist, Registered, Licensed (OTR/L); Occupational Therapy, Licensed (OT/L); Certified Occupational Therapy Assistant, Licensed (COTA/L); and Occupational Therapy Assistant, Licensed (OTA/L).
- All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure. An OTR/L or an OT/L may be self-employed or employed by an agency or business. Agencies or businesses may enroll as a provider of service and bill directly for services provided by qualified staff. A COTA/L or an OTA/L may not enroll as an independent billing provider.

For more information, please see:
MaineCare Benefits Manual, Section 68, Chapter II Policy (Description of Services and Requirements)
MaineCare Benefits Manual, Section 68, Chapter III Allowances (Reimbursement Rates)

Section 85 Physical Therapy Services

Service Descriptions:

MaineCare reimburses providers for the following physical therapy services:

85.06-1 **Evaluations or re-evaluations**: For adults, one evaluation or re-evaluation per member per condition or event is a covered service. For children, additional evaluations or reevaluations are allowed as medically necessary.

85.06-2 **Modalities**: Modalities are any physical agents applied to produce therapeutic changes to biologic tissues; including but not limited to thermal, acoustic, light, mechanical, or electric energy. Except when performing supervised modalities, the therapist is required to have direct (one-on-one) continuous patient contact.

85.06-3 **Therapeutic Procedures**: Therapeutic procedures effect change through the application of clinical skills and/or services that attempt to improve function.

85.06-4 **Tests and measurements**: The therapist is required to have direct (one-on-one) continuous patient contact in performing testing and measurement.

85.06-5 **Splinting**: Providers may bill for splinting supplies necessary for the provision of physical therapy services. Covered supplies under this Section must be billed and reimbursed at the lesser of acquisition cost or the maximum allowed cost set by the Department. The acquisition cost must be documented by an invoice in the Member's file.

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Personalized plan of service/plan of care
- ✓ Progress notes

Provider Staff Requirements:

- ➢ Qualified staff include the following: Physical Therapist, Physical Therapy Assistant.
- ➢ All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure. A Physical Therapist may be self-employed or employed by an agency or business. Agencies or businesses may enroll as a provider of service and bill directly for services provided by qualified staff. A Physical Therapy Assistant may not enroll as an independent billing provider.

For more information, please see:
MaineCare Benefits Manual, Section 85, Chapter II Policy (Description of Services and Requirements)
MaineCare Benefits Manual, Section 85, Chapter III Allowances (Reimbursement Rates)

Section 94 Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

The term EPSDT is shorthand for Early and Periodic Screening, Diagnosis and Treatment, and is the standard applied when evaluating the need for services for children under the age of 21. The EPSDT standard requires that a Medicaid agency cover preventive, dental, mental health, and developmental and specialty services when such services are medically necessary to correct, ameliorate, or prevent health conditions. Any medically necessary service that is included under section 1905(a) as a mandatory or optional service may be covered under the EPSDT standard, regardless of whether the service is included in MaineCare's State Plan.

- Treatment services covered under EPSDT consist of all medically necessary services listed in §1905(a) of the *Social Security Act* (42 U.S.C. §1396(a) and (r)) are needed to correct or ameliorate defects and physical or mental conditions detected through the EPSDT screening process. The program covers only those treatment services that are not specifically included under any other MaineCare regulation, because:

    1. They are of a type not described in any other regulation.
    2. The frequency exceeds that covered by the regulation.
    3. The duration exceeds that covered by the regulation.

To receive payment for services under the EPSDT program, the member or provider must:

- Obtain prior authorization; demonstrate that the service is medically necessary, as the term is defined in Chapter I, §1.02 (D) of the MaineCare Benefits Manual; and show that the service is not covered by another MaineCare regulation.

- For more information regarding EPSDT services, please see MaineCare Benefits Manual, Chapter II, Section 94.

For more information, please see:
MaineCare Benefits Manual, Section 94, Chapter II Policy (Description of Services and Requirements)

Section 96 Private Duty Nursing and Personal Care Services

Service Description:

- If a student is eligible for services under Section 96, Private Duty Nursing and Personal Care Services, and the services are listed on the IFSP/IEP, and have a prior authorization, reimbursement may be sought for Nursing Services.
- At this time, school-based nursing services can be provided by (1) An agency, (2) an independent RN, or (3) an RN/LPN who is an employee of the school district.
- Under current policy, as employees of school districts, RNs or LPNs are able to perform tasks within the Nurses Practice Act, and under the scope of their individual licensures.
- An "Independent" RN has his or her own NPI number and bills directly with the correct Place of Service Code being 03. (The rate is lower because an Independent RN would not have the same overhead costs as an agency).
- Schools must ensure that their contracts do include Section 96 Services. In order to be considered school-based, services must be listed on the member's IFSP or IEP.
- A Prior Authorization must be obtained by the provider prior to the start of any nursing services.
- At this time there is no option to utilize the modifiers TL or TM for these services.

Documentation Requirements:

- ✓ Prior authorization
- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Authorized plan of care
- ✓ Nursing treatment plan of care
- ✓ Written progress notes

Provider Staff Requirements:

Nursing services may be provided by

1. An independently practicing registered professional nurse;
2. A registered professional nurse or licensed practical nurse employed by, or under contract with, a licensed home health agency. Provider must enroll the RN or LPN as a rendering provider.

For more information, please see:
MaineCare Benefits Manual, Section 96, Chapter II Policy (Description of Services and Requirements)
MaineCare Benefits Manual, Section 96, Chapter III Allowances (Reimbursement Rates)

Section 109 Speech and Hearing Services

Service Description:

The following services are covered for all members:

Speech, Voice and Language Evaluation, Diagnosis and Plan of Care by Speech-Language Pathologist
A direct encounter between a licensed speech-language pathologist and the member to determine the status of both receptive and expressive communication skills.

Speech, Voice and Language Therapy and/or Aural Rehabilitation, Individual
The process of producing behavioral change in the member with a communication disorder involving a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

Speech, Voice and Language Therapy and/or Aural Rehabilitation, Group
The process of producing behavioral change in the member with a communication disorder involving other than a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

Speech and Language Periodic Re-Evaluation
A direct encounter between member and speech-language pathologist to determine current status with periodicity determined by plan of care.
At minimum, re-evaluations will occur and plans shall be updated within six (6) months of the date of the plan of care.

Speech Pathology Diagnostic Services at Physician or PCP's Request
Specialty testing by speech-language-pathologist to assist in diagnosis and development of a medical plan of care. Report will include speech-language pathologist's recommendations. Currently acceptable medical tests and procedures are to be utilized as medically necessary.

Hearing Screening by a Speech-Language Pathologist
Pure tone air conduction testing by a speech-language pathologist as part of a hearing screening program.

Speech, Voice and/or Language Screening
Speech, voice and/or language screening performed by a licensed speech-language pathologist or a registered speech-language pathology assistant as part of screening.

Augmentative and Alternative Communication Evaluation Services
The scope of augmentative and alternative communication evaluation services including: diagnostic, screening, preventive, and corrective services provided by a licensed speech-language pathologist or, as appropriate, a registered speech-language pathology assistant. Specific activities include: evaluation for, recommendations of, design, set-up, customization, reprogramming, maintenance, and training related to the use of an AACD. Refer to Chapter II, Section 60, "Durable Medical Equipment", of the *MaineCare Benefits Manual* for criteria for augmentative communication devices.

T**herapeutic Adaptations and Set-Up for Assistive/Adaptive Equipment**
This shall include customizing the operational characteristics of an AACD in order to meet the needs of the individual member and to maximize the use and effectiveness of the device. This service shall be performed by a licensed speech-language pathologist who is familiar and has experience with augmentative communication devices.

Reprogramming
This shall include any necessary reprogramming of AACD equipment when performed by a licensed speech-language pathologist or registered speech-language pathology assistant who is familiar and has experience with augmentative communication devices.

Audiologic Evaluation, Diagnosis and Plan of Care, by Audiologist
A direct encounter between a member and an audiologist to determine the member's hearing status.

Audiologic Evaluation for Persons Difficult to Test
Based on a written plan of care serial evaluation for persons difficult to test in order to obtain reliable audiologic information necessary for case management.

Audiologic Evaluation for Site of Lesion
A direct encounter between a member and an audiologist which determines site of lesion; this may include, but is not limited to, the following tests: pure tone air, pure tone bone, speech audiometry, Bekesy, tone decay, short increment sensitivity index (SISI), impedance, alternate binaural loudness balance tests (ABLB).

Audiologic Evaluation as a Result of Change in Hearing Status Because of Disease, or Trauma
Audiologic evaluation necessitated by an observed or suspected change in a member's hearing status because of disease or injury, on referral from a physician or PCP.

Audiologic Diagnostic Services at Physician or PCP's Request
Specialty testing performed by an audiologist to assist in diagnosis and developing a medical plan of care. The report shall include audiologist's recommendations.

Aural or Language Rehabilitation (including speech reading), Individual, by Audiologist
The process of producing behavioral change in the member presenting communication disorders related to auditory function, involving a one-to-one relationship, and following a plan of care. This includes cochlear implant follow-up aural rehabilitation services.

Aural or Language Rehabilitation (including speech reading), Group, by Audiologist
The process of producing behavioral change in the member presenting a communication disorder related to auditory function involving other than a one-to-one relationship and following a plan of care.

* **Hearing Aid Evaluation and Related Procedures, by Audiologist**
Covered services must be provided by an audiologist and include evaluating members for hearing aid and demonstrating the basic features of hearing aids to the member. For each evaluation of a member, the audiologist will write a written report.

Members are eligible for one hearing aid or one replacement hearing aid every five years, through Section 60 (Medical Supplies and Durable Medical Equipment). Providers must submit prior authorization request and documentation for hearing aids, as required in Section 60.

* Hearing and/or Hearing Aid Periodic Recheck

Covered services must be provided by an audiologist and include re-evaluating members in accordance with a written plan of care.

* Ear Molds

NOTE: "Group" is defined as two to four individuals with one clinician. When services are provided, a brief notation must be made for each individual in his/her medical record.

Hearing Screening for Children up to Age Five (5) by an Audiologist

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Personalized plan of service/plan of care
- ✓ Progress notes
- ✓ Re-evaluation every six months

Provider Staff Requirements:

- ➢ To receive reimbursement, a speech-language pathologist must hold a valid license from the State or Province in which the services are provided.
- ➢ Audiologists must hold a valid license for the State or Province in which the services are provided.
- ➢ A speech-language pathology assistant must be registered as a speech-language pathology assistant by the Maine Board of Examiners on Speech-Language Pathology and Audiology, as documented by written evidence from such Board, or be registered in accordance with the licensure of the State or Province in which services are provided.
- ➢ A speech-language pathology assistant must be supervised by a licensed speech-language pathologist.
- ➢ A speech and language clinician must be a licensed speech-language pathologist.

Additional Note:

- ➢ MaineCare policy requires that re-evaluations occur and plans of care be updated within six months of the date of the plan of care.

For more information, please see:
MaineCare Benefits Manual, Section 109, Chapter II Policy (Description of Services and Requirements)
MaineCare Benefits Manual, Section 109, Chapter III Allowances (Reimbursement Rates)

Section 113, Non-Emergency Transportation (NET) Services

Service Description:

School-based transportation includes transportation services for members with special needs that are outside of traditional transportation services provided for members without disabilities.

- Special needs transportation services are covered when all of the following criteria are met:
    1. Transportation is provided to and/or from a MaineCare-covered service on the day the service was provided.
    2. The MaineCare-covered service is included in the member's IEP.
    3. The member's IEP includes specialized transportation service as a medical need.

- Special needs transportation includes the following:
    1. Transportation from the member's place of residence to school (where the member receives medically-necessary services covered by MaineCare's school-based services program, provided by the school, and/or return to the residence).
    2. Transportation from the school to the office of a medical provider who has a contract with the school to provide medically necessary services covered by MaineCare's school-based services program.
    3. In most cases, members with special education needs who ride the regular school bus to school with other non-disabled children will not have a medical need for transportation services and will not have transportation listed in their IEP. The fact that members may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

In order to comply with MaineCare's Non-Emergency Transportation (NET) policy (Section 113 of the MBM), all requests will be handled through MaineCare's NET brokerage system. This includes requests to provide transportation directly, and requests for reimbursements made through MaineCare's Friends, Family, Neighbors program. At no time would MaineCare be billed or reimbursed directly from providers. However, school requests will be facilitated to ensure efficient processes for these requests.

To initiate new transportation requests, please contact the appropriate broker for your location as procedures and forms vary by broker, based on transportation region. Please see the Non-Emergency Transportation Brokers document to identify your regional broker.

- School-based Transportation involves utilization of MaineCare's Non-Emergency Transportation system. All providers must adhere to policy requirements in Section 113 of the MaineCare Benefits Manual.
- This is a shared-ride system. This means that rides are shared within the transportation broker system by all MaineCare members in need of rides in order to access medical services. In some cases that means adult MaineCare members may be traveling in the same vehicles as child MaineCare members.
- Complaints regarding transportation should first be directed to the appropriate transportation broker. MaineCare members may also call MaineCare Member Services.

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP.
- ✓ All transportation request forms as mandated by broker being utilized,
- ✓ Consent to bill Medicaid for both transportation and medical service must be on file.

Documentation Requirements by Service

Medical Service	IEP with Service Listed	Prior Authorization Required	Member Written Record	Comprehensive Assessment (CA)	Plan of Service		Individual Treatment Plan (ITP)	Progress Notes
Section 28	Yes	Yes	Yes	Yes	-		Yes	Yes
Section 65	Yes	Yes	Yes	Yes	-		Yes	
Section 68	Yes	No	Yes	-	Yes		_	Yes
Section 85	Yes	No		-	Yes		-	Yes
Section 96	Yes	Yes		-				
Section 109	Yes	No		-	Yes			Yes
Section 113	Yes	Yes		-	No		No	No
Section 94	Yes	Yes	Yes	-	-		-	-

Documentation Requirements by Service

All MaineCare providers must maintain records to document medical services being provided to members. Following is a list of the documents required for School-based services. These documents may be reviewed during the Prior Authorization process or through the Program Integrity review process. These documents may also be reviewed by MaineCare staff, or their contracted entity at other times per 1.03 MBM.

Individualized Education Plan (IEP) / Individualized Family Services Plan (IFSP)

All medical services for which reimbursement is sought must be listed as services, in a student member's IEP or IFSP.

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), amended section 1903(c) of the Act, permits Medicaid payments for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) through a child's Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP).
In August 1997, the Centers for Medicare and Medicaid Services (CMS) issued a school-based guide entitled *Medicaid and School Health: A Technical Assistance Guide* (the Technical Guide). According to the Technical Guide, school health-related services included in the IEP may be covered by Medicaid if all relevant statutory and regulatory requirements are met. In addition, the technical guide provides that a State Medicaid Agency may cover medical services included in an IEP or IFSP as long as (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all federal and state regulations are followed, including those specifying provider qualifications; and (3) the services are included in the State plan or are available under the EPSDT benefit.

As MaineCare does not provide oversight or direction for the development of IEPs or IFSPs, all additional questions relating to the format of the IEP or IFSP should be directed to the Maine Department of Education.

At any time, MaineCare may request and review IEPs and IFSPs for compliance with this guidance for reimbursement for claims identified as a School-based service.

Using the IEP as a Plan of Care and ITP

At this time, an IEP or IFSP may be used as a member's "Plan of Care" or "Individual Treatment Plan" only if it includes all information required for services being provided, as outlined in the pertinent section of the MaineCare Benefits Manual (MBM).

MaineCare understands that the Department of Education and federal IDEA regulations have different requirements than MaineCare. Therefore, MaineCare recommends that districts develop separate ITP and IEP/IFSP documents to ensure that all MaineCare required information is included pursuant to the MBM. After reviewing instances where districts are utilizing one document instead of two, here are three examples of areas that need to be considered when deciding whether or not to use an IEP as an ITP or Plan of Care.

Staff Required to Participate in development of IEPs and ITPs.

For example, IDEA and MUSER stipulate participants necessary in the development of IEPs. When providing services through Section 65, Children's Behavioral Day Treatment, there is a requirement that "Qualified Staff must assume clinical responsibility for medical necessity and the ITP development." If one document is being used to fulfill both IDEA and MUSER requirements for an IEP and MaineCare requirements regarding an ITP, a district could potentially meet both requirements by ensuring that "Qualified Staff" as defined in the MaineCare Manual, are a part of

the child member's IEP team. If that is not possible, the district would need to consider using two separate documents so that the Qualified Staff is part of the development of the ITP even if they are not part of the IEP/IFSP team.

Signature Requirements

Another example which needs to be considers is with regards to signatures. Although IDEA and MUSER do not require signatures on an IEP document, (and as such there is no signature line on the state IEP template), MaineCare policy does stipulate that signatures must be included on Individual Treatment Plans. That means if a district chooses to use one document in lieu of two documents, they would need to add a signature line in order to be compliant with MaineCare policy. Choosing to use the IEP as a framework for a combined document does not negate the need to follow all MaineCare regulations as outlined in the *MaineCare Member Manual*.

90 Day Reviews

MaineCare policy stipulates there is a 90-day review requirement for Individual Treatment Plans. Although IEPs are not required to have this same review, it does not negate the requirement for MaineCare. If the IEP is being used as the treatment plan, it must still be reviewed every 90 days.

Comprehensive Assessment

For Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations Section 28 Services (28.05-2 MBM)

- A supervisor must complete a comprehensive assessment within thirty (30) days of initiation of services and must be included in the members record. The comprehensive assessment process must include a direct encounter with the member, if appropriate, and parents or guardians.
- The comprehensive assessment must be updated as needed, annually at a minimum.
- The comprehensive assessment must contain documentation of the following:
    1. the member's identifying information, including the reason for referral,
    2. family history relevant to family functioning including, but not limited to, concerns regarding mental health, developmental disabilities, substance abuse, domestic violence and trauma,
    3. the member's developmental history, if known, educational history and current status, and transition planning if age appropriate, and
    4. identification of the member's strengths and needs regarding functioning in the areas of behavior, social skills, activities of daily living, communication, cultural issues and need for accommodation and for members fourteen (14) years of age or older, independent living skills.
- The assessment must be summarized, signed, credentialed with licensure or certification, if applicable, and dated by the staff conducting the assessment, the parent or guardian and the member, if appropriate, and include the source and date of the diagnosis.
- The assessment must contain documentation if information is missing and the reason the information cannot be obtained.

For Ch II, Section 65 Behavioral Health Services (65.09-4 MBM)

- A clinician must complete a Comprehensive Assessment that integrates co-occurring mental health and substance abuse issues within thirty (30) days of the day the member begins services. The Comprehensive Assessment must be included in the member's record. The Comprehensive Assessment process must include a direct encounter with the member and if appropriate, family members, parents, friends and guardian. The Comprehensive Assessment must be updated at a minimum, when there is a change in level of care, or when major life events occur, and annually.
- The Comprehensive Assessment must contain documentation of the member's current status, history, strengths and needs in the following domains: personal, family, social, emotional, psychiatric, psychological, medical, drug and alcohol (including screening for co-occurring services), legal, housing, financial, vocational, educational, leisure/recreation, potential need for crisis intervention, physical/sexual and emotional abuse.
- The Comprehensive Assessment may also contain documentation of developmental history, sources of support that may assist the member to sustain treatment outcomes including natural and community resources and state and federal entitlement programs, physical and environmental barriers to treatment and current medications. Domains addressed must be clinically pertinent to the service being provided.
- Additionally, for a Comprehensive Assessment for a member with substance abuse, the documentation must also contain age of onset of alcohol and drug use, duration, patterns and consequences of use, family usage, types and response to previous treatment.
- The Comprehensive Assessment must be summarized, and include a diagnosis using all *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) axes or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC 0-3) diagnosis, as appropriate. The Comprehensive Assessment must be signed, credentialed and dated by the clinician conducting the Comprehensive Assessment. A Comprehensive Assessment for a member with a substance abuse diagnosis

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

- If a provisional diagnosis is made by an MHRT or CADC providing the direct service, the diagnosis will be reviewed within five (5) working days by the supervising licensed clinician and documented in the record.
- Historical data may be limited in crisis services. The Comprehensive Assessment must contain documentation if information is missing and the reason the information cannot be obtained or is not clinically applicable to the service being provided.

Individualized Treatment Plan (ITP) Document Requirements

For Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (28.05-3 MBM)

- Within thirty days of initiation of services, the treatment team must develop an ITP. The ITP is based on the comprehensive assessment and is appropriate to the member's developmental level.
  The ITP **must** contain the following:

1. The member's diagnosis and reason for receiving the service.
2. Specific medically necessary treatment services to be provided with methods, frequency and duration of services and designation of who will provide the service.
3. Objectives with target dates that allow for measurement of progress toward meeting identified developmentally appropriate goals.
4. Special accommodations needed to address barriers to provide the service.
5. The parent or guardian and the member, if applicable, must sign and date the ITP.
6. Be reviewed every ninety (90) days by the treatment team.
7. If indicated, the member's needs may be reassessed and the ITP revised.
8. The provider will provide the member with a copy of the initial and reviewed ITP within ten (10) days of signing.

- Discharge plan must:

1. Identify discharge criteria that are related to the goals and objectives described in the ITP; and
2. Identify the individuals responsible for implementing the plan; and
3. Identify natural and other supports necessary for the member and family to maintain the safety and well-being of the member, as well as sustain progress made during the course of treatment; and be reviewed by the treatment team every ninety (90) days.

- Crisis/Safety Plan, as applicable must:
    1. Identify the potential triggers which may result in a crisis;
    2. Identify the strategies and techniques that may be utilized to assist the member who is experiencing a crisis and stabilize the situation;
    3. Identify the individuals responsible for the implementation of the plan including any individuals identified by the member (or parents or guardian, as appropriate) as significant to the member's stability and well-being.

For Ch II, Section 65 Behavioral Health Services (65.09 MBM)

- The clinician, member, and other participants (service providers, parents, or guardian) must develop an ITP based on the comprehensive assessment that is appropriate to the member's developmental level within thirty days of the day the members begins services.
- When an ITP is required, it must contain the following unless there is an exception:
  1. The member's diagnosis and reason for receiving the service;
  2. Measurable long-term goals with target dates for achieving the goals;
  3. Measurable short-term goals with target dates for achieving the goals with objectives that allow for measurement of progress; specific services to be provided with amount, frequency, duration and practice methods of services and designation of who will provide the service, including documentation of co-occurring services and natural supports, when applicable;

4. Measurable Discharge criteria;
5. Special accommodations needed to address physical or other disabilities to provide the service; and
6. All participants must sign, credential (if applicable) and date the ITP. The first ninety (90) day period begins with date of the initial, signed ITP. The ITP must be reviewed at all major decision points but no less frequently than ninety (90) days, or as described in 65.09-3.B.7. If clinically indicated, the member's needs may be re-assessed and the ITP may be reviewed and amended more frequently than every ninety (90) days. Changes to the ITP are considered to be in effect as of the date it is signed by the clinician and member or, when appropriate, the parent or guardian. All participants must sign, credential (if applicable) and date the reviewed ITP.

- For members receiving crisis resolution services, a written plan of care is substituted for the ITP.

- For members receiving family psychoeducation, no comprehensive assessment is required. For members receiving psychological testing, no comprehensive assessment or ITP is required. For members receiving a neurobehavioral status exam, no ITP is required.

- If a member receives covered case management services (MaineCare Benefits Manual, Section 13) or services under MaineCare Benefits Manual Section 17, the member's mental health provider's ITP will coordinate with the appropriate portion of the member's ITP described in MaineCare Benefits Manual Section 13 or MaineCare Benefits Manual Section 17.

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

- The ITP must be completed and reviewed every ninety days.

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

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

- Crisis/safety plan must:
    1. Identify the precursors to the crisis;
    2. Identify the strategies and techniques that may be utilized to stabilize the situation;
    3. Identify the individuals responsible for the implementation of the plan, including any individuals whom the member (or parents or guardian, as appropriate) identifies as significant to the member's stability and well-being; and
    4. Be reviewed every ninety days or as part of the required review of the ITP.

Plan of Service

For Ch II, Section 68 Occupational Therapy Services (68.09-2 MBM)

- Personalized plan of service must include at minimum:
    1. Type of occupational therapy needed;
    2. How the service can best be delivered, and by whom the service shall be delivered;
    3. Frequency and expected duration of services;
    4. Long- and short-range goals;
    5. Plans for coordination with other health service agencies for the delivery of services;

For Ch II, Section 85 Physical Therapy Services (85.09 MBM)

- Personalized plan of services must include at minimum:
    1. Type of physical therapy needed;
    2. How the service can best be delivered, and by whom the service shall be delivered;
    3. Frequency and expected duration of services;
    4. Long- and short-range goals;
    5. Plans for coordination with other health service agencies for the delivery of services;
    6. Medical supplies for which a Practitioner of the Healing Arts' order is necessary; and
    7. Practitioner of the Healing Arts' orders including, for adults, their documentation of the member's rehabilitation potential.

The plan of care must be kept in the member's record and is subject to Departmental review along with the contents of the member's record.

For Ch II, Section 109 Speech and Hearing Services (109.09 MBM)

- A plan of care which includes identified problems, treatment in relation to the problems, and obtainable goals. This plan shall be updated in relation to the member's progress in reaching the goals.

Authorized Plan of Care

For Ch II, Section 96, Private Duty Nursing and Personal Care Services (96.07)

- The authorized plan of care must indicate the type of services to be provided to the member, specifying who will perform the service, the number of hours per week, specifying the begin and end dates, and specifying the tasks and reasons for the service.
- For all members age 21 and over, excluding those eligible for medication services or venipuncture services, and for those members under age 21 receiving care under the family provider service option, the Assessing Services Agency has the authority to determine and authorize the plan of care.
- Members may receive Medicare covered services, as applicable, during the same time period they receive MaineCare covered PDN/PCS. The authorized plan of care must identify the types and service delivery levels of all other home care services to be provided to the member whether or not the services are reimbursable by MaineCare. These additional home care services might be provided by such individuals as homemakers, personal care attendants and companions. These additional services shall include, but not be limited to, case management, home-delivered meals, physical therapy, speech therapy, occupational therapy, MSW services and hospice.

Nursing Treatment Plan of Care

For Ch II, Section 96, Private Duty Nursing and Personal Care Services (96.07)

- The licensed home health agency provider or independent contractor shall obtain the signature of the physician at least every 62 days on the nursing plan of care and on the physician's orders for nursing treatments and procedures, medications, medical treatment plan, and the frequency and level of personal care services. (The physician orders and nursing plan of care may be combined into one document.) These shall be made available to the Department or its Authorized Entity upon request. Covered services must be authorized by the Department or the ASA. Content of the nursing treatment plan must include the following information:

    1. All pertinent diagnoses, including mental status;
    2. All services, supplies, and equipment ordered;
    3. The level of care, frequency and number of hours to be provided;
    4. Prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, and any additional items the PDN services provider or physician choose to include. Orders for care must indicate a specific range in the frequency and number of hours. Orders may not be open-ended or "as needed;" and
    5. The nursing plan of care and physician's orders for nursing treatments and procedures must be reviewed and signed by the member's physician as required by the Department in this Section at least every 62 days.

Prior Authorization

Certain school-based services must be prior authorized by the MaineCare Services' Prior Authorization Unit or its authorized entity before the service is referred and/or provided. Services requiring prior authorization include:

1. Nursing services;
2. Certain extended psychological evaluations as described in 65.08-8;
3. Audiological evaluations, if an evaluation has been performed by another audiologist within the previous four (4) months;
4. Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations applied behavioral analysis services;
5. Day treatment services; and,
6. Transportation

Frequency: Prior authorizations for ongoing services must be resubmitted quarterly with the exception of transportation. Transportation authorizations must be submitted with start and end dates consistent with current IFSP/IEP provided, as often as requests are being made.

Documentation submitted in support of a prior authorization request must be sufficient to establish medical necessity, as opposed to educational necessity. The following documentation must be submitted in order to initiate a prior authorization request:

1. A copy of the IEP or IFSP that includes information sufficient to establish medical necessity; OR
2. A copy of the IEP or IFSP AND additional supporting documentation (such as a Comprehensive Assessment report) including an ITP (Individualized Treatment Plan); AND
3. Parental consent form to bill Medicaid (required only for transportation prior authorizations)

**MaineCare or its contracted entity may request additional information in order to determine medical necessity for a service.

Progress Notes

For Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (28.05-4 MB)

- Providers must maintain written progress notes for all treatment services, in chronological order.
- All entries must include the treatment service provided, the provider's signature, the date on which the service was provided, the duration of the service, and the progress the member is making toward attaining the goals or outcomes identified in the ITP.
- For in-home services, the provider must ask the member, or an adult responsible for the member, to sign off on the progress note documenting the date, time of arrival, and time of departure of the provider.

For Section 65 Behavioral Health Services (65.05 MBM)

- Providers must maintain written progress notes for all services, in chronological order.
- All entries in the progress note must include the service provided, the provider's signature and credentials, the date on which the service was provided, the duration of the service, and the progress the member is making toward attaining the goals or outcomes identified in the ITP.
- For in-home services, the progress note must also contain the time the provider arrived and left. Additionally, the provider must ask the member or an adult responsible for the member to sign off on a time slip or other documentation including the date, time of arrival, and time of departure of the provider.
- In the case of co-therapists providing group psychotherapy, the provider who bills for the service for a specific member is responsible for maintaining records and signing entries for that member. Facsimile signatures will be considered valid by DHHS if in accordance with mental health licensing standards.
- Separate clinical records must be maintained for all members receiving group psychotherapy services. The records must not identify any other member or confidential information of another member.
- For crisis services, the progress note must describe the intervention, the nature of the problem requiring intervention, and how the goal of stabilization will be attempted, in lieu of an ITP.
- The clinical record shall also specifically include written information or reports on all medication reviews, medical consultations, psychometric testing, and collateral contacts made on behalf of the member (name, relationship to member, etc.).
- Documentation of cases where a member requires more than two (2) hours of outpatient services per week to prevent hospitalization must be included in the file. This documentation must be signed by the supervising clinician.
- A closing summary shall be signed, credentialed and dated and included in the clinical record at the time of discharge. This will include a summary of the treatment, to include any after care or support services recommended and outcome in relation to the ITP.

For Ch II, Section 68 Occupational Therapy Services (68.09 MBM)

- Written progress notes shall contain: Identification of the nature, date and provider of any service given; the start time and stop time of the service, indicating the total time spent in delivering the service; any progress toward the achievement of established long and short range goals; the signature of the service provider for each service provided; and a full account of any unusual condition or unexpected event, including the date and time when it was observed and the name of the observer.
- Entries are required for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify why more, less, or different care than is specified in the plan of care was provided.

For Ch II, Section 85 Physical Therapy Services (85.09 MBM)

- Written progress notes each day the member is seen (also referred to as the treatment or session note) shall contain: Identification of the nature, date, and provider of any service given; the start time and stop time of the service, indicating the total time spent delivering the service; any progress toward the achievement of established long and short range goals; the signature of the service provider for each service provided; and a full account of any unusual condition or unexpected event, including the date and time when it was observed and the name of the observer.
- Entries are required for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify why more, less, or different care than that specified in the plan of care was provided.

For Ch II, section 96, Private Duty Nursing and Personal Care Services (96.07 MBM)

- Written Progress Notes for Services Delivered by a Direct Care Provider must contain: The service provided, date, and by whom; entrance and exit times of nurse's, home health aides, certified nursing assistants and personal care assistant' visits and total hours spent in the home for each visit. Exclude travel time (unless provided as a service as described in this Section); a written service plan that shows specific tasks to be completed and the schedule for completion of those tasks; progress toward the achievement of long and short-range goals. Include explanation when goals are not achieved as expected; signature of the service provider; and full account of any unusual condition or unexpected event, date and documented.

- Written Progress Notes for the Service Coordination Agency must contain: Date and time of every contact with the member and by whom, and progress toward the achievement of long- and short-range goals. Include explanation when the goals are not met as expected; signature and date of the Service Coordination Agency staff member entering the note; full account of any unusual condition or unexpected event, dated and documented; and all entries must be signed by the individual who performed the service. Authorized and valid electronic signatures are acceptable.

For Ch II, Section 109 Speech and Hearing Services (109.09 MBM)

- Progress notes written regularly (at least quarterly), which state the progress which the member has made in relation to the plan of care.

Member Written Record

For Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (28.05-1 MBM)

- The provider must keep a specific written record for each member, which must include:
    1. Member's name, address, birth date, and MaineCare ID number;
    2. A written copy of the member's comprehensive assessment;
    3. Individual Treatment plan (ITP), including the strengths and needs identified in the planning process;
    4. Written, signed, credentialed with licensure or certification, if applicable, and dated progress notes, kept in the member's records;
    5. DHHS, or its authorized agent, must approve changes regarding intensity and duration of treatment services provided. The Provider must document the approval of the changes in the ITP and in the member's record.

For Ch II, Section 65 Behavioral Health Services (65.09-4 MBM)

- A member's record must contain written documentation of a Comprehensive Assessment, an Individual Treatment Plan and progress notes.

  The Comprehensive Assessment process determines the intensity and frequency of medically necessary services and includes utilization of instruments as may be approved or required by DHHS. Individual Treatment Plans are the plans of care developed by the clinician or the treatment team with the member and in consultation with the parent or guardian, if appropriate, based on a Comprehensive Assessment of the member. Individualized plans include the Individual Treatment Plan, the Crisis/Safety Plan (where indicated by the Covered Service), and the Discharge Plan.

For Ch II, Section 68 Occupational Therapy Services 68.09-2

- Providers must maintain a specific record for each member, which shall include, but not necessarily be limited to:

    1. Member's name, address, birthdate, and MaineCare ID number;
    2. The member's social and medical history, and medical diagnoses indicating the medical necessity of the service or services;
    3. A personalized plan of service
    4. Written progress notes

For Ch II, Section 85 Physical Therapy Services (MBM 85.09 MBM)

- Providers must maintain a specific record for each member, which shall include, but not necessarily be limited to:

    1. Member's name, address, birthdate, and MaineCare ID number
    2. The member's social and medical history and medical diagnoses indicating the medical necessity of the service or services
    3. A personalized plan of service
    4. Written progress notes each day the member is seen (also referred to as the treatment or session note).

For Ch II, Section 96, Private Duty Nursing (MBM 96.07-7)

There shall be a specific record for each member which shall include the following:

1. Member's name, address, phone number, emergency contact, birth date;
2. The member's medical eligibility determination form, release of information, authorized plan of care and copies of the eligibility determination notice and service authorizations issued by the Service Coordination Agency for members over age 21;
3. Names and telephone numbers of the persons to call in case of an emergency or for advice or information. This information must be readily available to the HHAs, CNAs, PSSs, CRMAs and other in-home care workers;
4. The plan of care which specifies the tasks and the schedule of tasks to be completed by the PSS, CNA, HHA or CRMA and authorized services. Whenever a RN or LPN delivers services to more than one patient in the same setting during the same visit (see Section 96.04(F) multiple patient nursing services), then this service must be described and documented in each member's plan of care;
5. Entrance and exit times, and total hours spent in the home for each visit by each nurse, PSS, HHA, and CNA;
6. The number of medication passes performed by the CRMA for each Member under Level IX; and
7. Progress notes reflecting changes in the Member's condition, needs, communications with the Member, other information about the Member, and contacts with other involved agencies. Progress notes must be signed and dated by the person entering the note.

For Ch II, Section 109 Speech and Hearing Services (109.09-1)

- The provider will maintain an individual record for each member eligible for MaineCare reimbursement, including but not limited to:

1. Name, birthdate, MaineCare ID Number.
2. Referral from a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice, made in writing or by telephone prior to the delivery of service. Written referral confirming a telephone referral must be included in the record within thirty (30) days of the original order.
3. Pertinent medical information, as available, regarding the member's condition.
4. Appropriate hearing and/or speech-language evaluation and diagnosis.
5. A plan of care which includes identified problems, treatment in relation to the problems, and obtainable goals. This plan shall be updated in relation to the member's progress in reaching the goals.
6. Documentation of each visit, showing the date of service, the service performed, the start time and stop time of the service, indicating the total time spent in delivering the service, and the signature of the individual performing the service.
7. Progress notes written regularly (at least quarterly), which state the progress which the member has made in relation to the plan of care.
8. A discharge summary with a copy sent to the referring practitioner of the healing arts.
9. Copies of prior authorization or any other pertinent information concerning the member.

- Members' records will be kept current and available to the Department as documentation of services included on invoices.

Additional Information

Record Retention

- Records must be consistent with the unit of service specified in the applicable policy covering that service. Records must include, but are not limited to all required signatures, treatment plans, progress notes, discharge summaries, date and nature of services, duration of services, titles of persons providing the services, all service/product orders, verification of delivery of service/product quantity, and applicable acquisition cost invoices. Providers must make a notation in the record for each service billed. For example, if a service is billed on a per diem basis the provider must make a notation for each day billed. If a service is billed on a fifteen-minute unit basis, a notation for each visit is sufficient.
- Records must be kept in chronological order with like information together as appropriate. For MaineCare purposes, such records must be retained for a period of not less than five years from the date of service or longer if necessary to meet other statutory requirements. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and a settlement has been made.

For a list of complete regulations related to MaineCare records, please see "Requirements of Provider Participation" as listed in Chapter I, Section 1.03-8 of the MaineCare Benefits Manual (MBM).

Review and Submission of Claims

MaineCare claims are electronically processed and not always reviewed by medical claim experts prior to payment to determine if the services provided were appropriately billed. Although the claims system can detect and deny some erroneous claims, there are claim errors which it cannot detect. For this reason, payment of a claim does not confirm that the service was correctly billed or the payment to the provider was correct. Periodic retrospective reviews will be performed which may lead to the discovery of incorrect billing or payment issues. If a claim is paid and the Department later discovers that the service was incorrectly billed or the claim was erroneous in some other way, the Department is required by federal regulations to recover any overpayment.

Claims may be filed using Direct Data Entry on the MaineCare portal. This is the preferred method of billing.

Paper claims may be mailed to: MaineCare Claims Processing, M-5500, Augusta, ME 04333.

The Maine Integrated Health Management Solution (MIHMS) website is available at here:

- Claims and billing
- Excluded providers
- Prior Authorization (PA)
- Provider enrollment
- Referrals

Through the above link you can access the MIHMS portal, known as Health PAS-Online. From here, you can access your Trading Partner Account, check the status of claims, member eligibility, billing instructions, and complete Direct Data Entry (DDE). This portal also provides you with any up-to-date additional information on the MIHMS system.

Providers of Services to Child Members: School-Based vs. Non-School-Based Claim Submissions

As long as there is clear documentation for each session, showing that separate services are being provided, and as long as overall limits for services are not exceeded (even if services are provided by the same person/agency), concurrent billing is allowable when a member is provided services in more than one setting, on the same day.

Providers are able to provide services in more than one setting, pursuant to any limitations on the service outlined in the MaineCare Benefits Manual.

For example: If a member received speech services at school, they can also still access speech services after school with a different provider, on the same day.

Claims submitted for school-based services provided in connection with an IFSP or an IEP must indicate the correct Place of Service Code as "03," along with a modifier of either TL or TM in order for us to differentiate between the school and the non-school-based service provided.

Modifiers

For OT, PT, Speech, and Section 65 services, providers are required to utilize the modifiers below for school-based claims. This indicates which claims should match a student's IFSP or IEP. Modifiers do not need to be used for the prior authorization; however, they do need to be included when the claim is submitted.

"TL" - Services delivered under an Individualized Family Service Plan (IFSP)
"TM" - Services delivered under an Individualized Education Plan (IEP) with MaineCare addendum denoting medical necessity of the service.

Place of Service Code

All schools will need to make sure that the Place of Service Code is "03" when a school-based claim is submitted. Providers who perform services in a school that not directed by and IFSP or IEP as described above may remain eligible to bill for services and must also use the Place of Service Code "03" when providing a service in a school.