# TABLE OF CONTENTS

103.01 **DEFINITIONS** 1

 103.01-1 Covered Services 1

 103.01-2 Homebound Member 1

 103.01-3 Plan of Treatment 1

 103.01-4 Primary Health Care 1

 103.01-5 Rural Health Clinic 1

 103.01-6 Rural Health Clinic Services 1

 103.01-7 Unit of Rural Health Clinic Service 2

 103.01-8 Incidental Services and Supplies 2

103.02 **ELIGIBILITY FOR CARE** 2

103.03 **DURATION OF CARE** 2

103.04 **COVERED SERVICES** 2

 103.04-1 Core Services 2

 103.04-2 Other Ambulatory Services 3

 103.04-3 Off-Site Delivery of Services 5

 103.04-4 Visiting Nurse Services 6

 103.04-5 Interpreter Services 6

103.05 **NON-COVERED SERVICES** 6

103.06 **POLICIES AND PROCEDURES** 6

 103.06-1 Professional Staff 6

 103.06-2 Supervision by a Physician 7

 103.06-3 Member Records 7

 103.06-4 Program Integrity 9

103.07 **REIMBURSEMENT** 9

 103.07-1 General Reimbursement 9

 103.07-2 PPS Reimbursement Methodology 9

103.08 **COPAYMENT** 11

103.09 **BILLING INSTRUCTIONS** 12

103.01 **DEFINITIONS**

103.01-1 **Covered Services** are those services described in 103.04 for which payment can be made under Title XIX and Title XXI by the Department of Health and Human Services.

 103.01-2 **A Homebound Member** is an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or long term care facility.

103.01-3 **Plan of Treatment** is a written plan of medical services for part-time or intermittent visiting nurse care that is established and reviewed at least every sixty (60) days by a supervising physician of the clinic. When delegated by the supervising physician, and when in compliance with all other State licensure requirements it may also be established by a physician assistant, nurse practitioner, nurse midwife, or clinical nurse specialist and reviewed and approved at least every sixty (60) days by a supervising physician of the clinic.

103.01-4 **Primary Health Care** refers to preventative, diagnostic and therapeutic services furnished by the clinic's professional staff and, where appropriate, the supplies commonly used to support those services, basic laboratory services essential for diagnosis and treatment, and emergency medical care for the treatment of life-threatening injuries and acute illness.

103.01-5 **Rural Health Clinic** means a Primary Health Care clinic that is both certified as a Rural Health Clinic by Medicare and enrolled as a MaineCare provider. A clinic may be either a provider based clinic or an independent clinic.

A. A provider-based clinic exists when:

 1. the clinic is an integral part of an existing hospital, skilled nursing facility, or home health agency participating in Medicare; and

 2. the clinic is operated with other departments of the provider under common licensure, governance, and professional supervision.

B. An independent clinic is a Rural Health Clinic operating as a separate entity.

103.01-6 **Rural Health Clinic Services** are those Primary Health Care services furnished by the facility's professional staff during a visit.

* 1. **DEFINITIONS** (cont.)

103.01-7 **A Unit of Rural Health Clinic Service** is a visit that includes a face-to-face contact with one or more of the clinic's health professional staff and, where appropriate, receipt of appropriate supplies, treatments, and laboratory services.

 103.01-8 **Incidental Supplies and Services** refer to certain services and supplies authorized by licensed medical, dental and mental health practitioners.

103.02 **ELIGIBILITY FOR CARE**

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

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

103.03 **DURATION OF CARE**

 Each Title XIX and Title XXI member may receive as many Covered Services as are medically necessary. The Department reserves the right to request additional information to evaluate medical necessity.

* 1. **COVERED SERVICES**

 Covered Services include core services, and other ambulatory services.

103.04-1 Core Services are billable at the PPS rate. Core Services include:

A. services provided by physicians, physician assistants, advanced practice registered nurses, clinical psychologists, licensed clinical social workers, and licensed clinical professional counselors;

 B. services and supplies furnished as incident to services of conditionally, temporarily, fully licensed, otherwise legally recognized or approved practitioners who are designated in Section 103.06-1 of this Manual; and

C. basic laboratory services essential for the immediate diagnosis and treatment of illness or injury, including, but not limited to:

1. chemical examination of urine by stick or tablet method or both (including urine ketones);

2. hemoglobin test or hematocrit;

103.04 **COVERED SERVICES** (cont.)

3. blood sugar test;

4. examination of stool specimens for occult blood;

5. pregnancy tests; and

1. primary culturing for transmittal to a certified laboratory.

 Note: To qualify for reimbursement, laboratory services must be in compliance with the rules implementing the *Clinical Laboratory Improvement Amendments of 1988* (CLIA "88") and any related amendments.

D. emergency medical care treating life-threatening injuries and acute illnesses, including drugs and biologicals such as:

1. analgesics

2. local anesthetics

3. antibiotics

4. anticonvulsants

5. antidotes and emetics

6. serums and toxoids

E. visiting nurse services (as described in 103.04-4).

103.04-2 **Other Ambulatory Services** include:

 A. Podiatric services for the diagnosis and treatment of problems concerning the human foot. These are limited by the conditions in Chapter II, Section 95, “Podiatry Services”, of the *MaineCare Benefits Manual*.

 B. Prevention, Health Promotion and Optional Treatment Services ((PHPOT) formerly EPSDT) provided to eligible children in accordance with Chapter II, Section 94, of the *MaineCare Benefits Manual*.

 C. Asthma programs are reimbursable if they are based on the Open Airways or Breathe Easier curricula. Any other asthma management service which is approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America, is also reimbursable.

103.04 **COVERED SERVICES** (cont.)

 Each asthma program must have:

1. physician advisor;

2. primary instructor (a licensed health professional or a health educator with baccalaureate degree);

1. pre-assessment and post-assessment for each participant which shall be kept as part of the member's record;

4. an advisory committee which may be part of an overall patient education advisory committee; and

5. a physician referral for all participants.

 Note: Providers should bill the actual cost of the asthma program upon completion of the service, using the procedure code listed in Chapter III, Section 103.

 D. Ambulatory Diabetes Education and Follow-Up (ADEF) Services, or similar services approved by the Centers for Medicare and Medicaid Services (CMS) approved national accreditation organization, will be reimbursed when a provider enrolled with the Maine Diabetes and Prevention Control Program furnishes this service to a MaineCare member whose physician has prescribed this program for the management of the member's diabetes. The service includes:

 1. a pre-assessment interview to determine the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;

2. group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes and Prevention Control Program and based on the individualized education plan;

 3. a meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;

 4. A post-assessment interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and

* 1. **COVERED SERVICES** (cont.)

5. follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three-month, six-month, and one-year follow-up visits from the date of the last class are required to complete the member's participation in the service.

 When the MaineCare member is under age 21, this service will also be reimbursed when provided to the person/people who provide the member's daily care.

 E. Effective August 1, 2014, Tobacco cessation treatment services will be reimbursed, for eligible Members, provided by physicians or other providers who can provide tobacco cessation treatment services under their licenses or permits. There are no annual or lifetime limits on tobacco cessation treatment services. Counseling services may be provided in the form of individual or group counseling. Both forms of counseling may be provided by licensed practitioners within the scope of licensure as defined under State law and who are eligible to provide other coverable services in Section 103.

 Tobacco cessation treatment services includes the provision of all pharmacotherapy approved by the Food and Drug Administration (FDA) for tobacco dependence treatment. MaineCare members are not required to participate in tobacco cessation counseling to receive tobacco cessation products Tobacco cessation products are “covered services” reimbursable pursuant to Ch. II, Section 80.05 of the *MaineCare Benefits Manual*. The services for tobacco cessation treatment are copay exempt. Tobacco cessation treatment services may be billed alone, or in combination with other RHC services. Documentation of the tobacco cessation treatment services must be contained in the medical record.

 F. Contraception (injectable, implantable capsules, intrauterine devices) and the administration of influenza and pneumococcal vaccines.

103.04-3 **Off-site delivery of services** furnished by clinic staff are reimbursed when Rural Health Clinic Services are provided away from the clinic and when it is documented in the member's chart that it is the most appropriate setting for the provision of services. Examples of off-site service locations include: a nursing facility, an emergency room, or a member’s home.

103.04 **COVERED SERVICES** (cont.)

 103.04-4 **Visiting nurse services** will be reimbursed when:

 A. a registered nurse or licensed practical nurse provides the services to a member who is homebound;

B. the services are provided in accordance with a written Plan of Treatment;

 C the member's record documents that the member would not otherwise receive these services;

 D. the services are provided in an area that the Secretary of the U.S. Department of Health and Human Services has determined has a shortage of home health agencies; and

E. the Rural Health Clinic that provides in-home services by a registered licensed practical nurse is licensed by the State of Maine as a home health service provider.

 103.04-5 **Interpreter Services** – Refer to Chapter I of the *MaineCare Benefits Manual* for information about reimbursement for interpreter services.

103.05 **NON-COVERED SERVICES**

All services must be provided geographically in the federally defined service area, and/or be otherwise provided in conformance with federal requirements. See Chapter I of the *MaineCare Benefits Manual* for other details on non-covered services.

103. 06 **POLICIES AND PROCEDURES**

103.06-1 **Professional Staff**

 In order for a clinic to receive reimbursement, its professional staff must be conditionally, temporarily or fully licensed, or otherwise recognized or approved to practice, in the state where services are provided as documented by written evidence from the appropriate governing body, including: physicians, podiatrists, physician assistants, advanced practice registered nurse practitioners, nurse-midwives, clinical nurse specialists, clinical psychologists, clinical social workers, clinical professional counselors, registered nurses, licensed practical nurses, respiratory therapists, dentists and dental hygienists. MaineCare will also reimburse for advanced practice or registered nurses who hold a current, unencumbered compact license from another compact state that they claim as their legal residence. Qualifications of any other staff must be provided and billed in accordance with all other applicable sections of the *MaineCare Benefits Manual*.

103. 06 **POLICIES AND PROCEDURES** (cont.)

103.06-2 **Supervision By a Physician**

 The responsible supervising physician, or other suitably licensed practitioner, to the extent required by applicable state laws or regulations, whose presence at the clinic is not required at all times, must:

1. always be available through telecommunication for consultation, assistance or referral;

2. supervise the services of the clinic's medical staff providing services under the responsible physician supervisory agreement;

3. supervise nurses and other auxiliary medical staff providing services or supplies; and

 4. review, approve, cosign and date the medical records of members seen by the clinic's medical staff practicing under the physician's supervision.

103.06-3 **Member Records**

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

A. the member's name, address, and birth date;

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

C. a description of the findings from the physical examination;

D. long and short range goals, as appropriate;

E. a description of any tests ordered and performed and their results;

F. a description of treatment or follow-up care and dates scheduled for revisits;

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

H. any recommendations for and referral to other sources of care;

I. the dates on which all services were provided; and

J. written progress notes, which shall identify the services provided and progress toward achievement of goals.

K. For members receiving mental health services, the following additional record-keeping requirements apply:

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

1. **Initial Assessment/Clinical Evaluation**. An initial assessment, which must include a direct encounter with the member, and his/her family if appropriate, shall be performed and included in the member's RHC record. The assessment must include the member's medical and social history and must include the member's diagnosis and the professional who made the diagnosis and that person's credentials.

2. **Individual Treatment/Service Plan**. An individual treatment/service plan must be developed by the third mental health visit. This individual treatment/service plan shall be in writing and shall identify mental health treatment needs, and shall delineate all specific services to be provided, the frequency and duration of each service, the mental health personnel who will provide the service, and the goals and/or expected outcomes of each service. Treatment plans must be reviewed and approved by a psychiatrist, physician, psychologist, or licensed clinical social worker, licensed clinical professional counselor or advanced practice psychiatric and mental health nurse, or a registered nurse certified in the specialized field of mental health within thirty (30) days of entry of the member into mental health treatment.

3. Written treatment or progress notes shall be maintained in chronological order, and shall be made for each mental health visit. These notes shall identify who provided the service, the provider's credentials, on what date the service was provided, its duration, and the progress the member is making toward attaining the goals or outcomes identified in the treatment plan.

4. 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.).

5. In cases where RHC mental health services are needed in excess of two hours per week to prevent hospitalization, documentation must be included in the file and signed by a psychiatrist, physician, psychologist, licensed clinical social worker, licensed clinical professional counselor, clinical nurse specialist, or a registered nurse certified in the specialized field of mental health.

6. **Discharge/Closing Summary**. A closing summary shall be signed and dated and included in the clinical record of discharge treatment and outcome in relation to the individual treatment/service plan

7. In the event a member receives group services, there shall be no names of other group participants in the member's record.

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

Entries are required for each service billed and must include the name, credentials, and signature of the service provider. See Chapter I of the *MaineCare Benefits Manual* for additional record keeping requirements.

Physician supervision must be performed in accordance with the Maine Board of Licensure in Medicine or the Maine Board of Licensure in Osteopathy requirements.

103.06-4 **Program Integrity**

See Chapter I of the *MaineCare Benefits Manual*.

103.07 **REIMBURSEMENT**

103.07-1 **General Reimbursement**

RHCs are reimbursed in accordance with the requirements of section 702 of the *Benefits Improvement and Protection Act (BIPA) of 2000*, including requirements for a Prospective Payment System.

Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor, clinical nurse specialist, or a registered nurse certified in the specialized field of mental health, on the same day. An additional visit of any kind will only be reimbursed for unforeseen circumstances as documented in the member’s record.

Additional clinic visits required in the member’s treatment plan that do not qualify as clinic visits for reimbursement purposes, such as a visit for venipuncture only, are non-billable and are included in the RHC’s cost based reimbursement.

103.07-2 **PPS Reimbursement Methodology**

 A. **Initial PPS Rates and Annual Adjustments**

Effective January 1, 2020, Rural Health Clinics can choose to be reimbursed on the basis of 100% of the average of their reasonable costs of providing MaineCare-covered services during: (a) calendar years 1999 and 2000 with historical Medicare Economic Index (MEI) adjustments; or (b) calendar years 2016 and 2017. The resulting average will be adjusted to take into account any increase or decrease in the approved scope of services furnished during the provider’s fiscal year 2001 (for choice (a)), or 2018 (for choice (b)), respectively (calculating the amount of payment on a per visit basis).\*

103.07 **REIMBURSEMENT** (cont.)

At the start of each subsequent year, beginning in CY 2002 (for choice (a)) or CY 2021 (for choice (b)), each RHC is entitled to the payment amount (on a per visit basis) to which the clinic was entitled under the Act in the previous fiscal year, inflated by the percentage increase in the MEI for primary care services, and adjusted to take into account any increase or decrease for a MaineCare approved “change in scope of services.” \*

**\* The Department submitted to CMS and anticipates approval of a State Plan Amendment (SPA) related to these provisions.**

Newly qualified RHCs after state fiscal year 2017 will have initial payments (calculated on a per visit basis) established either by reference to payments to other RHCs in the same or adjacent areas with similar caseload, or in the absence of such other RHCs, through cost reporting methods. Cost reports must accurately reflect the costs of the individual RHC (i.e. may not be a consolidated report of multiple sites or organizations that is not able to distinguish RHC costs.) For each fiscal year following the initial year, payment shall be adjusted for MEI and approved “change in scope of services.” This applies to each new RHC site or location with a separate National Provider Identifier that is opening for the first time, regardless of affiliation to an existing organization, and regardless of previous service delivery.

B. **“Change in Scope of Services” Requests and Adjustments**

A “change in the scope of services” refers to a change in the overall picture of a RHC’s services through a change in the type, intensity, duration and/or amount of services.

The following examples are offered as guidance to RHCs to facilitate understanding of the types of changes that may be recognized as a “change in scope of services.” These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of “change of scope of services.”

1. The addition of a new covered service or deletion of an existing covered service that is present in the existing PPS rate. Covered services are those which meet the definition of RHC services as provided in section 1905(a)(2)(B) of the *Social Security Act*;
2. The addition of a new professional staff (i.e. employed or contracted) who is licensed to perform a covered service that no current professional staff is licensed to perform;
3. A change in the intensity of a service that fundamentally alters the service delivery model and increases or decreases the quantity of labor and materials consumed by an individual during an average encounter. This change may be attributed to changes in the types of patients served.

103.07 **REIMBURSEMENT** (cont.)

An increase or decrease in “scope of services” does not necessarily result from any of the following (although some of these changes may occur in conjunction with a “change in scope of services”):

1. A change in the cost of providing an existing service;
2. A change of ownership;
3. A change in status between free-standing and provider-based;
4. The expansion of an existing service to a new population;
5. The expansion of the RHC to a new site which provides the same services;
6. The addition or reduction of staff members to or from an existing service;
7. A change in office hours; or,
8. An increase or decrease in the number of encounters.

It is the RHC’s responsibility to notify the Department of any “change in the scope of services” and provide proper documentation to support the rate change request. The RHC must submit either at least six (6) months of actual cost data for changes that have already taken place, or twelve (12) months of projected costs for anticipated changes.

When an RHC submits projected costs for an anticipated change in the scope of services that amounts to a PPS rate change that is greater than or equal to five percent (5%), the Department may request data from the RHC when at least six (6) months of actual data becomes available for a rate review and adjustment as determined by the Department. The RHC must also submit a narrative describing the change. Requests for a rate adjustment based on a prior change must be received no later than one hundred and fifty (150) days after the RHC’s fiscal year end in which the “change in scope of services” occurred. The Department will respond with a decision to a rate adjustment request within sixty (60) days of receiving a completed application. An application is considered complete when the Department confirms that it has received all the information needed to process the application.

Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate beginning with services provided the first day of the month immediately following either the date the Department approves the “change in scope of services” adjustment or the date an anticipated change will begin, whichever is later.

 103.08 **COPAYMENT**

 Providers will charge a copayment to each MaineCare member receiving services, unless exempt per the provisions of Chapter I of the *MaineCare Benefits Manual*. Effective August 1, 2014, no copayment shall be charged for tobacco cessation treatment services. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

 **MaineCare Payment for Service Member Copayment**

 $10.00 or less $ .50

 $10.01 - 25.00 $1.00

 $25.01 - 50.00 $2.00

 $50.01 or more $3.00

 The member shall be responsible for copayments up to $30.00 per month whether the copayment has been made or not. After the $30.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for Covered Services. Providers are subject to the Department’s copayment requirements. Refer to Chapter I, “General Administrative Policies and Procedures”, for rules governing copayment requirements, exemptions and dispute resolution.

103.09 **BILLING INSTRUCTIONS**

 In accordance with Chapter I, Section 1, of the *MaineCare Benefits Manual*, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, worker's compensation, etc.) that are available to pay for the rendered service, and to seek payment from such resources prior to billing MaineCare.

If a member has third party coverage other than MaineCare, and if that third party carrier requires a co-pay but makes no fee-for-service payment in order to cover Rural Health Clinic Services, MaineCare reimbursement will be limited to the amount of the co-pay alone.

Providers billing for RHC services must bill using standard CPT and HCPC procedure codes as detailed in Chapter III, Section 103, Table 1. For Core Services, as described under Covered Services-Section 103.04, providers must bill the code T1015 and include the appropriate revenue codes. When billing, providers must use a UB 04 claim form. Effective October 1, 2010, in addition to billing the code T1015 for Core and Ambulatory Services, providers must also report all services provided including all procedures with the standard CPT and HCPCS codes on the UB 04 claims form for reporting purposes.

RHCs have the option of obtaining a separate MaineCare provider billing number for the limited purpose of fee-for-service billing and reimbursement for such services as X-ray, EKG, inpatient hospital visits and other Medicare defined non-RHC Services that are billable under Medicare Part B.

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 17, 2025