DATE: June 14, 2016
TO: Interested Parties
FROM: Stefanie Nadeau, Director, MaineCare Services
SUBJECT: Proposed Rule: MaineCare Benefits Manual (MBM), Chapters II and III, Section 103, Rural Health Clinic Services

This letter gives notice of a proposed rule: MBM, Chapters II and III, Section 103, Rural Health Clinic Services (RHCs). This rule proposes more specific guidance around the rate setting and adjustment processes for the Prospective Payment System (PPS) used in Rural Health Clinic Services’ (RHC) reimbursement.

The payment methodology for RHCs conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. According to this methodology, RHCs are reimbursed based on average reasonable costs of providing MaineCare scope of services during calendar years 1999 and 2000, adjusted annually by the Medicare Economic Index (MEI) for primary care services, and also adjusted to take into account any increase or decrease based on Department approved “change in scope of services.”

The Department proposes to outline the types of changes that may or may not be eligible for a rate adjustment based on a “change in scope of services” request, and includes examples as guidance. In addition, MaineCare proposes to change the data requirements for submitting a “change in scope of services” request. Adjustments to the PPS rate will be effective 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.

The Department also proposes to amend the current process for establishing rates for newly qualifying RHCs. Currently, newly qualifying sites have PPS payments established by reference to payments to other RHCs in the same or adjacent areas, or in the absence of such other centers, through cost reporting methods. This proposed change would require that reference sites must also have a “similar caseload” in order to provide a basis for the new RHC’s rate.

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

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapters II and III, Section 103, Rural Health Clinic Services

PROPOSED RULE NUMBER:

CONCISE SUMMARY: This proposed rule amends the rate setting and rate-adjustment processes for the Prospective Payment System (PPS) used to reimburse Rural Health Clinic Services (RHCs).

This rulemaking clarifies and expands the current RHC policy and procedures as follows:

- Provides additional guidance in the methodology for adjustments of PPS rates;
- Amends the process of rate establishment for newly qualifying RHCs;
- Provides specific guidance in what constitutes “a change in scope of services”; and
- Expands the reporting requirements to support requests for rate adjustments due to a change in scope of services.

The Centers for Medicare and Medicaid Services (“CMS”) has approved a Maine State Plan Amendment related to initial rate-setting and “change in scope of services.” The payment methodology for RHCs conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.


STATUTORY AUTHORITY: 22 M.R.S. §§ 42, 3173

PUBLIC HEARING:

Date: Tuesday, July 12, 2016
Time: 1:00 p.m.
Location: 19 Union St., Room 110, Augusta, ME

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before July 5, 2016.

DEADLINE FOR COMMENTS: Comments must be received by 11:59 p.m., July 22, 2016

AGENCY CONTACT PERSON: Anne Labonte Perreault, Comprehensive Health Planner II
  [Anne.Labonte-Perreault@maine.gov](mailto:Anne.Labonte-Perreault@maine.gov)

AGENCY NAME: MaineCare Services

ADDRESS:
242 State St.
11 State House Station
Augusta, Maine  04333-0011

TELEPHONE: 207-624-4082  FAX: (207) 287-1864
TTY: 711 (Deaf or Hard of Hearing)

IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department does not anticipate this rulemaking will have any impact on municipalities or counties.
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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.
103.01 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.

103.04 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
6. 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 self-management services are reimbursable if they are based on the Open Airways or Breathe Easter 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.
Each asthma self-management service must have:

1. physician advisor;

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

3. 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 self-management services 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 American Diabetes Association (ADA) 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 service 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
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 Smoking Cessation Counseling will be reimbursed, for eligible Members, provided by physicians or other providers who can provide smoking tobacco cessation counseling under their licenses or permits. There are no annual or lifetime limits on smoking tobacco cessation counseling services. These 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 Smoking cessation counseling may be billed alone, or in combination with other RHC services. Documentation of the smoking tobacco cessation counseling must be contained in the medical record. Documentation must include:

1. A nicotine or tobacco dependence code from the applicable version of the International Classification of Diseases (ICD) Manual required by CMS, on the date the service is delivered. Providers can check the Department’s website at https://mainecare.maine.gov/ProviderHomePage.aspx to determine which version of the ICD Manual is being utilized;

2. An assessment of the member’s willingness to quit smoking, or of his or her progress in quitting;

3. Documentation of any ongoing barriers to quitting or staying tobacco-free;

4. A brief outline of whatever motivational or educational information was provided; and

5. The name and license level of person providing the smoking cessation services.

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 or province 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 or provincial 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.
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.

A. Provider based clinics are reimbursed in accordance with the Medicare Principles of Reimbursement which apply to the hospital, nursing facility, or home health agency to which the clinic is attached.

B. Independent clinics are reimbursed at a per unit of service rate established by the Medicare fiscal intermediary.

103.07.2 PPS Reimbursement Methodology

C. Effective January 1, 2001, Rural Health Clinics will be reimbursed on the basis of 100% of the average of their reasonable costs of providing MaineCare-covered services during calendar years (CY) 1999 and 2000, adjusted to take into account any increase or decrease in the approved scope of services furnished during the provider’s fiscal year 2001 (calculating the amount of payment on a per visit basis).

At the start of each subsequent year, beginning in CY 2002, 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 Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in any rate adjustment for a MaineCare approved “change in scope of services.” changes furnished during that fiscal year. Until the initial new payment rate is calculated according to this methodology, Rural Health Clinics will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated.
103.07 REIMBURSEMENT (cont.)

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 RHC centers in the same or adjacent areas with similar caseload, or in the absence of such other RHC centers, 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, After the initial year, payment shall be set using the MEI methods used for other clinics, 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.

D—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.

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.

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.
103.07 REIMBURSEMENT (cont.)

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.

E. 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.

103.08 COPAYMENT

A. 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 smoking cessation counseling. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

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<th>MaineCare Payment for Service</th>
<th>Member Copayment</th>
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<td>$2.00</td>
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<tr>
<td>$50.01 or more</td>
<td>$3.00</td>
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</table>

B. 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.
103.09 **BILLING INSTRUCTIONS** (cont.)

Upon the implementation of MIHMS, 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.

A. **Ongoing billing instructions**

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 clinic’s cost based reimbursement.

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.

RHC Clinics 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.
<table>
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<th>PROCEDURE CODE/REVENUE CODE</th>
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<th>UNIT OF SERVICE</th>
<th>MAXIMUM ALLOWANCE</th>
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<td>T1015 0521</td>
<td>CLINIC VISIT/ENCOUNTER, ALL INCLUSIVE</td>
<td>PER VISIT</td>
<td>BY REPORT</td>
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<td>T1015 HE 0521</td>
<td>CLINIC VISIT/ENCOUNTER, ALL INCLUSIVE</td>
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<td>T1015 0525</td>
<td>VISIT TO SNF (NON-COVERED*)</td>
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<td>DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, INDIVIDUAL, PER 30 MINUTES</td>
<td>30 MINUTES</td>
<td>BY REPORT</td>
</tr>
<tr>
<td>PROCEDURE CODE/REVENUE CODE</td>
<td>DESCRIPTION</td>
<td>UNIT OF SERVICE</td>
<td>MAXIMUM ALLOWANCE</td>
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<td>G0109</td>
<td>DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, GROUP SESSION (2 OR MORE) PER 30 MINUTES</td>
<td>30 MINUTES</td>
<td>BY REPORT</td>
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<td>0521</td>
<td>RURAL HEALTH CLINIC</td>
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<tr>
<td>99406</td>
<td>SMOKING AND TOBACCO CESSATION COUNSELING; INDIVIDUAL, INTERMEDIATE</td>
<td>3-10 MINUTES</td>
<td>$8.67</td>
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<tr>
<td>0521</td>
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<tr>
<td>99407</td>
<td>SMOKING AND TOBACCO CESSATION COUNSELING; INDIVIDUAL, INTENSIVE</td>
<td>GREATER THAN 10 MINUTES</td>
<td>$16.81</td>
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<td>RURAL HEALTH CLINIC</td>
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<tr>
<td>99411S9453</td>
<td>SMOKING CESSATION[TOBACCO CESSATION] PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE), APPROXIMATELY 30 MINUTES</td>
<td>PER SESSION</td>
<td>$20.00 $11.54</td>
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<td>0521</td>
<td>RURAL HEALTH CLINIC</td>
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<td>99412</td>
<td>[TOBACCO CESSATION] PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES</td>
<td>PER SESSION</td>
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<td>RURAL HEALTH CLINIC</td>
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<td>G0008</td>
<td>ADMINISTRATION OF INFLUENZA VIRUS VACCINE</td>
<td>PER UNIT</td>
<td>$5.00</td>
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<tr>
<td>G0009</td>
<td>ADMINISTRATION OF PNEUMOCOCCAL VACCINE</td>
<td>PER UNIT</td>
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## Section 103

### Rural Health Clinic Services

<table>
<thead>
<tr>
<th>MODIFIERS</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>GT</td>
<td>VIA INTERACTIVE AUDIO AND VIDEO TELECOMMUNICATION SYSTEMS</td>
</tr>
<tr>
<td>HE</td>
<td>BEHAVIORAL HEALTH</td>
</tr>
<tr>
<td>SL</td>
<td>STATE SUPPLIED VACCINE</td>
</tr>
<tr>
<td>UF</td>
<td>SERVICES PROVIDED IN THE MORNING (6 A.M. TO 11:59 A.M.)</td>
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<tr>
<td>UG</td>
<td>SERVICES PROVIDED IN THE AFTERNOON (12 P.M. TO 5:59 P.M.)</td>
</tr>
<tr>
<td>UH</td>
<td>SERVICES PROVIDED IN THE EVENING (6 P.M. TO 11:59 P.M.)</td>
</tr>
<tr>
<td>UJ</td>
<td>SERVICES PROVIDED AT NIGHT (12 A.M. TO 5:59 A.M.)</td>
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