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DATE: June 18, 2019

TO: Interested Parties

FROM: Michelle Probert, Director, MaineCare Services

SUBJECT: Emergency Adoption: Chapter 101, MaineCare Benefits Manual, Section 90, Chapter II, Physician Services

This letter gives notice of an emergency rulemaking that eliminates transsexual procedures from the list of non-covered services in Section 90.07. Elimination of this prohibition on transsexual medical procedures complies with Section 1557 of the Affordable Care Act (ACA) (Pub. L. 111-148, Title I, Sec. 1557), as codified in 42 USC Sec. 18116 and its enabling regulation, 45 C.F.R. Part 92, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.

Pursuant to 5 M.R.S. Section 8054, the Department has determined that immediate adoption of this rule is necessary to avoid an immediate threat to public health, safety, or general welfare by immediately removing the access barrier for transgender individuals that the current language creates. The Department is promptly following this emergency rulemaking with proposed rulemaking.

Rules and related rulemaking documents may be reviewed at and printed from 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.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

Notice of Agency Rule-making Adoption

EMERGENCY RULE

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Section 90, Chapter II, Physician Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This emergency rulemaking eliminates transsexual procedures from the list of non-covered services in Section 90.07. Elimination of this prohibition on transsexual medical procedures complies with Section 1557 of the Affordable Care Act (ACA) (Pub. L. 111-148, Title I, Sec. 1557), as codified in 42 USC Sec. 18116 and its enabling regulation, 45 C.F.R. Part 92, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.

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<http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

EFFECTIVE DATE: June 18, 2019

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10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

TABLE OF CONTENTS

90.01	DEFINITIONS	1
90.01-1	Cosmetic Surgery	1
90.01-2	Elective Surgery	1
90.01-3	Physician Services	1
90.01-4	Rendering Provider.....	1
90.01-5	Supplies and Materials.....	1
90.02	ELIGIBILITY FOR CARE	1
90.03	DURATION OF CARE	1
90.04	COVERED SERVICES	2
90.04-1	Anesthesiology Services.....	2
90.04-2	Vision Services.....	4
90.04-3	Laboratory Services.....	4
90.04-4	Obstetrical Services.....	4
90.04-5	Behavioral Health Services	6
90.04-6	Medical Imaging Services	8
90.04-7	Drugs Administered by Other Than Oral Method in Office Setting	8
90.04-8	Orthopedic Shoes	9
90.04-9	Medical Supplies & Durable Medical Equipment.....	9
90.04-10	Reimbursement for Services of Interns, Residents, and Locum Tenens	9
90.04-11	Mileage.....	10
90.04-12	Preventive Services	10
90.04-13	Physician Services for Children Under Age Twenty-One (21).....	10
90.04-14	Services by Other Providers in Association with Physician Services	11
90.04-15	Interpreter Services for Members Who Are Hearing Impaired.....	12
90.04-16	Team Conferences.....	12
90.04-17	Tobacco Cessation.....	13
90.04-18	Prescriptions	13
90.04-19	Independent Procedures	13
90.04-20	Consultation and Referral.....	14
90.04-21	Immunizations, Therapeutic Injections and Hypo-sensitization	14
90.04-22	Prepaid Kits	15
90.04-23	Surgical Services	15
90.04-24	Oral and TMJ Surgery Billed with CPT Codes.....	17
90.04-25	Chiropractic Services	17
90.04-26	Occupational Therapy Services.....	17
90.04-27	Physical Therapy Services.....	18
90.04-28	Speech and Hearing Services	18
90.04-29	Topical Fluoride Varnish.....	18

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90	PHYSICIAN SERVICES	ESTABLISHED 10/15/81
		EMERGENCY RULE 6/18/19

TABLE OF CONTENTS (cont.)

90.04-30	Oral Evaluation of a Patient Under Three Years of Age.....	18
90.04-31	Podiatry Services.....	19
90.05	RESTRICTED SERVICES.....	19
90.05-1	Services Covered With Prior Authorization.....	19
90.05-1 A (1)	Out of State Services	19
90.05-1 A (2)	Vagus Nerve Stimulation.....	20
90.05-1 A (3)	Orthognathic Surgery.....	20
90.05-1 B (1)	Breast Reduction and Mastopexy	21
90.05-1 B (2)	Gastric Bypass, Gastroplasty and Adjustable Gastric Banding ...	21
90.05-1 C (1)	Breast Reconstruction.....	22
90.05-1 C (2)	Removal of Excess Skin and Subcutaneous Tissue of Abdomen	22
90.05-2	Services Covered When Special Criteria Are Met	22
90.05-2 A	Abortion Services	22
90.05-2 B	Sterilization Procedures and hysterectomies	23
90.05-2 C	Circumcision.....	28
90.05-2 D	Cochlear Implants.....	29
90.05-2 E	Cosmetic Procedures	30
90.05-2 F	Hyperbaric Oxygen Therapy	30
90.05-2 G	Infertility Treatments.....	33
90.05-3	Services Covered When Rehabilitation Potential Is Documented	34
90.06	SERVICES FOR MEMBERS IN DIFFERENT SETTINGS	34
90.06-1	Nursing Facility and Other Group Care	34
90.06-2	Outpatient Hospital Services	35
90.06-3	Inpatient Hospital Services.....	35
90.07	NON COVERED SERVICES.....	36
90.07 A	Cosmetic Surgery.....	36
90.07 B	Infertility Services.....	36
90.07 C	Other Non-Covered Services.....	36
90.08	POLICIES AND PROCEDURES	37
90.08-1	Medical Record Requirements	37
90.08-2	Evaluation and Management (EM) Services	39
90.08-3	Disclosure Requirements.....	39
90.08-4	Supplementation.....	39
90.08-5	Procedure to Request Prior Authorization.....	40
90.08-6	Program Integrity	40

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90	PHYSICIAN SERVICES	ESTABLISHED 10/15/81 EMERGENCY RULE 6/18/19
-------------------	---------------------------	--

TABLE OF CONTENTS (cont.)

90.09	REIMBURSEMENT	40
90.09-1	Fee Schedule	40
90.09-2	MaineCare Reimbursement Rate.....	41
90.09-3	Reimbursement Rate for Drugs Administered Other than Oral Method.....	42
90.09-4	Primary Care Provider Incentive Payment	42
90.09-5	Primary Care Provider Increased Reimbursement	44
90.10	BILLING INSTRUCTIONS	44

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.01 DEFINITIONS

90.01-1 Cosmetic Procedures and Surgery

Cosmetic procedures and cosmetic surgery are any procedure or surgery done primarily to improve or change appearance without improving the way the body works.

90.01-2 Elective Surgery

Elective surgery is surgery that can be scheduled in advance, is not an emergency, and, if delayed, would not result in death or permanent impairment of health.

90.01-3 Physician services

Physician services are those services provided by a licensed physician or other qualified rendering provider, within the scope of practice of his or her profession as defined by state law in the state where services are provided, or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

90.01-4 Rendering Provider

The rendering provider is the trained and appropriately licensed professional who actually renders the medical service to a member.

90.01-5 Supplies and Materials

Supplies and materials are items provided by the rendering provider, such as sterile trays, drugs, dressings, wadding, and plaster, that may be reimbursed as separate items. Providers must use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for supplies and materials, and the charges must not exceed the total acquisition costs. MaineCare does not reimburse for shipping, handling, and related costs. Requirements for financial record keeping are detailed in *MaineCare Benefits Manual* (MBM), Chapter I, Section 1.03-3.

90.02 ELIGIBILITY FOR CARE

Individuals must meet financial eligibility 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.

90.03 DURATION OF CARE

Each MaineCare member is eligible for those medically necessary covered services as set forth below. The Department reserves the right to request additional information to evaluate medical necessity.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES

A covered service is a service for which the Department may make payment. The Department covers those reasonably necessary medical and remedial services that are provided in an appropriate setting and recognized as standard medical care required for the prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary for health and well-being.

The Department will not give additional reimbursement to providers who are salaried by a hospital for services billed by the hospital and whose payment is included in the hospital cost report for services provided while a member is hospitalized as an inpatient or receiving outpatient services.

When a non-MaineCare provider covers the practice for a MaineCare provider and performs services, MaineCare will only reimburse the MaineCare billing provider. The MaineCare billing provider must maintain adequate records to document the actual rendering provider. The MaineCare billing provider is responsible for reimbursing the non-MaineCare provider.

Providers should direct any questions about coverage of particular services to the Provider Relations Unit prior to provision of the service. Providers should contact the provider relations specialist assigned to their geographic area.

90.04-1 Anesthesiology Services

A. Reimbursement of Anesthesiology Services

The Department covers anesthesiology services when personally performed or medically directed by a rendering provider appropriately licensed or certified in the state in which he or she is practicing. All anesthesiology providers must practice only within the scope of his or her licensure or certification, and qualified to deliver treatment under this Section.

- (1) Anesthesiology services include the following activities:
 - (a) Pre-operative examination and evaluation;
 - (b) Prescribing an anesthetic plan;
 - (c) Administration and monitoring of the full anesthesia service; and
 - (d) Post-anesthesia care.
- (2) Anesthesia administered by a Certified Registered Nurse Anesthetist (CRNA) must be under the supervision of the operating practitioner or of an anesthesiologist in accordance with 42 C.F.R. §482.52.
 - (a) When a physician medically directs anesthesia services, the following physician services are required for each patient:

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.04 COVERED SERVICES (cont.)

- (i) Pre-anesthetic examination and evaluation;
- (ii) Prescribing an anesthesia plan;
- (iii) Personal participation in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
- (iv) Assurance that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual in accordance with state laws;
- (v) Monitoring the course of anesthesia administration at frequent intervals;
- (vi) Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
- (vii) Provision of indicated post-anesthesia care.

The physician shall not direct more than four (4) anesthesia patients concurrently and shall not perform any other services while he or she is directing the single or concurrent services so as to not violate Section 90.04-1(A)(2)(a) above.

B. Requirements for Billing Anesthesia Services

MaineCare covers anesthesiology services by computing a price based on a basic value for each procedure, with time unit values added to administer the procedure. The Department assigns a basic value to specific procedures that require anesthesia. Time required to administer the anesthetic is then billed in one (1) minute units.

Billable anesthesia time starts when the anesthesia provider begins to prepare the patient for anesthesia services and ends when the anesthesia provider is no longer furnishing anesthesia services to the member, that is, when the member may be placed safely under postoperative care. Providers may include the time spent administering regional and local injections and placing catheters and other monitoring devices in billable time for the delivery of the anesthesia services. Providers should bill these procedures separately only when they are performed independently and not in conjunction with an anesthesia service.

MaineCare requires providers to use the latest HCPCS and Current Procedural Technology (CPT) procedure codes when billing for anesthesia services. These codes already have associated values assigned for each procedure and available modifiers to describe unusual situations. Providers should add the appropriate modifier identified in billing instructions.

MaineCare will reimburse anesthesia performed by certified registered nurse anesthetists (CRNAs) at seventy-five percent (75%) of the amount allowed for physician services.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

C. Anesthesia for Non-Surgical Services

When billing for anesthesia for all non-surgical diagnostic, medical services, or dental services, providers should bill the appropriate code for the procedure, with the appropriate anesthesia modifier to indicate that anesthesia was provided for a procedure not usually requiring anesthesia.

D. Anesthesia Administered by Operating Surgeon

MaineCare will make no allowance for topical anesthesia, local infiltration, or digital block anesthesia administered by the operating surgeon. When the surgeon provides regional or general anesthesia, the Department will reimburse for the basic anesthesia value without added time units.

90.04-2 Vision Services

Ophthalmologic procedures for diseases of the eye are covered when billed with appropriate CPT codes. Vision services must meet the guidelines detailed in MBM, Section 75, "Vision Services".

90.04-3 Laboratory Services

Allowances for laboratory procedures apply to lab services provided by physicians or by independent laboratories. Providers must be willing to participate in proficiency testing. Tests that produce an index or ratio based on mathematical calculations using two (2) or more separate results may not be billed as separate tests, i.e., A/G ratio, free thyroxine index, etc.

MaineCare reimburses for tests that are frequently done as a group (panel) on automated equipment as a group under a single code in its reimbursement rate. For any combination of these tests, providers must bill the appropriate CPT code that correctly designates the tests included in the panel. MaineCare will reimburse no more than the price of the most appropriate panel for any tests performed individually on the same day.

Please refer to MBM, Chapter II, Section 55, regarding Laboratory Services provided in a physician's office and referrals for laboratory services.

90.04-4 Obstetrical Services for Pregnant Women

A. Provider Qualifications

MaineCare reimburses for obstetric services provided to a woman who is pregnant only when provided by a provider appropriately licensed or certified in the state in which he or she practices, practicing within their scope of that licensure or certification, and qualified to deliver services under this Section. Providers are expected to engage in collaborative management of individual

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

members with appropriate consultation, referrals, and transfers of care including, but not limited to, transfer of care for the purpose of specialized treatment and admission to an approved MaineCare hospital, with such treatment including maternity services.

B. Obstetrical Services

Obstetrical care services include antepartum care, delivery, postpartum care, and other services normally provided in uncomplicated maternity care. Antepartum care includes usual prenatal services (e.g., initial and subsequent history, physical examination, recording of weight, blood pressure, fetal heart tones, maternity counseling, etc.).

Delivery includes management of labor and vaginal delivery (with or without episiotomy, with or without forceps), or cesarean section, and resuscitation of newborn infant when necessary. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, including routine postpartum visits.

MaineCare covers treatment of medical complications of pregnancy (e.g., toxemia, cardiac problems, neurological problems, etc.) or other problems requiring additional or unusual services and requiring hospitalization.

When a non-MaineCare provider covers the practice for a MaineCare provider and performs obstetrical services, MaineCare will only reimburse the MaineCare billing provider. The MaineCare billing provider must maintain adequate records to document the actual rendering provider. The MaineCare billing provider is responsible for reimbursing the non-MaineCare provider.

C. Reimbursement for Obstetrical Care

MaineCare provides two methods for maternity care billing, global charge basis or per service charge basis. Providers may choose only one (1) of the two (2) methods for each delivery as set forth below:

- i. **Global charge basis.** Several procedure codes are all-inclusive of delivery, antepartum, and postpartum care and can be used to bill one all-inclusive charge following the member's delivery. Providers may not bill a global charge for patients who were not MaineCare eligible during the entire pregnancy.

Providers may bill total maternity care codes (global charge basis) only in those instances where the provider performs each of the components of maternity care, and only if eight (8) or more visits over a period of at least four (4) months are provided during the antepartum phase of maternity care. Providers may bill maternity related office visits in excess of eleven (11) visits in addition to the global code.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.04 COVERED SERVICES (cont.)

- ii. Per service charge basis. Providers may bill on per service basis for maternity care.

90.04-5 Behavioral Health Services

MaineCare covers behavioral health services as defined below when provided by an individual appropriately licensed or certified in the state in which he or she practices, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section.

A. Covered Services

The Department reimburses for behavioral health services as defined below. When the same provider performs two (2) services for the same member on any one day, MaineCare will reimburse for only one (1) service, at the higher payment rate of the two (2) services.

Providers must use appropriate CPT codes when providing psychotherapy services. MaineCare members receiving psychotherapy services under this section of the *MaineCare Benefits Manual* are ineligible to receive comparable or duplicative services, during the same time period, except as otherwise noted in MBM, Chapter II, Section 14, “Advanced Practice Registered Nurse (APRN) Services”, Chapter II, Section 45, “Hospital Services”, Chapter II, Section 65, “Behavioral Health Services”, or Chapter II, Section 46, “Psychiatric Facility Services”.

MaineCare reimburses for the following services:

1. Medication management or drug therapy, defined as the prescription by a physician of psychoactive drugs to favorably influence a present mental illness or to preclude the recurrence of a mental illness, will not be reimbursed as a separate charge if no other behavioral health service is provided; providers should bill medication management as an office visit.
2. Evaluation and Diagnosis is the formulation or evaluation of a treatment plan for the member that includes a direct encounter between the member and the provider.
3. Psychotherapy, both with the individual member and his or her family, is a method of treatment of mental disorders using the interaction between the therapist and a member or a family member in an individual or group setting to promote emotional or psychological change to alleviate mental disorder. Family therapy sessions without the member being present are

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

allowed if the purpose of the family therapy session is to address goals in the member's individual treatment plan

Providers must keep clinical records that include, but are not limited to: the member's name, address, attending physician, other providers, and the member's history, diagnosis, and treatment plan, treatment documentation, and any discharge/ closing summaries. The provider of the therapy service shall sign all entries.

4. Electro-shock Treatment i.e., the administration of a stimulating electric current to the head, affecting the brain cortex and producing a changed level of consciousness of the patient.
5. Inpatient Services, including admission, daily care, and inpatient psychotherapy.

Hospital admission is the initial hospital visit, comprehensive and complete diagnostic history and physical examination, preparation of hospital records and initiation of diagnostic and treatment services.

Daily Care, i.e., is the interval history, examination and treatment of members in an inpatient hospital setting. MaineCare will reimburse for as many inpatient hospital visits per week as are medically necessary. Providers must include a personalized plan of care in the medical record that itemizes the type of behavioral health services needed, how the service can best be delivered, short and long-range goals, and a discharge plan.

6. Psychometric Testing for diagnostic purposes to determine the level of intellectual function, personality characteristics, etc., through the use of standardized test instruments. Testing for educational purposes is not a covered service.

Psychometric testing includes the administration of the test, the interpretation of the test, and the preparation of test reports. Providers do not have to include preliminary diagnostic interviews or subsequent consultation visits in the limits or rates for psychological testing.

MaineCare limits reimbursement for psychological testing sessions to no more than four (4) hours for each test, except for the following:

1. Each Halstead-Reitan Battery is limited to no more than seven (7) hours (including testing and assessment). This test is limited to cases where there is a question of a neuropsychological deficit.
2. Testing for intellectual level is limited to no more than two (2) hours for each test.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

3. Each self-administered test is limited to thirty (30) minutes.
4. MaineCare limits reimbursement for psychometric testing to a total of four (4) hours.

90.04-6 Medical Imaging Services

Chapter II, Section 101, of the *MaineCare Benefits Manual* further details Medical Imaging Services. Medical Imaging Services are comprised of two parts, A) the professional component, and B) the administrative and technical component, and are reimbursed using a global fee unless standard modifiers are utilized to identify that only one component was provided. Providers must follow HCPCS and CPT guidelines for radiology using appropriate modifiers.

MaineCare reimburses Computerized Axial Tomography (CAT) scans of the head and full body. MaineCare does not reimburse for repeat x-ray examinations of the same body part for the same condition required because of technical or professional error in the original x rays.

90.04-7 Drugs Administered By Other Than Oral Method in the Office Setting

Drugs and biologicals must meet all the general requirements for coverage of items as incidental to a provider's services. MaineCare does not cover the dispensing of prescription and nonprescription drugs and biologicals to members.

To be reimbursable, a drug or biological must meet all of the following criteria:

1. The drug or biological cannot be self-administered;
2. It is not an immunization;
3. It is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered; and
4. It has not been determined by the Food and Drug Administration (FDA) to be less than effective.

Providers must bill following the Department's billing instructions when billing for these codes. Although drugs must have an assigned J-code to be eligible for reimbursement, providers must also indicate National Drug Code (NDC) codes on the claim in order to be reimbursed. MaineCare will not reimburse claims without both a valid J-code and NDC. MaineCare will not reimburse for provider administered drugs that are not rebateable under Section 1927 of the *Social Security Act* (42 U.S.C.A. §1396r-8(a)) and implementing CMS regulations (42 C.F.R. §447.500 *et seq.*) unless the provider obtains Prior Authorization (PA). PA procedures can be found in Chapter 1 of the *MaineCare Benefits Manual*. PA will not be granted for non-rebateable, provider administered drugs for which there are therapeutically

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

equivalent alternatives that are rebateable. Instructions for billing, a crosswalk of J-codes and a list of rebateable NDC codes are available on the MaineCare Services website at <https://mainecare.maine.gov>. Providers must bill acquisition cost only, excluding shipping and handling.

90.04-8 Orthopedic Shoes

MaineCare covers orthopedic shoes when prescribed by a provider, but they may not be billed under physician services. The provision and billing of shoes must comply with the guidelines of MBM, Chapter II, Section 60, “Medical Supplies and Durable Medical Equipment”.

90.04-9 Medical Supplies & Durable Medical Equipment

Providers may bill for those supplies needed in performing office procedures that are above and beyond what is usually used in a normal office visit. MaineCare reimburses acquisition cost only, excluding shipping and handling.

MaineCare reimburses for certain medical and durable medical equipment (e.g., essential prosthesis, braces, intermittent positive pressure breathing (IPPB) machines, oxygen, etc.) when prescribed. Providers providing this equipment must inform members of their freedom of choice to obtain these items from other suppliers. MaineCare shall not reimburse providers for both prescribing and supplying durable medical equipment to the same member unless the durable medical equipment is otherwise unobtainable or the item typically requires no maintenance or replacement during the period used by a member. If these circumstances do exist, reimbursement to the prescribing provider for also supplying an item shall be on the basis of the reasonable acquisition cost of the item to the provider.

Providers must maintain documentation of acquisition cost, including receipts and a copy of the original invoice, and make such documentation available to the Department upon request. Providers must also maintain documentation supporting the necessity of providing the supplies and/or equipment during the office visit. MaineCare shall not reimburse physicians for on-going medical supplies that are obtained through providers enrolled as Medical Supplies and Durable Medical Equipment Providers.

90.04-10 Reimbursement for Services of Interns, Residents, and Locum Tenens

MaineCare does not reimburse for services of interns and residents provided in a hospital or hospital affiliated facility or physician’s office when the cost of the services of interns and residents is included in hospital reimbursement. Residents, locum tenens and temporaries must enroll as rendering providers under a physician’s practice in order for their services to be reimbursed by MaineCare.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.04 COVERED SERVICES (cont.)

90.04-11 Mileage

Providers may bill for mileage, one-way, beyond a ten (10) mile radius of point of origin (office or home). MaineCare does not reimburse mileage for trips to a hospital, nursing facility, ICF, or residential care facility where the provider is an active member of the medical staff or where the provider has ownership.

90.04-12 Preventive Services

MaineCare reimburses for preventive and routine physical examinations for children and adults. MaineCare does not cover physical exams performed solely for the purpose of school, sports, disability benefits, life or health insurance coverage, Workers' Compensation, the Driver Education and Evaluation Program (DEEP), work, or any other reason not related to medical necessity.

Except when medically contra-indicated, immunization(s) must be given at time of examination(s) as appropriate for age and health history.

MaineCare reimburses certain preventive services when using the following guidelines:

A. For Children

MaineCare covers Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children and young adults up to the age of twenty-one (21) when performed in accordance with the Bright Futures Guidelines for Preventive Child Health Supervision. Providers who elect to enroll as an EPSDT provider must also comply with MBM, Chapter II, Section 94, "Early and Periodic Screening, Diagnosis and Treatment Services".

B. For Adults

MaineCare covers initial and periodic comprehensive health histories and examinations for adults age twenty-one (21) and older. The frequency of routine physicals for adults must not exceed one time per twelve (12)-month period. Covered screening services include, but are not limited to, those recommended by the United States Preventive Service Task Force. Providers should bill the preventive medicine evaluation and management procedure codes.

90.04-13 Physician Services for Children Under Age Twenty-one

MaineCare reimbursement is available for physician services provided to a child under age twenty-one (21) only when the provider meets at least one of the following criteria:

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

- A. Is board eligible or certified in family practice, pediatrics, or internal medicine by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or the appropriate approved specialty board of the American Osteopathic Association;
- B. Is employed by or affiliated with a federally qualified health center as defined in §1905(1)(2)(B) of the Act;
- C. Holds admitting privileges at a hospital participating in MaineCare;
- D. Is a member of the National Health Service Corps;
- E. Documents a current, formal consultation and referral arrangement with a pediatrician or family practitioner who has the certification described above in Section 90.04-13 (A) for purposes of specialized treatment and admission to a hospital; or
- F. Is an approved provider of services in a rural health center (RHC), ambulatory care clinic, or is otherwise approved as a provider under MBM, Chapter II, Section 94, “Early and Periodic Screening, Diagnosis and Treatment Services”.

90.04-14 Services by Other Providers in Association with Physician Services

When employed in a physician’s practice, services provided by the following professionals practicing within the scope of their certification and licensure are reimbursable:

- Advanced Practice Registered Nurse (APRN);
- Audiologist;
- Certified Clinical Nurse Specialist (CNS);
- Certified Nurse Midwife (CNM);
- Certified Nurse Practitioner (NP);
- Certified Registered Nurse Anesthetist (CRNA);
- Licensed Clinical Professional Counselor (LCPC);
- Licensed Clinical Social Worker (LCSW);
- Licensed Master Social Worker (LMSW);
- Licensed Professional Counselor (LPC);
- Nurse Practitioner (NP);
- Occupational Therapist (OT);
- Physician’s Assistant (PA);
- Physical Therapist (PT);
- Registered Nurse First Assist (RNFA).

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

The following criteria must be met prior to reimbursement of these services:

- A. The rendering provider must be enrolled with MaineCare as a rendering provider within the physician's practice, and must bill in accordance with MaineCare and CMS 1500 billing instructions;
- B. The rendering provider must be providing services within the scope of practice of his or her license;
- C. The rendering provider must be licensed to practice in accordance with current laws and regulations in the state in which he or she is practicing;
- D. The services must be provided under the delegation or supervision of a MaineCare enrolled physician licensed under state law to practice medicine or osteopathy. The responsible supervising physician shall be available at all times for consultation with all rendering providers identified in Section 90.04-14. MaineCare does not cover supervision of rendering providers. Consultation may occur in person, by telephone or by some other appropriate means consistent with instant communication.

Rendering providers must be an integral part of the physician's practice, and must be based within the setting/facility.

- E. Audiologists, Occupational Therapists, and Physical Therapists practicing under a physician's supervision and billing under physician's services are also subject to the provisions found in their applicable sections of the *MaineCare Benefits Manual*.

90.04-15 Interpreter Services

Please see MBM Chapter 1, Section 1.06-2 for the requirements for Interpreter services.

90.04-16 Team Conferences

MaineCare covers face-to-face medical conferences by a physician or rendering provider with an interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care when the member is not present.

MaineCare does not cover conferences between staff of the same clinic or agency or team conferences by telephone.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

90.04-17 Tobacco Cessation

MaineCare covers counseling and treatment for tobacco dependence to educate and assist members with smoking cessation.

Effective August 1, 2014, with retroactivity contingent upon the provider's compliance with MBM, Chapter I, Section 1.10-2 and 42 C.F.R. §447.45 regarding the timely submission of claims, tobacco cessation treatment shall be a covered service for all MaineCare members who currently use tobacco products and who wish to cease the use of tobacco products. Tobacco cessation treatment includes both counseling and products. These services are provided to educate and assist members with tobacco cessation. During counseling, providers must educate members about the risks of tobacco use, the benefits of quitting and assess the member's willingness and readiness to quit. Providers should identify barriers to cessation, provide support, and use techniques to enhance motivation to quit for each member. 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 90.

In addition to counseling, tobacco cessation treatment services include the provision of all pharmacotherapy approved by the Federal Food and Drug Administration for tobacco dependence treatment. Tobacco cessation products are "Covered Drugs," reimbursable pursuant to Chapter. II, Section 80.05 of the *MaineCare Benefits Manual*. MaineCare members are not required to participate in tobacco cessation counseling to receive tobacco cessation products. Members shall be provided with tobacco cessation treatment services with no annual or lifetime dollar limits, and no annual or lifetime limits on attempts to cease tobacco use.

Providers may bill these services alone or in addition to other outpatient evaluation/management services provided on the same date of service. MaineCare only reimburses separately for these additional services when used for the express purpose of counseling and/or risk factor reduction directed at tobacco addiction, and only when used in conjunction with an appropriate tobacco use disorder documented in the medical record.

90.04-18 Prescriptions

Any prescriber who has an individual DEA number must use that identifier when writing prescriptions, rather than a number assigned to an institution.

90.04-19 Independent Procedures

Providers may not bill separately for services commonly carried out as an integral part of a total service (e.g.: dipstick urinalysis). However, providers may bill separately for independent service not immediately related to other services.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

90.04-20 Consultation and Referral

MaineCare distinguishes a consultation from a referral. A consultation includes services rendered by a provider whose opinion or advice is requested by another provider for the further evaluation and or management of the member.

If the consulting provider assumes responsibility for the continuing care of the member, any subsequent services rendered by this provider are not considered to be consultation.

A referral is the transfer of the total or specific care of a member from one provider to another.

90.04-21 Immunizations, Therapeutic Injections, and Hyposensitization

When provided as part of an examination and/or treatment, MaineCare will reimburse for the services described below in addition to the office visit. However, when the only service provided is immunization, therapeutic injection, or hyposensitization the rate is all-inclusive.

A. **Immunizations:** Immunization codes include both administration of and the immunological material. Providers should report the size of the dose administered when billing for immunizations. To be reimbursed for the immunological materials, providers must bill only the acquisition cost of the serum, excluding shipping and handling, plus the appropriate code for administration of the immunization. MaineCare does not cover documentation of immunizations.

MaineCare only reimburses for the materials used for oral or intra-nasal immunizations, without an administration fee.

1. Vaccines Distributed by the State of Maine Center for Disease Control and Prevention (Maine CDC) Immunization Program

Providers should bill for administration of vaccines distributed by the Maine CDC in accordance with MaineCare Services billing instructions.

Providers administering immunizations to children ages birth through age eighteen (18) years of age, must participate in the Vaccines for Children (VFC) program. Providers who would like more information or would like to enroll in the VFC program should contact the Maine CDC's Immunization Program or visit their website at:

<http://www.maine.gov/dhhs/mecdc/infectious-disease/immunization/index.shtml>.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.04 COVERED SERVICES (cont.)

Providers should direct any questions about the administration of State supplied vaccines to the Maine CDC.

2. Vaccines Not Distributed by the Maine CDC

When not supplied by the Maine CDC, providers should bill therapeutic injections and immunizations using the proper NDC code. The charged amount for the therapeutic and immunological material must reflect the acquisition cost of the material to the provider. Providers must keep copies of invoices in their files. Any vaccine that could be obtained by distribution from the Maine CDC is not reimbursable, e.g., Measles, Mumps and Rubella (MMR).

MaineCare will only reimburse the provider fee for the administration of such a vaccine.

- B. Therapeutic injections:** Providers should consult MaineCare billing instructions to bill therapeutic injections using the proper code for the type of injection delivered. The charged amount for the therapeutic material must reflect the acquisition cost of the material to the provider.
- C. Hyposensitization:** Hyposensitization codes include allergy sensitivity testing only; the allergenic extract is billed separately.

90.04-22 **Prepaid Kits Purchased From the Maine Center for Disease Control and Prevention, Health and Environmental Testing Laboratory**

The Maine CDC, Health and Environmental Testing Laboratory has specimen kits available for use in submitting certain specimens to the State laboratory for analysis. Providers must purchase these kits from the State laboratory. When a provider uses a kit to collect a specimen from a MaineCare member, providers should notify the State laboratory of the name and MaineCare ID number of the member for whom the kit was used. The State laboratory will then bill the kit to MaineCare. A replacement kit will be sent to the provider.

90.04-23 **Surgical Services**

A. General Information

MaineCare reimburses all covered surgical procedures as global packages with post-operative periods of 0-, 10- or 90-days and according to the MaineCare Global Surgery Fee Schedule available at <https://mainecare.maine.gov>.

Allowances for surgery include payment for the following all-inclusive global-packaged services:

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

1. Pre-operative visits (except the initial consultation for major surgical services);
2. The surgery itself (including anesthesia that is not regional or general);
3. Complications following surgery which do not require additional trips to the operating room;
4. Post-operative visits during the postoperative period of surgery that are related to recovery from the surgery;
5. Post-surgical pain management by the surgeon;
6. Supplies – except for those identified as exclusions; and
7. Miscellaneous services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Some services are not included in the global surgical package and may be paid for separately. These include, but are not limited to, initial consultation or evaluation to determine the need for surgery for major surgical services, visits unrelated to the diagnosis for which the surgical procedure is performed or for complications of the surgery, diagnostic tests and procedures, clearly distinct surgical procedures during the post-operative period that are not re-operations or treatment for complications, and some critical care services unrelated to the surgery.

B. CPT Coding for Common Situations

MaineCare requires use of standard CPT codes and modifiers. Providers should consult current CPT and HCPCS publications for these modifiers. The following are examples of situations that often arise in regard to surgical procedures. Special CPT modifiers may be required for these situations:

1. **Additional Surgical Procedures:** When an additional surgical procedure is carried out within the applicable 0-, 10-, or 90-day post-operative period for a previous surgery, the post-operative periods will continue concurrently to their normal termination.
2. **Incidental Procedures:** Certain procedures are commonly carried out as an integral part of a total service and are not covered separately. When an incidental procedure (e.g. incidental appendectomy, lysis of adhesions, excision of scar, puncture of ovarian cyst) is performed through the same incision, the allowance will be for the major procedure only.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

3. **Independent Procedures:** No allowance will be made for services listed in CPT coding as "independent procedures" when they are carried out as a part of a total service. However, when such a procedure is carried out as a separate entity, not immediately related to other services, the procedure will be covered. (e.g.: cystoscopy in conjunction with bladder surgery does not warrant additional payment; cystoscopy in conjunction with hysterectomy is an independent procedure .)
4. **Multiple Surgical Procedures:** When multiple or bilateral surgical procedures are performed at the same operative setting and add significant time or complexity to patient care, the total reimbursement equals the allowance for the major procedure plus fifty percent (50%) of the allowance for the lesser procedure(s).
5. **Assistance at Surgery:** MaineCare will reimburse for a physician as a surgical assistant (including physician's assistants and Registered Nurse First Assists) for major surgery at twenty percent (20%) of the surgical allowance. Providers should use the appropriate modifier code when reporting a surgical assist.
6. **Co-Surgeons:** When the skills of two (2) physicians are required to perform the procedure, providers may allocate the allowance according to the responsibility and work done. The physicians must make the Department aware of the allowance distribution.
7. **Surgical Team:** Allowances for surgery performed under the surgical team concept will be determined on a "By Report" basis.

90.04-24 Oral and TMJ Surgery Billed with CPT codes

Providers of oral and temporomandibular joint (TMJ) surgery must also comply with all applicable rules of MBM, Chapter II and III, Section 25, "Dental Services", including but not limited to urgent care guidelines and prior authorization. All TMJ surgeries require prior authorization.

90.04-25 Chiropractic Services

Chiropractic services must be performed as detailed in MBM, Chapter II, Section 15, "Chiropractic Services". Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-26 Occupational Therapy Services

Occupational therapy services must be performed as detailed in MBM, Chapter II, Section 68, "Occupational Therapy Services". Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.04 COVERED SERVICES (cont.)

90.04-27 Physical Therapy Services

Physical therapy services must be performed as detailed in MBM, Chapter II, Section 85, "Physical Therapy Services". Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-28 Speech and Hearing Services

Speech and hearing services must be performed as detailed in MBM, Chapter II, Section 109, "Speech and Hearing Services". Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-29 Topical Fluoride Varnish

Application of topical fluoride varnish is covered for members under the age of twenty-one (21). MaineCare will cover the following services, depending on age.

- A. Members under age three (3): Two (2) times per calendar year; a third treatment per calendar year is permitted for Members who either have a high caries rate or the Member has had new restorations placed in the previous eighteen (18) months.
- B. Members age three (3) through age twenty (20): Two (2) times per calendar year, but no more than once every 150 days; a third treatment per calendar year is permitted for Members who either have a high caries rate or the member has had new restorations placed in the previous eighteen (18) months.

These limits apply across eligible providers and may be exceeded for children under the age of twenty-one (21) pursuant to the MBM, Chapter 1, Section 1.14-3. Coverage is allowable for physicians with subspecialties of general or family practice, preventative medicine, pediatric, or internal medicine.

90.04-30 Oral Evaluation of a Patient Under Three (3) Years of Age

MaineCare covers oral evaluation by a medical provider of a child under the age of three (3) who does not have a dental home and/or has not seen a dentist in the past year. The provider must:

- A. Question about the existence of a current primary dentist/dental home;
- B. Include risk screening questions based on oral health history;
- C. Include assessment of mouth and teeth; and

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.04 COVERED SERVICES (cont.)

- D. Develop an oral health plan which includes parent, legal guardian, and/or primary caregiver education about importance of establishing a primary dentist/dental home for the child, and provide a referral to a dentist (when possible).

MaineCare will cover two (2) evaluations per calendar year across all qualified providers, but no more than once every 150 days. These limits may be exceeded for children under the age of twenty-one (21) pursuant to the MBM, Chapter 1, Section 1.14-3. Additional information is available in MBM, Chapter III, Section 25, “Dental Services”.

90.04-31 Podiatry Services

All podiatry services are subject to requirements in MBM, Chapter II, Section 95, and many podiatric procedures require prior authorization.

90.05 RESTRICTED SERVICES

90.05-1 Services Covered With Prior Authorization (PA)

Some services and procedures require prior authorization for MaineCare to provide payment. MaineCare lists provider procedures, the amount paid for the service, and whether the procedure requires prior authorization on the MaineCare Services website. When new procedure codes are added to MaineCare reimbursement, MaineCare may require prior authorization. Only some of the categories of procedures requiring prior authorization are detailed in this section; providers are responsible for checking each procedure code on the OMS website to determine whether it is covered and whether it requires prior authorization. Providers can find procedures requiring PA and PA requirements at: <https://mainecare.maine.gov>. In cases where the criteria are not met, the Provider/Member may submit additional supporting evidence such as medical documentation, to demonstrate that the requested service is medically necessary.

- A. MaineCare covers the following services only when the Department has granted prior authorization using the criteria outlined below:

- 1. Out-of-State Services**

- All services, including but not limited to diagnosis, evaluation or treatment to be provided outside the State of Maine require prior authorization. (See *MaineCare Benefits Manual*, Chapter I, Section 1.14 for policies and procedures regarding out-of-state services). Use of out-of-state diagnostic services, excluding lab or radiology tests by enrolled MaineCare providers, requires prior authorization. MaineCare providers referring

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

out-of-state services are responsible for assuring that services are referred to a MaineCare provider. Providers cannot bill the member unless the member was advised at the provider's office prior to provision of the service that the service may not be covered by MaineCare and that the member may be responsible for the services. Prior notification must be documented in the member's record.

2. Vagus Nerve Stimulation

MaineCare covers medically necessary vagus nerve stimulation for treatment of partial onset seizures for adults and children over twelve (12) years of age when clinically appropriate medications are refractory.

3. Orthognathic Surgery

Orthognathic surgery requires prior authorization, and is not covered for cosmetic purposes. Orthognathic surgery is only covered for medically necessary indications such as:

- i. Jaw and craniofacial deformities causing significant functional impairment for the following clinical indications:
 - a. repair or correction of a congenital anomaly that is present at birth; or
 - b. restoration and repair of function following treatment for a significant accidental injury, infection, or tumor.
- ii. Anteroposterior, vertical, or transverse discrepancies or asymmetries that are two or more standard deviations from published norms and that cause one or more of the following documented functional conditions:
 - a. difficulty swallowing and/or choking, or ability to chew only soft or liquid food for at least four (4) months; or
 - b. speech abnormalities determined by a speech pathologist or therapist; or malnutrition related to the inability to masticate, documented significant weight loss over four (4) months and a low serum albumin related to malnutrition; or
 - c. intra-oral trauma while chewing related to malocclusion; or
 - d. significant obstructive sleep apnea not responsive to treatment.

Documentation must include, but is not limited to, study models with appropriate bite registration, intra-oral and extra-oral photographs, and cephalometric x-ray.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

- B. MaineCare covers the following services using the following criteria in addition to industry recognized prior authorization criteria utilized by a national company under contract, which can be found at: <https://mainecare.maine.gov/>.

1. Breast Reduction and Mastopexy

For members under the age of twenty-one (21), the following additional criteria must be met:

- a. Second surgical opinion in support of the procedure from a surgeon in a practice not affiliated with the first surgeon; and
- b. Counseling with a mental health professional to document the member's understanding of the indications, alternatives, and lifelong ramifications of this surgery or
- c. consultation with another primary care provider.

2. Gastric Bypass, Gastroplasty Surgery or Adjustable Gastric Banding

Reimbursement will be made to the physician, hospital or other health care provider for services related to gastric bypass, gastroplasty surgery or adjustable gastric banding only when prior approval has been granted by the Department . The request for prior authorization must be submitted by the surgeon who will be performing the surgery.

For Members age twenty-one (21) years and younger, the surgery must also be recommended by all of the following, with documentation submitted with the prior approval request:

- a. a primary care provider;
- b. an endocrinologist;
- c. second surgeon not affiliated with the first surgeon's practices; and
- d. a licensed mental health professional specializing in children's mental health

- C. MaineCare covers the following services using industry recognized prior authorization criteria utilized by a national company under contract, which can be found at <https://mainecare.maine.gov/>.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

1. Breast Reconstruction
2. Removal of Excess Skin and Subcutaneous Tissue of Abdomen

90.05-2 Services Covered When Special Criteria Are Met

MaineCare covers the services described below when performed in accordance with the following criteria:

A. Abortion Services

In compliance with PL 103-112, the Health and Human Services Appropriations bill, reimbursement for abortion services will be made only if necessary to save the life of the mother, or if the pregnancy is the result of an act of rape or incest.

Abortion services are covered only when performed in a licensed general hospital or outpatient setting, and when the following conditions are met:

1. A physician has found, and so certified in writing to the Department, that on the basis of his/her professional judgment an abortion is necessary to save the life of the mother; or the pregnancy is the result of an act of rape; or the pregnancy is the result of an act of incest.
2. If the abortion is performed in order to save the life of the member, the certification must contain written justification as to the necessity of the abortion procedure.
3. The certification must contain the name and address of the member.
4. The member's medical record shall be documented as to the circumstances of the abortion procedure.

A sample letter of certification is shown below:

I, _____ (Name of physician), certify that on the basis of my professional judgment, an abortion is necessary for _____ (name of member) of _____ (member's address) for the following reason(s): (Check all that apply)

- in order to save the member's life.
- the pregnancy is the result of an act of rape.
- the pregnancy is the result of an act of incest.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

Present justification as to the necessity of an abortion performed in order to save the life of the member. (Attach supporting information, as necessary.)

(Signature of Physician)

(Date)

The physician's certification must be submitted to the Department. The member's medical record is not required for submission, however, it must be available for review by the Department, upon request.

In compliance with federal requirements, the Department will reimburse for the procedure if the treating physician certifies that in his or her professional opinion, the member was unable for physical or psychological reasons to comply with established reporting requirements, if any, in cases of rape or incest.

Although no payment can be made until the provider submits all required documentation to the Department, the provider should provide necessary medical services immediately as needed.

B. Sterilization Procedures and Hysterectomies

MaineCare will reimburse for sterilization procedures and hysterectomies only when all of the conditions spelled out below are met in order to comply with 42 CFR 441.250 through 441.259 of the *Code of Federal Regulations*.

1. Definitions for the Purpose of This Section

- a. Sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing, and can apply to both men and women.
- b. Hysterectomy means a medical procedure or operation for the purpose of removing the uterus.
- c. Institutionalized Individual means an individual who is (A) involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or (B) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
- d. Mentally Incompetent Individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

declared competent for purposes that include the ability to consent to sterilization.

2. Sterilization Procedures

Reimbursement for sterilization procedures will be made only if they are performed in accordance with the following criteria:

- a. The individual to be sterilized is:
 - i. At least twenty-one (21) years of age at the time the consent for sterilization is obtained.
 - ii. Not considered a "Mentally Incompetent Individual" as defined in 90.05-2(B)(1)(D) above.
 - iii. Not an "Institutionalized Individual" as defined in 90.05-2(B)(1)(C) above.
 - iv. Not in labor or childbirth when the consent to be sterilized is obtained.
 - v. Not seeking to obtain or obtaining an abortion when the consent to be sterilized is obtained.
 - vi. Not under the influence of alcohol or other substances that affect the individual's state of awareness when the consent to be sterilized is obtained.
- b. The individual must have given voluntary Informed Consent in accordance with the following conditions:
 - i. The individual who is blind, deaf or otherwise handicapped must be provided the same information as defined below through any suitable arrangements that ensure it is effectively communicated.
 - ii. When necessary, an interpreter is provided to insure that the member understands the language used on the consent form and by the provider obtaining consent.
 - iii. The member to be sterilized must be permitted to have a witness present when the consent is obtained.
 - iv. The provider who obtained the informed consent offered to answer any questions the member may have concerning the procedure.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

- v. The member to be sterilized was provided a copy of the consent form and orally given the following information or advice:
 - a. that he/she is free to withhold or withdraw consent to the procedure at any time;
 - b. that his/her choice to withhold or withdraw consent will not affect the right to future care or treatment; and
 - c. that he/she may withhold or withdraw consent at any time, and will not lose any benefits from any federally funded benefits for which the individual is eligible.
- vi. The member is provided with a description of alternative methods of family planning and birth control.
- vii. The member is advised that the procedure is considered irreversible.
- viii. The member is provided with a thorough explanation of the specific procedure to be performed.
- ix. The member is told of any and all discomforts and risks that may accompany or follow the performing of the procedure.
- x. The member is given a full description of the benefits or advantages that may be expected as a result of the procedure.
- xi. The member is advised that the procedure will not be performed for at least thirty days, except in the case of emergency abdominal surgery or premature delivery.
- c. A properly completed consent form, as defined below, is provided to the Department. To be acceptable it must meet the conditions as follow:
 - i. The consent form must be the one furnished by the federal government or an exact copy. A member may consent to be sterilized at the time of emergency abdominal surgery if at least seventy-two hours have passed since the member gave informed consent for the sterilization.

A member may consent to be sterilized at the time of a premature delivery if at least seventy-two hours (72) has passed since the member gave informed consent for the sterilization and the informed consent was obtained at least thirty (30) days before the expected delivery date.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

- ii. The form is completed at least thirty (30) days but no more than one hundred eighty (180) days prior to the date of the sterilization procedure. (The only exception to this requirement is i above.)
- iii. The form is signed and dated by:
 - a. The member to be sterilized;
 - b. The interpreter, if applicable;
 - c. The provider who obtained the consent; and
 - d. The physician who performed the sterilization.
- iv. Copies of the signed consent form are to be distributed as follows:
 - a. One (1) copy to the member to be sterilized;
 - b. One (1) copy to be retained by the physician; and
 - c. One (1) copy forwarded to the OMS with the usual billing invoice.

Sterilization Consent Form

A properly completed consent form must be attached to the billing invoices. If it is necessary to send the consent form in separately, please send it to:

MaineCare Services
Claims Unit
11 State House Station
Augusta, Maine 04333- 0011

Additional copies of the consent form are available upon request from the unit named at the above address.

3. Sterilization Pamphlets

Two approved pamphlets containing required information on sterilization are available. They are entitled "Information for Women" and "Information for Men." Copies may be obtained from the Family Planning Association of Maine, 43 Gabriel Drive, Augusta, Maine 04330 or The National Clearinghouse for Family Planning Information, PO 2225, Rockville, Maryland 20852.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

4. Hysterectomy

In accordance with Federal regulations (42 CFR 441.255 and 441.256) payment for a hysterectomy and related services may be made from MaineCare funds only when specific criteria are met.

- a. MaineCare will not reimburse for hysterectomy when the procedure would not have been performed except to render an individual permanently incapable of reproducing.
- b. MaineCare will only reimburse procedures performed in accordance with the following criteria:
 - i. The provider who secured the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing.
 - ii. The individual and her representative, if any, were provided information orally and in writing about the procedures.
 - iii. The individual or her representative, if any, has signed a written informed consent with acknowledgment of receipt of the information referred to in (a) and (b) above prior to the individual having the procedures.

The "Hysterectomy Information Form" (BMS-045), which meets federal requirements, is available to meet this informed consent requirement. Documentation submitted in lieu of the above informed consent form, which contains all required information as shown on the BMS-045 is acceptable.

- c. The member or her representative must sign and date the consent form.

One (1) copy of the informed consent form is to be given to the member, one (1) copy is to be retained by the physician or hospital, and one (1) copy is to be forwarded to MaineCare with the usual billing invoice.

The only exceptions to the above requirements are:

- i. The member was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the member was already sterile at the time of the hysterectomy, and states the cause of sterility.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

- ii. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that informed consent is not possible, and certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior informed consent was not possible. The physician must also include a description of the nature of the emergency.
- iii. Hysterectomies performed during a period of a member's retroactive MaineCare eligibility if the physician who performed the hysterectomy certifies in writing that:
 - a. The member was informed before the operation that the hysterectomy would make her permanently incapable of reproducing, or
 - b. One of the conditions in Chapter II, Section 90.05-2(B)(4)(c) (i) and (ii) was met. The physician must supply the written information specified in Chapter II, Section 90.05-2(B)(4)(c) (i) and (ii) of this manual.

If it is necessary to submit the hysterectomy Informed Consent form separately please send it to:

MaineCare Services
Claims Unit
11 State House Station
Augusta, Maine 04333-0011

Additional copies of the "Hysterectomy Information Form" (BMS-045) are available upon request from the unit named at the above address.

C. Circumcision

Circumcision for cosmetic or routine purposes is not covered.

These criteria apply to all members: Documentation must outline conservative therapies tried for at least ninety (90) days, and the failure of these measures. Therapies to be tried include, when appropriate, behavioral and topical therapies. If no conservative therapy is medically appropriate, none is required.

The record must clearly document the medical condition for which the circumcision was performed and, when appropriate, conservative therapies tried and failed as outlined above. If the record is inadequate to document that the circumcision was not performed for cosmetic, routine, or ritual purposes,

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

the procedure may be determined to not be medically necessary and per, Chapter I of the MBM, payments may be recouped.

D. Cochlear Implants

All cochlear implants must meet the following criteria:

1. The member has a diagnosis of bilateral severe-to-profound sensorineural hearing impairment that has been treated with little or no benefit from appropriate hearing (or vibrotactile) amplification; and
2. The member has the cognitive ability to use age-appropriate auditory cues, and the member, directly or through a parent/guardian, has the capacity and willingness to undergo an extended course of rehabilitation; and
3. The member is free from middle ear infection; has accessible cochlear lumen that is structurally suited to implantation; and is free from lesions in the auditory nerve and acoustic areas of the central nervous system; and
4. There are no contraindications to surgery; and
5. The device is in accordance with FDA-approved labeling.
6. In addition to criteria 1-5 above, the following criteria must also be met

For children ages one (1) through seventeen (17):

MaineCare covers cochlear implants for prelinguistically and postlinguistically deafened children over the age of one (1). For children ages twelve (12) months through twenty-three (23) months providers must demonstrate bilateral profound sensorineural hearing loss and lack of progress in the development of auditory skills with hearing aid(s) or other amplification. For children ages twenty-four (24) months to seventeen (17) years, providers must demonstrate bilateral severe-to-profound hearing loss and lack of progress in the development of auditory skills with hearing aid(s) or other amplification.

7. In addition to criteria 1-5 above, the following criteria must be met for adults (age eighteen (18) and older):

MaineCare covers cochlear implants for prelinguistically, perilinguistically, and postlinguistically deafened adults. Providers must demonstrate little or no benefit from hearing aids, defined as speech recognition scores of less than

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.05 RESTRICTED SERVICES (cont.)

fifty percent (50%) on sentence level testing in the ear to be implanted and less than sixty percent (60%) in the non-implanted ear or in the binaural condition.

E. Cosmetic Procedures

MaineCare does not cover medical or surgical procedures performed solely for cosmetic purposes. Examples of potentially cosmetic procedures include, but are not limited to abrasion of skin or lesion, chemical peel or salabrasion, and cervicoplasty. Some procedures that are potentially cosmetic procedures are covered when done to correct deformities resulting from cancer, disease, trauma, or birth defects. All procedures that may be performed for cosmetic reasons require documentation of medical indication in the medical record for utilization review purposes.

F. Hyperbaric Oxygen Therapy

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

1. **Covered Conditions** - Reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one person unit) for the following conditions:
 - a. Acute carbon monoxide intoxication;
 - b. Decompression illness;
 - c. Gas embolism;
 - d. Gas gangrene;
 - e. Acute traumatic peripheral ischemia therapy used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
 - f. Crush injuries and suturing of severed limbs as an adjunctive treatment when loss of function, limb, or life is threatened;
 - g. Progressive necrotizing infections (necrotizing fasciitis);
 - h. Acute peripheral arterial insufficiency;
 - i. Preparation and preservation of compromised skin grafts (not for primary management of wounds);

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

- j. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;
- k. Osteoradionecrosis as an adjunct to conventional treatment;
- l. Soft tissue radionecrosis as an adjunct to conventional treatment;
- m. Cyanide poisoning;
- n. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment;
- o. Diabetic wounds of the lower extremities in patients who meet all of the following three (3) criteria:
 - i. Member has type I or II diabetes and has a lower extremity wound that is due to diabetes;
 - ii. Member has a wound classified as Wagner grade III or higher; and
 - iii. Member has failed an adequate course of standard wound therapy.

The use of HBO therapy for diabetic wounds is covered as adjunctive therapy only after there are no measurable signs of healing for at least thirty (30)–days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in members with diabetic wounds includes: assessment of a member’s vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least thirty (30) consecutive days. Wounds must be evaluated at least every thirty (30) days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any thirty (30)-day period of treatment.

- 2. **Noncovered Conditions** – MaineCare will not reimburse HBO in the treatment of the following conditions:
 - a. Cutaneous, decubitus and stasis ulcers;

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

- b. Chronic peripheral vascular insufficiency;
- c. Anaerobic septicemia and infection other than clostridial;
- d. Skin burns (thermal);
- e. Senility;
- f. Myocardial infarction;
- g. Cardiogenic shock;
- h. Sickle cell anemia;
- i. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency;
- j. Acute or chronic cerebral vascular insufficiency;
- k. Hepatic necrosis;
- l. Aerobic septicemia;
- m. Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, and Korsakoff's disease);
- n. Tetanus;
- o. Systemic aerobic infection;
- p. Organ transplantation;
- q. Organ storage;
- r. Pulmonary emphysema;
- s. Exceptional blood loss or anemia;
- t. Multiple sclerosis;
- u. Arthritic diseases; or
- v. Acute cerebral edema; or
- w. All other indications not listed as covered conditions above.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

3. **Reasonable Utilization Parameters** - Payment will only be made where HBO therapy is clinically practical. HBO therapy should not be a replacement for other standard successful therapeutic measures. Depending on the response of the individual member and the severity of the original problem, treatment may range from less than one (1) week to several months duration, the average being two (2) to four (4) weeks. The medical necessity for use of hyperbaric oxygen must be documented in the medical record for utilization review purposes.
4. **Topical Application of Oxygen** - This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no MaineCare reimbursement may be made for the topical application of oxygen.

G. Infertility Services

Infertility services, including evaluation and treatment, are not covered by MaineCare. Treatments and procedures that are usually performed for the sole purpose of evaluation or treatment of infertility require utilization review to document medical necessity of the procedure for reasons other than the treatment of infertility.

H. Penile Implants

Penile implants, including insertion, repair, or replacement will only be covered after surgery for cancer, trauma, or birth defect where pharmacologic treatments have failed.

I. Rhinoplasty

MaineCare does not cover these surgeries for cosmetic purposes. Medical necessity must be documented to show that symptomatic, ongoing, or recurrent breathing obstructions or infections are present despite at least a sixty (60) day trial of conservative treatment.

J. Skin Tag Removal

MaineCare will only cover skin tag removal when there is significant, ongoing, or recurrent irritation or discomfort that is documented in the medical record.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.05 RESTRICTED SERVICES (cont.)

90.05-3 Services Covered When Rehabilitation Potential Is Documented

Some MaineCare services that are not routinely performed by a physician nevertheless require documentation by a physician of medical necessity or rehabilitation potential. These services include, but are not limited to, chiropractic services, home health services, physical therapy, occupation therapy, or speech therapy services.

For services requiring documentation of rehabilitation potential, providers should include diagnosis or complaint, how member was assessed, (e.g. by phone, exam, therapist evaluation) why rehabilitation potential is expected, (e.g. acute condition, acute exacerbation of chronic condition, past response to therapy, etc.) and indicators of measurable functional improvement. Other providers may, if requested by the physician, use an evaluation to assist the physician in determining the member's rehabilitation potential. In the case of a service requiring recent surgery to obtain prior authorization, such as in the case of chiropractic services, surgery must have been performed within the previous sixty (60) days (to the PA request).

90.06 SERVICES FOR MEMBERS IN DIFFERENT SETTINGS

90.06-1 Nursing Facilities and Other Group Care

A. Nursing Facility Admissions

The admission of a member to a nursing facility under the MaineCare program requires prior approval from the Department of Health and Human Services. Approval for admission is given only when a member meets the medical eligibility requirements for nursing facility services, as set forth in Chapter II, Section 67 of the *MaineCare Benefits Manual*, and when adequate alternate arrangements cannot be made for home or community based care. NF applicants must receive a medical eligibility assessment with the Department's approved assessment instrument (see Section 67).

B. On-Going Nursing Facility Care

When the physician continues to serve as the attending physician to members after they enter a nursing facility, or accepts as new patients members who are receiving care in a nursing facility, he or she is expected to provide, at a minimum, those physician services that are required, by Federal regulations and by the *State of Maine Regulations Covering the Licensing and Functioning of Nursing Facilities*, to be provided in licensed MaineCare approved facilities.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.06 SERVICES FOR MEMBERS IN DIFFERENT SETTINGS (cont.)

C. Documentation in Member's Chart

All services provided to members in group care facilities by the physician or rendering provider are to be documented by the provider in the member's chart maintained in the facility. All orders to be carried out by facility staff are to be signed by the physician or rendering provider. A rubber stamp of the signature is not considered adequate.

D. Referrals by Attending Physician

Professional services in a group care facility are only covered when ordered by the attending physician or the rendering provider working under his/her supervision.

E. Physicians with Facility Ownership

No charges may be made for services provided to members in a group care facility by a physician or rendering provider in a physician's practice who derives a direct or indirect profit from ownership of the facility, except for emergency services provided for acute illness.

90.06-2 Outpatient Hospital Services

A. Referrals

A physician or rendering provider may refer members for essential services such as laboratory tests, x-ray examination, etc., that are provided by a hospital on an outpatient basis.

B. Emergency Services

Emergency services are those services provided to persons requiring immediate care in the emergency room of the hospital, necessitated by unforeseen conditions such as injury, accident or sudden illness.

Charges may be made by a physician who personally attends a member in the emergency room providing he or she is not salaried by the hospital or whose salary is or associated with a group of physicians with a financial contract to provide emergency room care.

90.06-3 Inpatient Hospital Services

A provider may admit a member for essential inpatient hospital services in connection with covered treatment of an illness or injury. The facility's patient care coordinator monitors the medical need for hospital admission and the length of the

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.06 SERVICES FOR MEMBERS IN DIFFERENT SETTINGS (cont.)

hospitalization. There are limitations on the length of stay according to the specific needs of the individual member for hospital care. The Department will only make payment for days certified by the patient care coordinator. MaineCare will deny payment of additional provider services provided during the non-certified hospitalization.

Exception: The Department will reimburse for provider services rendered from date of admission to the first review date even if the patient care coordinator denies the admission.

90.07 NON-COVERED SERVICES

When MaineCare does not cover specific procedures, all services related to that procedure are not covered, including physician, facility, and anesthesia services. Services that are not reimbursable by MaineCare include, but are not limited to:

A. Cosmetic Surgery

Surgeries that are performed solely for cosmetic reasons are not covered by MaineCare. MaineCare defines cosmetic surgery as any surgery done primarily to improve or change appearance without improving the way the body works. Procedures that may potentially be performed for either cosmetic or medical reasons require prior authorization documenting the medical indication for the procedure. MaineCare does cover some potentially cosmetic procedures when done to correct deformities resulting from cancer, disease, trauma, or birth defects, as detailed in Section 90.05. Examples of non-covered cosmetic surgery are:

1. Circumcision, which is usually a cosmetic procedure, is not covered unless medically necessary. Circumcision that is routine or cosmetic including routine newborn circumcision is not covered. Circumcision for preventative, social, ethnic, or religious reasons, regardless of age, is not covered. MaineCare covers some circumcisions with an appropriate medical indication.
2. Piercings and removal of tattoos.

B. Infertility Services

Treatments and procedures solely for the purpose of evaluation or treatment of infertility are not covered. In addition, MaineCare does not cover reversal of sterilization.

C. Other Non-Covered Services

1. Garren-Edwards Gastric Bubble;
2. Acupuncture;

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.07 NON-COVERED SERVICES (cont.)

3. Medical care provided by mail, telephone or internet, except as provided in accordance with Chapter I, Section 4, “Telehealth Services”;
4. Autopsy examinations;
5. Preparation and duplication of records, forms, and reports;
6. Hypnosis;
7. Reversal of sterilization procedures; and
8. Any service described in 90.04 that exceeds the stated restrictions.

90.08 POLICIES AND PROCEDURES

The following policies and procedures supplement the general information within this section:

90.08-1 Medical Record Requirements

Each provider shall maintain financial and professional records of sufficient quality to fully and accurately document the nature, scope, and details of the health care provided. Providers shall provide copies of financial and professional records to the Department in the form and manner requested without charge to the Department or the member. Chapter I details the five (5) year requirement for maintaining records.

- A. Physicians must maintain one office medical record for each member even in group practices, partnerships, and other shared practices. Providers must document specific services rendered in chronological order. Chapter I provides additional requirements for record-keeping. The medical records corresponding to office, home, nursing facility, hospital, outpatient and emergency room services billed to the Department must include but shall not be limited to:
 1. Date of each service ordered and provided;
 2. Member’s name, name of responsible person (if different from the member, e.g., parent or guardian), date of birth, and MaineCare ID number;
 3. Name and title of provider performing the service if it is other than the billing physician;
 4. Medical history/ including member’s health condition;
 5. Pertinent findings on examination;

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.08 POLICIES AND PROCEDURES (cont.)

7. Medications administered or prescribed, when applicable;
8. Description of treatment, when applicable;
9. Recommendations for additional treatments or consultations;
10. Medical goals;
11. Supplies dispensed or prescribed (if any); and
12. Tests and results; and
13. Dated provider signature.

B. Record Requirements for Psychotherapy Services

In addition to the above medical record requirements, when psychotherapy services are provided, a personalized plan of care must be developed and incorporated into the member's medical record, along with written progress notes. MaineCare requires that medical records and other pertinent information will be transferred, upon request, to other physicians or clinicians with member's consent.

The plan of care shall include, but is not limited to:

1. Member's presenting problem and diagnosis;
2. Long and short range goals;
3. A description of the service(s) needed by the member to address the goal(s);
4. An estimate of the frequency and duration of the needed service(s) and support(s);
5. The identification of providers of the needed service(s) and support(s);
6. Plans for coordination of services with other health care providers, as appropriate; and
7. A discharge plan.

The provider must document each service provided, showing the date of service, the type of service performed and its relationship to the plan of care, the length of time of the service, and the signature of the individual performing the service.

Providers must write progress notes regularly that state the progress the member has made toward the long and short-term goals.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.08 POLICIES AND PROCEDURES (cont.)

90.08-2 Evaluation and Management (E/M) Services

Providers should utilize the most recent edition of the Current Procedural Terminology (CPT), published by the American Medical Association, for definitions of levels and components of Evaluation and Management (E/M) Services.

Medical examinations, evaluations, treatment, and other services are defined by the component and level of service provided. The various components and levels require differing degrees of skill, knowledge, time, effort, and responsibility. The components and levels of service and the member status apply to evaluation and management services provided in the provider's office, the hospital, the member's home, and long-term care facilities. Providers must use appropriate CPT codes to indicate appropriate levels and components of service. Providers must document levels and components of service in the medical record.

90.08-3 Disclosure Requirements

Upon request, the provider must furnish to the Department, without additional charge, the medical records, or copies thereof, corresponding to and substantiating services billed by that provider.

90.08-4 Supplementation

- A. **Covered Services.** The provider shall accept as payment in full the amounts established by the Department for covered services.

Therefore, the provider shall not charge a member an amount in addition to the payment received, or to be received, from MaineCare for a covered service. This is a violation of federal and state laws.

In addition, providers may not bill members or other providers for documentation fees or to complete paperwork required for referrals for prior authorization, to document rehabilitation potential, to certify medical necessity of a MaineCare covered service, or to provide other written information required for services covered by MaineCare. Providers must provide copies of such documentation at no charge to members and to relevant providers upon the member's request and upon completion of appropriate consents for release of information.

- B. **Non-covered Services.** The member may be charged for a non-covered service. However, prior to provision of a non-covered service, the provider must clearly explain to the member that he or she will be financially liable for payment for such service. Providers shall document in the member's record that notification of financial liability for non-covered services has been made.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.08 POLICIES AND PROCEDURES (cont.)

Providers may not bill MaineCare or the member for missed appointments.

Please refer to MBM, Chapter I for policies and procedures applicable to all non-covered and non-reimbursable services. Providers must apply for prior authorization and receive a denial stating that the procedure is non-covered prior to initiating member consent for liability of non-covered services.

The member may voluntarily choose to pay for non-covered services and may be charged for those services, as long as he or she clearly understands prior to provision that he or she will be financially liable for such service. Providers must document the member's informed consent for provision of these non-covered services.

90.08-5 Procedure to Request Prior Authorization (PA)

All prior authorization requests should include pertinent information concerning the nature, extent, need, and charge for the procedure or service. For more information regarding PA forms and contact information, please visit:
<https://mainecare.maine.gov/>

Note: Refer to MBM, Chapter I, for policies and procedures regarding prior authorization for out-of-state services.

90.08-6 Program Integrity (PI)

All MaineCare services are subject to Program Integrity procedures as described in the *MaineCare Benefits Manual*, Chapter I.

90.09 REIMBURSEMENT

90.09-1 Fee Schedule

MaineCare reimburses for physician services using a fee schedule known as the MaineCare rate of reimbursement (See Section 90.09-2 A.) The fees or cap associated with service codes are in the MaineCare claims processing database, and are available to any provider who requests a paper or electronic copy. The information is also available on the MaineCare Services website: <https://mainecare.maine.gov/>. Fees are subject to change, although the rate in effect as of the date of service applies for procedures performed on that date.

Providers who use electronic information from the website should note that they are still subject to all applicable MaineCare rules. The MaineCare Program will provide quarterly updates on the website.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.09 REIMBURSEMENT (cont.)

Providers must bill using their usual and customary charges and reimbursement will be in accordance with the criteria cited below. Providers must bill medical supplies and therapeutic injections at their cost, using NDC codes where available. Providers should direct any questions to the provider relations specialist assigned to their geographic area of practice.

90.09-2 MaineCare Reimbursement Rate

MaineCare will reimburse the lowest of the following for covered services, except as otherwise outlined this Section (MBM, Chapter II, Section 90.09):

A. The Fee Schedule rate, which is set based on:

- (1) Seventy percent (70%) of the lowest level in the 2009 Medicare fee schedule (or 70% of the rate in the year CMS assigned a rate for that code) for Maine area “99” including appropriate Medicare fee adjustments for place of service and modifiers in effect at that time; or
- (2) The lowest amount allowed by Medicare Part B for Maine area “99” fee schedule including appropriate Medicare fee adjustments for place of service and modifiers; or
- (3) If the above two options are not available, the Department will research other State Medicaid agencies that cover the relevant service/code. The Department will base its rate on the average cost of the relevant services/codes from those other agencies.

OR

B. The provider’s usual and customary charges.

OR

C. 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 MBM, Chapter I. MaineCare considers a claim paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

When a member is covered by insurance with a service benefit principle, the insurance payment is considered payment in full in accordance with the service benefit agreement between the provider and the insurance company. MaineCare should not be billed in such instances.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.09 REIMBURSEMENT (cont.)

90.09-3 Reimbursement Rate for Drugs Administered By Other than Oral Methods

MaineCare will not reimburse claims without both a valid J-code and NDC. MaineCare will not reimburse for provider administered drugs that are not rebateable under Section 1927 of the *Social Security Act* (42 U.S.C.A. §1396r-8(a)) and implementing CMS regulations (42 C.F.R. §447.500 *et seq.*) unless the provider obtains Prior Authorization (PA). PA procedures can be found in MBM, Chapter 1, Section 1.14. PA will not be granted for non-rebateable, provider administered drugs for which there are therapeutically equivalent alternatives that are rebateable. Instructions for billing, a crosswalk of J-codes, and a list of rebateable NDC codes are available on the MaineCare Services website at: <https://mainecare.maine.gov>.

MaineCare determines drug fee schedules for drugs payable under this section as ninety five percent (95%) of Average Wholesale Price (AWP) as set by Medicare Part B for Maine area “99.” MaineCare will reimburse the lower of:

- 1) The fee schedule rate (when the AWP is available), or
- 2) The provider’s acquisition cost only, excluding shipping and handling.

90.09-4 Primary Care Provider Incentive Payment

The Primary Care Physician Incentive Payment (PCPIP) rewards physicians who have provided quality primary care to MaineCare members. Physicians receive scores in various categories such as the number of MaineCare patients, emergency room utilization and prevention/quality. Each physician’s practices are compared to other physicians in his/her primary care specialty and then are given an overall ranking. Physicians ranking above the twentieth percentile will receive a monetary share of their specialty pool, based on percentile. The twentieth percentile and below do not receive a monetary share of their specialty pool. The following describes how the incentives are calculated:

1. **Access** - Forty Percent (40%)
 - a. Total number of unduplicated MaineCare members served per quarter.
 - b. Total number of health care providers accepting new MaineCare members.
2. **Utilization** – Thirty Percent (30%)

Emergency visit and/or hospitalization rate per quarter for physicians unduplicated MaineCare members per quarter.

3. **Quality** - Thirty Percent (30%)

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19

90.09 REIMBURSEMENT (cont.)

- a. Preventive measures score higher.
- b. Comparison of quality indicators (QI) among specialty groups.

Examples:

Childhood immunization - percentage of children in the practice immunized by age two (2) against DPT, polio, measles/ mumps/rubella, type B influenza, and hepatitis B.

Adolescent immunization - percentage of adolescents in practice's children who have had following immunizations by age thirteen (13): second dose of measles/mumps/rubella, hepatitis B, tetanus/ diphtheria booster, and chicken pox.

Prenatal Care - percentage of women in practice who delivered a baby in previous year and received prenatal care in the first trimester.

Post-delivery checkup - percentage of mothers in practice who had a checkup within six (6) weeks after delivery.

Mammography - percentage of women in practice ages fifty-two (52) to sixty-nine (69) who had a mammogram in previous year.

Pap test - percentage of women in practice ages twenty-one (21) to sixty-four (64) who had a pap test for cervical cancer in previous year.

Board certification - percentage of practice board certified in appropriate discipline.

The specific indicators utilized will be selected quarterly as necessary to obtain targeted quality of care evaluations. The same criteria shall be used among similar groups of physicians, i.e., family practitioners/general practitioners, internal medicine, pediatrics, etc.

4. **Member Satisfaction** (percent allocation to be determined in second year of physician assessment)
 - a. Percentage of members who change primary physician.
 - b. Percentage of members who report they are completely or very satisfied with their care.
5. **Determination of Physician Incentive Payments**

The elements described above will be the basis for placing each participating MaineCare physician in an octal grouping as follows:

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**ESTABLISHED 10/15/81
EMERGENCY RULE 6/18/19**

90.09 REIMBURSEMENT (cont.)

Group 1 Percentile- Sixty Percent (60%) Of Total Payment

Octal 1	90 - 100	Thirty percent (30%) of Group 1 payment
Octal 2	80 - 89	Twenty percent (20%) of Group 1 payment
Octal 3	70 – 79	Ten percent (10%) of Group 1 payment

Group 2 Percentile - Twenty-Five Percent (25%) Of Total Payment

Octal 4	60 – 69	Ten percent (10%) of Group 2 payment
Octal 5	50 – 59	Eight percent (8%) of Group 2 payment
Octal 6	40 – 49	Seven percent (7%) of Group 2 payment

Group 3 Percentile - Fifteen Percent (15%) Of Total Payment

Octal 7	30 – 39	Ten percent (10%) of Group 3 payment
Octal 8	20 – 29	Five percent (5%) of Group 3 payment

No Payment for 0 - 19 Percentile

90.09-5 Primary Care Provider Increased Reimbursement

Effective January 1, 2015, MaineCare will provide increased reimbursement of select primary care services for eligible primary care providers. Eligible providers include:

- (A) physicians who attest on a MaineCare self-attestation form that they practice with a specialty designation of Family Medicine, Internal Medicine, or Pediatric Medicine or a subspecialty within these primary care categories recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA).
- (B) APRNs or PAs for whom an eligible physician (defined in 90.09-5(A)) has attested that he or she accepts direct professional responsibility.

Reimbursement rates are set using the 2014 Maine Medicare physician fee schedule and reflect the mean value over all counties in Maine for each of the specified evaluation and management and vaccine billing codes. For a full list of eligible codes and their rates, see the MaineCare Rate Setting website:
<https://mainecare.maine.gov/>.

90.10 BILLING INSTRUCTIONS

Providers must bill in accordance with the Department's billing requirements for the CMS 1500 specific to Physician Services.

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**10/15/81
EMERGENCY RULE 6/18/19**

Appendix A

90A-01 COVERED ORGAN TRANSPLANT PROCEDURES

MaineCare reimburses for services related to organ transplants only when all criteria of this section are met, and a Department-approved transplant center recommends that the transplant be performed. MaineCare does not cover transplants that are considered experimental or investigational in nature.

MaineCare covers procedures (evaluations and transplants) that include, but are not limited to: heart, heart-lung, bone marrow (autologous and allogeneic bone marrow or stem cell transplants), kidney, corneal, liver, lung, small intestine, combined liver-small intestine, and pancreas transplants.

90A-02 NON-COVERED TRANSPLANT SERVICES

MaineCare will not cover evaluations for transplant or transplants if any of the following apply:

- a. Another procedure of lower cost and of less risk may achieve the same or similar result; or
- b. The transplant is not expected to make a significant difference in the member's health and/or performing the transplant will serve primarily an academic purpose; or
- c. The transplant is contraindicated by the medical condition, age, and prognosis of the member; or
- d. The transplant center and/or the member's specialist do not recommend that the evaluation for transplant or transplant be performed.

90A-03 TRANSPLANTS NOT REQUIRING PRIOR AUTHORIZATION

- a. In-State Transplant Procedures Not Requiring Prior Authorization

The following transplant procedures and evaluations do not require prior authorization, as long as they are performed in the State of Maine:

- 1) **Kidney Transplants.** Title XVIII of the *Social Security Act* of the Medicare program reimburses for kidney transplants for members with end stage renal disease. For members who are dually eligible for both Medicare and MaineCare, MaineCare will reimburse for only Medicare coinsurance and deductible costs customarily reimbursed by MaineCare.
- 2) **Corneal Transplants.** MaineCare covers corneal transplantation to correct corneal opacity or keratoconus.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

10/15/81
EMERGENCY RULE 6/18/19

90A-03 TRANSPLANTS NOT REQUIRING PRIOR AUTHORIZATION (cont.)

- 3) **Autologous or Allogeneic Bone Marrow or Stem Cell Transplants.**
MaineCare covers bone marrow or stem cell transplants. MaineCare covers these procedures when used to replace bone marrow damaged by high doses of radiation therapy or chemotherapy.

90A-04 TRANSPLANTS REQUIRING PRIOR AUTHORIZATION

All transplants and transplant evaluations performed outside the State of Maine require prior authorization, as described in MBM, Chapter I. All transplants and transplant evaluations require prior authorization unless the transplant meets the criteria of 90A-03 above. Some Out of State transplants require additional criteria to be met based on industry recognized prior authorization criteria utilized by a national company under contract. In cases where the criteria are not met, the Provider/Member may submit additional supporting evidence such as medical documentation, to demonstrate that the requested service is medically necessary. This criteria can be found at: <https://mainecare.maine.gov/ProviderHomePage.aspx>

a. Transplant Procedures Requiring Prior Authorization

MaineCare will consider prior authorization for organ transplants when all of the following criteria are met:

- 1) Both the transplant center and the member's in-state specialist recommend that the transplant be authorized after the member is evaluated; and
- 2) The transplant meets all other criteria specified in Section 90 and this Appendix; and
- 3) MaineCare has received complete documentation from the transplant center to make a determination.

b. Overview of the Authorization Process

The provider must submit complete documentation and all criteria listed in this section must be met before MaineCare will consider requests for prior authorizations for evaluations and transplant services. In making a determination, MaineCare will utilize appropriate staff including but not limited to MaineCare Services medical consultants, a medical specialist in the relevant field of the requested transplant (e.g. cardiologist for heart transplants), a psychiatrist or psychologist and designee(s) of the Director of MaineCare Services. MaineCare prior authorization staff will review the materials and make a determination by considering established patient selection and facility criteria within this section. To make its decision, the Department will also look for evidence that the request conforms to general and organ specific patient selection criteria, and recommendations of relevant medical specialists.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

10/15/81
EMERGENCY RULE 6/18/19

90A-04 PRIOR AUTHORIZATION (cont.)

The Department will notify the requesting physician, other appropriate providers, and the member of the decision whether an evaluation or transplant is prior authorized within thirty (30) days of the request. Members may appeal decisions based on information in the *MaineCare Benefits Manual*, Chapter I, “General Administrative Policies and Procedures”.

1. Documentation for Prior Authorization

The Department will make a decision regarding prior authorization for the transplant procedure after reviewing the transplant center’s report submitted to the MaineCare Prior Authorization Unit. The report must include written assessments performed by the appropriate specialists and recommendations regarding all possible treatment options. The report must also include the specialists' general assessment of the member’s anticipated prognosis and the risks and benefits (e.g. quality of life) associated with each potential treatment option, including transplant.

Providers must clearly document all of the following information concerning the member’s health in the written report:

- i. Diagnosis;
- ii. Pertinent medical history;
- iii. Alternate treatments performed and their results;
- iv. Recommended transplant procedure;
- v. Expected prognosis after recommended treatment;
- vi. Second opinion of the member’s condition from a board-certified specialist affiliated with a tertiary care hospital. This assessment must be based upon a review of the member’s medical records and previous diagnostic studies and must provide recommendations regarding all possible treatment options for the member. Based upon the consultant's experience with similar cases, the report must also include the consultant's general assessment of the member’s prognosis and of the risks and benefits (i.e., quality of life) associated with each potential treatment option, including transplant; and
- vii. A report of an assessment by a mental health professional for members age nineteen (19) and older who are being assessed for transplants other than a bone marrow transplant. The assessment must address the member’s mental health and ability to understand both the procedure and its psychological aftermath. This report shall include comments on the

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

10/15/81
EMERGENCY RULE 6/18/19

90A-04 PRIOR AUTHORIZATION (cont.)

member's ability to take medications and comply with medical recommendations and on the member's family or other support system's ability to assist the member in coping with both the procedure and its psychological aftermath. The professional must state that the member is currently (in the prior six months) not abusing drugs or alcohol and has agreed to any on-going counseling recommended regarding drug or alcohol abuse.

- viii. A written medical record release signed by the member or the member's guardian.

MaineCare prior authorization staff may require additional information to make a determination.

Providers must submit the request for prior authorization for transplant evaluations and transplant. Contact information can be found at: http://www.maine.gov/dhhs/oms/provider_index.html .

2. Duration of Prior Authorization

Any prior authorization for reimbursement for an organ transplant procedure shall expire one (1) year after the date of prior authorization. If the transplant procedure has not been performed within that period, then prior authorization must once again be sought for the member.

Providers must repeat the prior authorization process for re-authorization. This second review will focus on reassessing the member's condition and updating the information submitted for the initial authorization. MaineCare will utilize this information to make the appropriate final decision regarding re-authorization for an evaluation and approval or denial of coverage for the transplant.

3. Patient Selection Criteria

a. General Selection Criteria

Members must meet all of the following general criteria before MaineCare grants prior authorization of the evaluation and/or the transplant:

1. The member's overall physiological condition must indicate a reasonable expectation for success; and

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

10/15/81
EMERGENCY RULE 6/18/19

90A-04 PRIOR AUTHORIZATION (cont.)

2. Alternative medical therapies have been tried and have failed or, if tried, would not prevent progressive disability or death; and
3. There is every reasonable expectation that the member will strictly adhere to the difficult long-term medical regimen required; and
4. The member is emotionally stable and has a realistic attitude toward illness; and
5. Current history (current and for at least 6 months preceding the transplant evaluation and actual transplant) is free of alcohol or drug abuse ; and
6. There is a reasonable likelihood that the transplant will extend the member's life expectancy at least two (2) years and to restore a range of physical and social functions of daily living; and
7. The member meets all established criteria and presents no contraindications set by the approved transplant center for the specific transplant procedure; and
8. The member has been evaluated by a transplant facility approved by the Department and the transplant center has recommended the transplant and indicated a willingness to perform the procedure.

b. Specific Selection Criteria

In addition to the general selection criteria stated above, each member must meet all transplant center specific criteria for each transplant. These criteria are set by the transplant center and include indications and contraindications for specific organ transplant procedures based on national standards. The Department will not prior authorize any transplant if the transplant center does not approve the procedure based on all specific selection criteria set by the transplant center.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 90

PHYSICIAN SERVICES

10/15/81
EMERGENCY RULE 6/18/19

90A-05 CRITERIA FOR SELECTION OF TRANSPLANT CENTERS

MaineCare will only cover transplants performed in Department-approved transplant centers.

While physicians may request specific transplant centers, the Department reserves the right to select the transplant center a specific transplant is approved for. Whenever possible, the Department will approve the physician's request for the site of the member's organ transplant evaluation. If several Department-approved transplant centers are available for specific transplants, the Department reserves the right to authorize the transplant in the most cost-effective transplant center. When all other factors are equal, the Department will give preference to the provision of services at an in-state or regional transplant center in order to enhance continuity of care by minimizing the distance that the member and family will have to travel for evaluation, the transplant procedure, and after-care.

a. Initial Approval of Out-of-State Transplant Centers (Not required for existing kidney transplant facilities or for any corneal or bone marrow transplant facility)

To approve the use of an out-of-state transplant center facilities must have the following:

1. Initial approval of an out-of-state transplant center requires documentation of a survival rate for the relevant transplant procedure comparable with the national experience. This survival rate must be based on a sufficient number of procedures (e.g. twelve (12) procedures over the past twelve (12) months) to enable the Department to compare the new transplant center with other national transplant centers that are performing the procedure.

b. On-going Approval of Out-of-State Transplant Centers

The Department will approve out-of state transplant center facilities on a continuing basis using the following criteria:

1. The transplant center has personnel experienced with the relevant specialized surgeries, infectious diseases, pediatrics, pathology, pharmacology, anesthesiology, tissue typing, immunological and immunosuppressive techniques and blood bank support services; and
2. The center has a consistent, equitable, and practical protocol for selection of candidates and, at a minimum, must adhere to the Department's General Patient Selection Criteria; and
3. The center has adequate services to provide emotional and social support for members and their families; and
4. The center has satisfactory arrangements for donor procurement services; and

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

SECTION 90

PHYSICIAN SERVICES

**10/15/81
EMERGENCY RULE 6/18/19**

90A-05 CRITERIA FOR SELECTION OF TRANSPLANT CENTERS (cont.)

5. The center has demonstrated willingness and the ability to provide relevant information to the member's physicians, to MaineCare staff, and to other transplantation center personnel; and
6. The transplant center maintains all required federal or state accreditations and certifications; and
7. The transplant center is a Medicare approved transplant center for all applicable transplants, including heart, lung, heart-lung, liver, and intestinal transplant centers; and
8. The transplant center maintains conformance to the national survival rate criteria as described in (a) above; and

The transplant center must maintain continuing approval dependent upon meeting all above criteria. The transplant center must report any changes in status regarding meeting the above criteria to the Department.

c. Initial Approval for In-State Transplant Centers

The Department will waive conformance to the national survival rate criteria described in (a) above for any new in-state transplant centers for a two (2) year period. All other criteria described above must be met. This two (2) year start-up period, which will begin with the first transplant procedure performed in the in-state facility, is designed to enable the in-state transplant center to secure sufficient experience to obtain a survival rate that can be compared with national experience.

d. Continued Approval for In-State Transplant Centers

Continued approval for the in-State center after this two (2) year start-up period requires evidence of a survival rate that is comparable with the national experience and of success with and safety of the transplant procedure. The Department must be able to base this survival rate on a sufficient number of procedures to enable the Department to compare the in-state transplant center with other national transplant centers that are performing the procedure. The in-state transplant center must meet all other criteria described in (b) above in order to receive continued transplant center approval. The transplant center must report any changes in status regarding meeting the above criteria to the Department.