DATE: November 13, 2014

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: 10-144 Chapter 101, MaineCare Benefits Manual, Chapter II, Section 15, Chiropractic Services

The Department is proposing to change the limit calculation methodology from “rolling year” to a calendar year for purposes of clarity. This rule also proposes to remove the current hard cap of 12 visits per year and allow for additional visits when medically necessary. The Department proposes to impose a prior authorization requirement for additional visits for members over the age of twenty-one (21).

In addition, the proposed changes clarify the types of medical providers that are required to be involved in determining a member’s eligibility for Chiropractic Services.

If approved by the Centers for Medicare and Medicaid (CMS), x-ray services that are medically necessary for diagnosis and treatment of a subluxation shall be a covered service in Section 15. This rulemaking proposes language that explains the reimbursement for chiropractic x-rays. X-ray services provided through this section do not require prior authorization.

Finally, the Department proposes to make a number of technical changes in an effort to provide clarity and eliminate duplicative language. These proposed changes include the elimination of Sec. 15.04 “Specific Eligibility for Care”; elimination of the reference to the Division of Program Integrity (Sec. 15.08); and elimination of other unnecessary language regarding reimbursement, co-pays, and dispute resolution.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services

RULE TITLE OR SUBJECT: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 15, Chiropractic Services

PROPOSED RULE NUMBER:

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THIS RULE WILL NOT HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 MRSA §§ 42, 3173

DATE AND PLACE OF PUBLIC HEARING:
Date: December 1, 2014
Time: 8:30 a.m.
Location: Large Conference Room #110
Department of Health and Human Services
19 Union Street, Augusta, ME 04333

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before Monday, November 17, 2014.

DEADLINE FOR COMMENTS: Comments must be received by midnight on Thursday, December 11, 2014

AGENCY CONTACT PERSON: Debbie Walsh, CHPII, Policy Writer
AGENCY NAME: MaineCare Services
ADDRESS: 242 State Street, 11 State House Station
Augusta, Maine 04333-0011
EMAIL: Debbie.Walsh@maine.gov
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E-MAIL FOR OVERALL AGENCY RULE-MAKING LIAISON: kevin.wells@maine.gov
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15.01 **PURPOSE**

The Department’s purpose for this rule is to provide medically necessary chiropractic services to MaineCare members who are adults (age twenty-one (21) and over) with rehabilitation potential, and medically necessary chiropractic services to MaineCare members who are under age twenty-one (21).

15.02 **DEFINITIONS**

15.02-1 **Chiropractic Services** are those services provided to a member by a licensed chiropractor.

15.02-2 **Chiropractor** is an individual who both is licensed by the state or province in which he/she provides chiropractic services and meets uniform minimum standards promulgated by the Secretary of Health and Human Services under 42 U.S.C. §1395 X (r) and 42 CFR 440.60.

15.02-3 **Rehabilitation Potential** is a documented expectation by the member’s *Primary Care Physician*, Provider or prescribing provider (Medical Doctor (MD), Doctor of Osteopathic (DO), Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)), who is licensed and acting within the scope of his or her *license indicating* that the member’s condition will improve significantly in a reasonable, predictable period of time as a result of the prescribed treatment plan. The physician’s documentation of rehabilitation potential must include the reasons used to support this expectation. New rehabilitation potential documentation must be reauthorized per episode of unrelated conditions.

15.02-4 **Prior Authorization (PA)** is the process of obtaining prior approval as to the medical necessity and eligibility for certain MaineCare services before they are delivered, as set forth herein and in Chapter I, Section 1 of the MaineCare Benefits Manual (MBM).

15.03 **ELIGIBILITY FOR CARE**

A. Individuals must meet the financial, residency and 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 *primary care provider or prescribing provider (MD, DO, PA, or APRN)* who is licensed and acting within the scope of his or her *license* to verify a member’s eligibility for MaineCare, as described in Chapter I, Section 1 of the MaineCare Benefits Manual “MBM”, prior to providing services.

15.04 **SPECIFIC ELIGIBILITY FOR CARE**

B. Covered services for members of all ages must be medically necessary, as determined by his or her *primary care provider or prescribing provider (MD, DO, PA, or APRN)* in an *initial evaluation*. The Department or its authorized agent has the right to perform eligibility
15.03 **ELIGIBILITY FOR CARE (cont.)**

determination and/or utilization review to determine if services provided were medically necessary.

**C.** Adult members (age twenty-one (21) and over) must obtain a referral have an initial evaluation by his or her physician or primary care physician provider or prescribing provider (MD, DO, PA, or APRN), who is licensed and acting within the scope of his or her license that documents the member's rehabilitation potential. The provider’s documentation of rehabilitation potential must include the reasons used to support this expectation. New rehabilitation potential documentation must be re-authorized per episode of unrelated conditions.

This referral requirement will not apply to members with Medicare coverage or other third party health insurance while meeting a deductible. This referral requirement will also not apply to members with Medicare coverage or other third party health insurance until the coverage for chiropractic services by the other payer has been exhausted.

15.0504 **COVERED SERVICES**

The Department can shall make payment for covered services that are specifically included in the Department's MBM, Chapter III, Section 15, Allowances for Chiropractic Services. Covered services are limited to the following:

A. Manual or mechanical manipulation of the spine must be medically necessary and indicate a diagnosis must indicate a of subluxation. Separate reimbursement for an examination/diagnosis will not be made.

B. If the Centers for Medicare and Medicaid (CMS) approves, Xx-ray services that are medically necessary for diagnosis and treatment of a subluxation.

15.0605 **NON-COVERED SERVICES**

MaineCare reimbursement shall cover only x-rays of the spine. Xx-rays that are not of the spine are Non-Covered services. Any service not described and/or listed in Chapters II and III, Section 15, is considered a non-covered service.

15.0706 **LIMITATIONS**

A. Reimbursement for acute and chronic care episodes for MaineCare members ages twenty-one (21) and over shall be strictly limited to twelve (12) visits per rolling calendar year and based upon medical necessity. For services beyond twelve (12) visits, all eligible MaineCare members twenty-one (21) and over require prior authorization as indicated in Section 15.07-2 (B). Medical necessity must be supported and documented in accordance with criteria defined in Section 15.0807-3, Member
15.06 LIMITATIONS (cont.)

Records. The Department reserves the right to request additional information to evaluate medical necessity.

B. Reimbursement and limitations on the number of x-rays will be based upon the criteria of medical necessity and documentation as specified in Section 15.08-3 15.07, Member Records, Policies and Procedures.

C. When repeat x-ray examinations of the same body part and spine for the same condition are required because of technical or professional error in the original x-rays, such repeat x-rays are not a covered service and are not reimbursable by MaineCare.

15.087 POLICIES AND PROCEDURES

15.087-1 Diagnosis

A. The diagnosis of subluxation must be demonstrated by a recent x-ray or a recent examination documenting a clinical manifestation of a subluxation.

B. A recent examination must include but is not limited to the examinations listed below:

1. Mensuration;
2. Biomechanical Evaluation;
3. Neurological Evaluation;
4. Kinesiological Evaluation; and
5. Orthopedic Evaluation.

C. Examination by observation and palpation (static and/or dynamic) will be accepted as fulfilling the requirements of Section 15.0807-1(A) above if all other examinations listed in Section 15.0807-1(B) above have been performed and abnormal findings are absent.

D. Recent examination and/or x-ray are interpreted to mean an examination or x-ray was made within thirty (30) days prior to the initiation of treatment.

If for any reason a course of treatment is discontinued for a period longer than one (1) year, re-examination is required for treatment to be a covered service following the guidelines specified in section 15.03 Eligibility of Care.
15.07 POLICIES AND PROCEDURES (cont.)

E. MaineCare members who also qualify for Medicare shall meet the diagnostic requirements of the Medicare program.

15.087-2 Treatment Exceeding Six (6) Months Twelve (12) visits per calendar year

Ongoing treatments require justification in the form of a recent examination or x-ray documenting a clinical manifestation of subluxation six (6) months after treatment first begins and every twelve (12) months thereafter. Recent examinations or x-rays used to justify treatment that exceeds six (6) months in duration, must fulfill the requirements of Section 15.08-1. The results of these examinations or x-rays should be made a part of the member record.

A. For all eligible MaineCare members requiring Covered Services herein beyond twelve (12) visits per calendar year, a primary care provider or prescribing provider (MD, DO, PA, or APRN), who is licensed and acting within the scope of his or her license, must provide a referral describing the medical necessity of Covered Services beyond twelve (12) visits per calendar year.

The Chiropractor must submit documentation to support the medical necessity of treatment exceeding twelve (12) visits per calendar year. This should include full clinical data, x-rays, progress notes, or other documentation to support the medical necessity for additional Covered Services.

B. In addition to the requirements of subpart (A), for all eligible members age twenty-one (21) and over, Prior Authorization is required before the delivery of any additional Covered Services beyond twelve (12) visits per calendar year.

C. X-ray services do not require Prior Authorization.

15.087-3 Member Records

The Department requires a specific record for each member that includes but is not limited to:

A. The member’s name, address, birthdate, and MaineCare I.D. number.

B. The member’s social and medical history, and diagnoses.

C. A personalized plan of service including (at a minimum):

1. Type of chiropractic services needed;
15.07 POLICIES AND PROCEDURES (cont.)

2. How the services can best be delivered, and the provider who will deliver the services;

3. Frequency of services and expected duration of services;

4. Long and short range goals;

5. Plans for coordination with other health service providers for the delivery of services and the transfer of x-rays, if needed; and

6. Documentation of x-ray findings or results of the examinations described in 15.0807-1 (Diagnosis) supporting the medical necessity of the services to be delivered.

See Chapter I of the MBM for additional documentation requirements.

D. The physician or primary care provider’s documentation of an adult member’s rehabilitation potential.

E. Written progress notes that must be maintained and includes:

1. The name of the provider, a full description of the condition, and the date of each service provided;

2. Any progress toward the achievement of established long and short-range goals;

3. The signature of the servicing provider for each service; and

4. A full account of any unusual condition or unexpected event, including the date when it was observed.

The Department requires entries to be made for each service billed. When the services delivered vary from the plan of care, entries in the member’s record must justify the changes.

15.08.4 The Division of Program Integrity

Please see the MBM, Chapter I, General Administrative Policies and Procedures for information on the Division of Program Integrity.

15.09.08 REIMBURSEMENT

A. The payment amount for services rendered shall be the lowest of the following:
15.08 REIMBURSEMENT (cont.)

A. The amount listed in the "Allowances for Chiropractic Services," Chapter III, MBM; or

B. The lowest amount allowed by the Medicare Part B carrier; or

C. The provider's usual and customary charge; or

D. The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set in Chapter I of the MBM. MaineCare considers a claim paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

E. If CMS approves, payment for x-ray services rendered medically necessary for diagnosis and treatment of a subluxation shall be: the lowest of the amounts set forth in 15.08 (A)-(C); OR, the fee for service rate is set at seventy (70%) of the lowest level in the 2009 Medicaid fee schedule for Maine area “99” for services under this policy, including adjustments for place of service and modifiers;

B. In accordance with Chapter I of the MBM, 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, or other liable third parties) that are available for payment of the rendered service, and to bill that potential payor prior to billing MaineCare.

C. Please refer to Chapter I of the MBM for reimbursement criteria for interpreter services.

15.1009 COPAYMENT

15.10-1 Copayment Amount

A. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

<table>
<thead>
<tr>
<th>MaineCare Payment for Service</th>
<th>Member Copayment</th>
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</thead>
<tbody>
<tr>
<td>$10.00 or less</td>
<td>$ .50</td>
</tr>
<tr>
<td>$10.01 - 25.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>$25.01 or more</td>
<td>$2.00</td>
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</tbody>
</table>
15.09 COPAYMENT (cont.)

B. The member shall be responsible for copayments up to $20.00 per month whether the copayment has been paid or not. After the $20.00 cap has been reached, the member will not be required to make additional copayments and the provider will receive full MaineCare reimbursement for covered services.

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

D. Providers are responsible for documenting the amount of copayments charged to each member regardless of whether the member has made payment.

15.10-2 Copayment Exemptions and Dispute Resolution

Refer to the MBM, Chapter I, General Administrative Policies and Procedures for copayment exemption and dispute resolution policies.

15.10.10 BILLING INSTRUCTIONS

A. Providers must bill in accordance with the Department's current Billing Instructions.

B. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.