

MaineCare in Education



2023

A MaineCare Billing Guide
for Providers of
School Health-Related Services

August 2023

Table of Contents

Part I: Introduction

MaineCare Program Overview	3
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Part II: Member Eligibility for MaineCare Covered Services

How Families Apply for MaineCare.....	4
What Factors Impact Eligibility	4
MaineCare Member Responsibilities.....	4
Katie Beckett Program.....	4

Part III: General Provider Requirements

Standards of Confidentiality	5
Release of Information.....	5
Accessing Data	5
Privacy and Security of Health Information	5
The Family Educational Rights and Privacy Act.....	6
Joint DHHS/MDOE Guidance and Training	6
Enrollment and Revalidations Provider Fees.....	6

Part IV: Provider Enrollment and Revalidation

Enrollment Instructions for School Providers.....	7
Enrollment Instructions for Non-School Providers	8
Provider Types and Specialty Code Descriptions.....	9

Part V: IDEA Health-Related Services

History	10
Consent to Bill MaineCare.....	10
Signature for Consent Bill MaineCare- Clarification	10
504 Plans.....	10
Superintendent Agreements.....	11
Child Development Services (CDS) Contracted Providers	11
Provider Guidelines	12
Rate Setting Guidance.....	13
MaineCare Rate Reform	13
Section 28 and Section 65 Services Rate Reform Specific Related Billing Guidance	14
Restraint Guidance.....	19
MaineCare Seed Payments	20
Transition from Child Member to Adult Member Services.....	20
Medical Necessity.....	20
Covered Services Details	21
Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations	22
Section 65 Behavioral Health Services.....	23
Section 68 Occupational Therapy Services	24
Section 85 Physical Therapy Services	25
Section 94 Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	26

Section 96 Private Duty Nursing and Personal Care Services	27
Section 109 Speech and Hearing Services	28
Section 113 Non-Emergency Transportation (NET) Services	31
Documentation Requirements	33
Authorized Plan of Care	33
Comprehensive Assessment	33
Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP)	34
Individual Treatment Plan (ITP)	36
Member Written Record	38
Nursing Treatment Plan of Care	39
Plan of Service	40
Prior Authorization	40
Prior Authorization Pre-Review of IEP Documentation	41
Progress Notes	42
Audit Findings Historical Guidance	44
Additional Information	45
IDEA vs. Non-IDEA Related Claim Submissions	45
Modifiers	45
Place of Service Code	46
Record Retention	46
Review and Submission of Claims	46

Part VI: School-Based Health Centers	47
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Part I: Introduction

MaineCare Program Overview

MaineCare is a health benefit for eligible individuals and families with lower income and resources. MaineCare is a means-tested program that is jointly funded by the state and federal governments and administered by the Maine Department of Health and Human Services (the “Department”). Among the groups of people served by MaineCare are certain eligible U.S. citizens and resident aliens, including lower income adults and their children, and people with disabilities who meet the Social Security Administration’s standard of disabled. The program is designed to meet the medically necessary needs of our members.

The purpose of this guide is to provide information to school administrative units and equivalent providers billing for services under the policy sections outlined below in the MaineCare Benefits Manual (MBM). The guide should be viewed as a supporting document to current policy, rather than as a stand-alone policy.

Enrolled providers are responsible for familiarizing themselves with all Medicaid regulations, policies, and procedures currently in effect, and as they are issued. School based providers can receive MaineCare provider updates by signing up for MaineCare’s e-messages or RSS feed [here](#). Archived provider updates are available [here](#).

Currently, MaineCare member students have two avenues to access Medicaid-covered services in Maine schools:

1: Through the provision of IDEA Health-Related Services. These services are available when a member has an Individualized Education Program (IEP) listing the specific Covered Service(s) needed, as determined by the member’s IEP team. Provider requirements and a description of Covered Services are explained in Part V of this guide. MaineCare does not have oversight of, or participate in the IEP process, however, once MaineCare covered services are listed on a student’s IEP, MaineCare can reimburse providers for claims submitted in accordance with the MaineCare Benefits Manual (MBM).

2: Through School-Based Health Centers. These services may be provided to any student who is eligible for MaineCare. School-Based Health Centers are described in Part VI of this guide.

Part II: Member Eligibility for MaineCare Covered Services

How Families Apply for MaineCare

To apply for MaineCare, individuals can:

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

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

What Factors Impact Eligibility for Different MaineCare Programs

OFI determines eligibility for several different MaineCare programs. At a basic level, the following are used to determine eligibility (not necessarily in this order): Family Household size, income, assets, citizenship, and disability.

MaineCare Member Responsibilities

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

Katie Beckett Program

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

Katie Beckett is a [MaineCare enrollment](#) option for children who have serious health conditions but are not eligible for regular coverage under MaineCare. Children who are eligible for MaineCare via Katie Beckett receive full MaineCare benefits.

More information regarding the eligibility process for the Katie Beckett Program can be found [here](#).

Members who have MaineCare through the Katie Beckett program are subject to an annual financial cap. Please note: services provided to members in school settings are not counted in the member's annual financial cap.

Katie Beckett is a premium-based program, so families do have to pay a monthly fee for this benefit. Fees are based on total monthly household income. Even though there is a premium, MaineCare benefits are the same for these children as they are for any other child receiving MaineCare.

Part III: General Provider Requirements

Standards of Confidentiality

Federal Medicaid regulations regarding confidentiality require those receiving released recipient information to have standards of confidentiality comparable to those of the state Medicaid agency itself. This requirement is an additional condition for the release of information.

Release of Information

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

Accessing Data

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

Privacy and Security of Health Information - HIPAA

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

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

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

The Family Educational Rights and Privacy Act - FERPA

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

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

Joint DHHS/MDOE Guidance and Training

The Department of Health and Human Services and the Department of Education now issue joint guidance notices to support providers and other stakeholders. All notices and related trainings are posted on MaineCare's [School Health-Related Services website](#).

Specific guidance was issued in February 2020, regarding the documentation of IDEA Services to comply with Medicaid regulations. Joint guidance was re-issued and shared again in [May 2021](#) on this same topic.

Enrollment and Revalidation Provider Fees

Schools, and most enrolled School Health-related service providers, are exempt from paying enrollment fees during MaineCare enrollment and revalidation.

Part IV: Provider Enrollment and Revalidation

Enrollment Instructions for Schools as Providers of School Health-Related Services

To provide consistency in the MaineCare enrollment process through MIHMS (MaineCare’s claims processing system), providers must follow the guidelines below when enrolling schools or when revalidating enrollment.

School Administrative Units that do not operate schools, but instead pay tuition to other schools, should not enroll as MaineCare providers. The school where the student receives the MaineCare-covered service must be the enrolled provider who bills for the services.

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

Naming Requirement for All Public Schools

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

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

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

Naming Requirement for All Special Purpose Private Schools (SPPS)

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

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

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

Naming Early Childhood Services Site Locations

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

Following the previous example, the name for location would be “Summerville – Early Childhood Services.” For billing purposes only, the physical address listed for the enrolling site is the main office location, not where the actual service takes place.

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

Regional Service Center Site Location Enrollments

Regional Service Center Site Locations- Providing Services to Members

When a Regional Service Center delivers services to MaineCare members, MaineCare will enroll the Regional Service Center as a Provider Type 89, Public School. Rendering providers will need to be set up for claims to be submitted.

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

In cases where a Regional Service Center is created to streamline administrative duties but not to provide services to members, the Regional Service Center will be enrolled as a third-party billing agent for the participating schools and/or SAUs. This will allow the service locations to continue as they have already been set up and provide access to the billing resources through the portal for claims submission.

New School-Based Health Center Location Enrollments

Enrolled School providers who would like to set up School-Based Health Centers may contact [Provider Enrollment](#) to add an additional Service Location. All claims provided to members as described in Chapter II, Section 3 of the MaineCare Benefits Manual, also included in Section II of this guide, must be billed only through the additional service locations. Schools who are not currently enrolled but who would like to enroll as a School-Based Health Center should contact MaineCare’s [Provider Enrollment](#) unit.

Department of Education Verification

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

Requests for enrollment as Early Childhood Providers will require a copy of the provider’s program approval letter issued annually by the Department of Education.

Enrollment Instructions for Providers Who Are Not Schools

This update to the enrollment and claims submission guidance is being made to ensure that all School Health-Related service claims are correctly paid in accordance with MaineCare Benefits Manual 65.06-13, 65.03-4 and that the appropriate entity is assessed for the state share cost of the claims.

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

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

Provider Types and Specialty Code Descriptions for IDEA Related Services

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

Part V: IDEA Health-Related Services

Background

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

The Centers for Medicare and Medicaid Services (CMS) recently updated guidance on the provision of these services and has published an online resource called [Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming](#).

School Health-Related services included in the IEP may be covered by Medicaid if all relevant statutory and regulatory requirements are met. In addition, the technical guide provides that a State Medicaid Agency may cover medical services included in an IEP or IFSP if (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all federal and state regulations are followed, including those specifying provider qualifications; and (3) the services are included in the State plan or are available under the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) benefit.

MaineCare members may also access medical services at schools through enrolled School-Based Health Centers (Clinics) as defined in MBM Ch II, Section 3.04-1, or through MaineCare providers who contract with schools to provide additional medical services outside of school settings. When appropriate, MaineCare providers may also decide with members to provide medically necessary services to members at a school location. In these instances, the services are not identified as IDEA related services.

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

The use of Medicaid funds to provide or pay for MaineCare services in a school setting **will not**:

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

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

504 Plans

MaineCare reimbursement through IDEA Services is not available for students receiving services from an accommodation plan in accordance with Section 504 of the Rehabilitation Act.

Homeschooled Students & Parentally Placed Private School Students

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

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

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

Superintendent Agreements

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

Child Development Service (CDS) Contracted Providers

Providers may be contracted through CDS to deliver services listed on an IFSP or IEP to MaineCare enrolled children. When delivering health related services on behalf of CDS, it is vital that providers ensure the correct use of modifiers when billing for services listed on an IEP.

If a member receives similar services from the same or multiple providers, the provider(s) will need to keep documentation indicating that two separate services were provided on the same day. This applies whether services are provided by one or multiple providers. One claim could be submitted for the service provided (with script from PCP), and another claim could be submitted for the IDEA service provided.

Minimum Requirements for IDEA Health-Related Service Provision

All services being provided to comply with IDEA must meet the following minimum requirements:

- 1. Be medically necessary.**
 - 2. Be ordered, prescribed, or recommended by a physician or other licensed practitioner of the healing arts.**
 - 3. Be included in the member’s Individualized Education Plan or Individualized Family Service Plan; and,**
 - 4. Be medical in nature (as opposed to academic).**
- ❖ It is the provider’s responsibility to verify a member’s eligibility for MaineCare prior to providing services, as described in Chapter I, Section 1 of the MaineCare Benefits Manual.
 - ❖ It is also the provider’s responsibility to verify the MaineCare billable service is listed in a member’s IEP or IFSP prior to providing services to the member.

Provider Guidelines

Billing and Rendering Providers

The following may bill MaineCare for School Health-Related services:

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

- A Special Purpose Private School or a regular education public school program under 05-071 C.M.R. ch 101 §XII and 20-A MRSA §7204 (4), 7252-A and 7253, and 05-071 C.M.R. ch 101, §12, or
 1. A program operated by the Child Development Services system 20-A MRSA §7001(1-A).
 2. An enrolled MaineCare provider who has contracted with a school to provide services.

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

1. **Direct reimbursement of health professionals:** The school (or SAU) **employs** health professionals. When the school employs staff who will provide the health services, the school can enter a provider agreement with MaineCare and receive payments for the covered services provided.
2. **Contracting with health professionals:** The school (or SAU) **contracts** with health practitioners to furnish services. Under this type of arrangement, the health practitioner (not the school) is the provider of services, and payments are made to the practitioner, unless the practitioner assigns its right to payment to the SAU.
3. **Combination of direct employment and contracting:** The school (or SAU) uses a combination of employed health professionals and contracted health professionals to furnish services; or the school provides some services directly, but contracts out entire service types without directly employing any practitioner in a particular service category.

How does MaineCare Define “School?”

As relates to Section 28 services:

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

As relates to Section 65 services:

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

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

Rate Setting Guidance

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

MaineCare Rate Reform – 2023

Where do providers find current MaineCare rates for other covered services? The MaineCare Benefits Manual (MBM) is where providers should first look for reimbursement rates, with the exception of Behavioral Health services. Below are the links to each allowance section, by type of service as listed in the MaineCare Benefits Manual.

For Behavioral Health Services, providers can use the link below where recently updated rates are now posted, or review pages 17-19 of this guide where the most commonly billed updated rates are included.

Links to MaineCare Member Benefits Manual (MBM), Chapter III Sections, Covered Service Allowance Rates

- [Occupational Therapy Services](#) (Section 68, MBM)
- [Physical Therapy Services](#) (Section 85, MBM)
- [Private Duty Nursing Services](#) (Section 96, MBM)
- [Speech and Hearing Services](#) (Section 109, MBM)

Link to [MaineCare Provider Fee Schedules](#)- Updated Rates for Behavioral Health Covered Services

- Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (Section 28, MBM)
- Children's Behavioral Health Day Treatment (Section 65, MBM)

For more details about billing and authorizations for services for Sections 17, 28 and 65, see the [Behavioral Health Rate Frequently Asked Questions \(FAQs\) document](#).

Specific Updated Billing Guidance for Sections 28 and 65

On January 9, 2023, the Department issued Section by Section Guidance for billing due to the Rate Study Increase. Information on MaineCare’s Rate System Reform may be found [here](#).

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

Services with modifier changes for rates:

There are modifier changes for **all Section 28 services**. New modifiers will:

1. Distinguish school-related from home and community Section 28 services, and
2. For school-related services, further differentiate billing practices by enrolled provider type. This is because schools are exempt from the Service Provider Tax (SPT), while **non-school** providers of Section 28 school-related services are subject to the SPT. Rates for schools therefore do not include payment to reimburse for the tax, while rates for other providers do include payment for the tax.

Service	Old Mods	New Mods
Children’s Rehab and Community Support (H2021)		
Home and Community (<i>not school-related</i>)	HQ HI	TJ HI
School-Related (<i>for non-school providers</i>)	HQ HI	TR HI
School-Related – SPT exempt (<i>for school providers</i>)	HQ HI	HI
Specialized Children’s Habilitative Services (H2021)		
Specialized Home and Community (<i>not school-related</i>)	HQ HK	U1 HK
School-Related (<i>for non-school providers</i>)	HQ HK	U2 HK
School-Related – SPT exempt (<i>for school providers</i>)	HQ HK	HK
Children’s Rehab. And Community Support, BCBA (G9007)		
BCBA School-Related – SPT exempt (<i>name change, for school providers</i>)	HA	HA
BCBA Services (Community Based Wrap Around)	HA	HA AF

Please review the more detailed rate descriptions and modifiers for Section 28 on the [Section 28 Provider Fee Schedule](#) carefully to ensure that you are billing the correct rate for your provider type and service location.

Additional billing guidance for Section 28 services:

Board Certified Behavior Analyst (BCBA) and Specialized Services:

In the new Specialized Service rate model, the cost of delivering BCBA services are included in the updated rate (H2021 HK), pursuant to MaineCare Benefits Manual, Chapter II, Section 28.04-3. The Department anticipates providers will bill for standalone BCBA services (G9007 HA) in exceptional circumstances when the services were not delivered as part of a Specialized Service model.

As a reminder, providers should be billing claims for Individuals with Disabilities Education Act (IDEA) services using the correct TL and TM reporting modifiers as detailed in the [May 17, 2022 provider notice](#). These reporting modifiers are **in addition to** the modifiers identified on the [State Plan Methodology page](#).

Section 65, Behavioral Health Services

Services with modifier and/or unit changes to rates:

Changes to the units of service:

Service	Old Unit	New Unit
Children’s Behavioral Health Day Treatment	Hourly	15-minute
Specialized Group Services	15-minute	Per session
Children’s HCT	15-minute	Weekly
Children’s ACT	Daily	Weekly
Triple P	15-minute	Per session
Incredible Years	15-minute	Per session

Important Note Regarding Modifiers for IDEA Services

We would also like to remind providers that they should be billing claims for Individuals with Disabilities Education Act (IDEA) services using the correct TL and TM reporting modifiers as detailed in the [May 17, 2022 provider notice](#). These reporting modifiers are in addition to the modifiers identified on the [Provider Fee Schedules](#).

Updated Rates for Most Commonly Billed School Health-Related Services
Section 28 Rehabilitative and Community Support Services
for Children with Cognitive Impairments and Functional Limitations

Section	Service	Service Description	Procedure Code	Modifiers	Unit	Final Rate
Section 28	Children's Rehab. and Community Support	Home and Community, One-to-One (BHP)	H2021	TJ HI	15 min.	\$20.60
Section 28	Children's Rehab. and Community Support	Home and Community, 2 person group (BHP)	H2021	TJ HI UN	15 min.	\$11.23
Section 28	Children's Rehab. and Community Support	Home and Community, 3 person group (BHP)	H2021	TJ HI UP	15 min.	\$8.00
Section 28	Children's Rehab. and Community Support	Home and Community, 4 person group (BHP)	H2021	TJ HI UQ	15 min.	\$6.48
Section 28	Children's Rehab. and Community Support	School-Related, One-to-One (BHP)	H2021	TR HI	15 min.	\$17.43
Section 28	Children's Rehab. and Community Support	School-Related, 2 person group (BHP)	H2021	TR HI UN	15 min.	\$9.63
Section 28	Children's Rehab. and Community Support	School-Related, 3 person group (BHP)	H2021	TR HI UP	15 min.	\$6.80
Section 28	Children's Rehab. and Community Support	School-Related, 4 person group (BHP)	H2021	TR HI UQ	15 min.	\$5.41
Section 28	Children's Rehab. and Community Support	School-Related, One-to-One (BHP) - SPT Exempt	H2021	HI	15 min.	\$16.44
Section 28	Children's Rehab. and Community Support	School-Related, 2 person group (BHP) - SPT Exempt	H2021	HI UN	15 min.	\$9.09
Section 28	Children's Rehab. and Community Support	School-Related, 3 person group (BHP) - SPT Exempt	H2021	HI UP	15 min.	\$6.41
Section 28	Children's Rehab. and Community Support	School-Related, 4 person group (BHP) - SPT Exempt	H2021	HI UQ	15 min.	\$5.11
Section 28	Specialized Children's Habilitative Services	Specialized Home and Community, One-to-One	H2021	U1 HK	15 min.	\$27.97
Section 28	Specialized Children's Habilitative Services	Specialized Home and Community, 2 person group	H2021	U1 HK UN	15 min.	\$15.24
Section 28	Specialized Children's Habilitative Services	Specialized Home and Community, 3 person group	H2021	U1 HK UP	15 min.	\$10.86

Section 28	Specialized Children's Habilitative Services	Specialized Home and Community, 4 person group	H2021	U1 HK UQ	15 min.	\$8.79
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, One-to-One - SPT Exempt	H2021	**HK	15 min.	\$22.20
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, 2 person group - SPT Exempt	H2021	**HK UN	15 min.	\$12.27
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, 3 person group - SPT Exempt	H2021	**HK UP	15 min.	\$8.66
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, 4 person group - SPT Exempt	H2021	**HK UQ	15 min.	\$6.90
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, One-to-One	H2021	**U2 HK	15 min.	\$23.53
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, 2 person group	H2021	**U2 HK UN	15 min.	\$13.01
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, 3 person group	H2021	**U2 HK UP	15 min.	\$9.18
Section 28	Specialized Children's Habilitative Services	Specialized School-Related, 4 person group	H2021	**U2 HK UQ	15 min.	\$7.31
Section 28	Children's Rehab. and Community Support, BCBA	BCBA School-Related Services - SPT Exempt	G9007	HA	15 min.	\$22.47
Section 28	Children's Rehab. and Community Support, BCBA	BCBA Services (Community Based Wrap Around Services)	G9007	HA AF	15 min.	\$23.82

**Section 28 – The U2 modifier was incorrectly placed with certain Specialized School-Related Services. The U2 modifier has been moved from Specialized School-Related- SPT Exempt Services to Specialized School-Related Services.

Section 65 Behavioral Health Services

Section	Service	Service Description	Procedure Code	Modifiers	Unit	Final Rate
Section 65	Children's Behavioral Health Day Treatment	BHP, One-to-One - School	H2012	HN	15 min.	\$17.26
Section 65	Children's Behavioral Health Day Treatment	BHP, Group of 2 - School	H2012	HN UN	15 min.	\$9.54
Section 65	Children's Behavioral Health Day Treatment	BHP, Group of 3 - School	H2012	HN UP	15 min.	\$6.73
Section 65	Children's Behavioral Health Day Treatment	BHP, Group of 4 - School	H2012	HN UQ	15 min.	\$5.36
Section 65	Children's Behavioral Health Day Treatment	Master's, One-to-One - School	H2012	HO	15 min.	\$25.43
Section 65	Children's Behavioral Health Day Treatment	Master's, Group of 2 - School	H2012	HO UN	15 min.	\$12.85
Section 65	Children's Behavioral Health Day Treatment	Master's, Group of 3 - School	H2012	HO UP	15 min.	\$9.07
Section 65	Children's Behavioral Health Day Treatment	Master's, Group of 4 - School	H2012	HO UQ	15 min.	\$7.22

Reminder: Guidance Regarding Reimbursement when Restraint is Utilized in Outpatient Behavioral Health Settings, Including Schools

MaineCare does not reimburse providers for time periods when a provider subjects a member to a restraint in outpatient behavioral health settings, including school settings. Department rules, in particular the Rights of Recipients of mental health services (RoR) for adults and children (14-193 C.M.R. ch. 1 and 14-472 C.M.R. ch. 1), limit the ability of providers of behavioral health services to use restraint interventions in outpatient settings, including offices, schools, clinics, outpatient hospital sites, homes, and community-based settings.

If a MaineCare provider seeks prior authorization for treatment and the service plan includes the use of restraint during the provision of an outpatient behavioral health service, DHHS or its Authorized Entity will request additional information, and will consider whether the request is consistent with Department rules such as the RoR and other governing law, including MaineCare Benefits Manual (MBM) provisions. In determining whether a service is reimbursable, MaineCare or its Authorized Entity considers the nature and components of the service being delivered and the role of the individual provider during service delivery. This includes reviewing the member's treatment goals and methods employed to support the member in accomplishing their goals. Restraint is a safety intervention utilized as a last resort when all attempts of medical services have failed. Thus, the use of restraint is inconsistent with medically necessary covered services in the MBM. When a restraint is initiated, delivery of the covered service as described in the MBM will necessarily end or pause until such time that the restraint has ended, a member has resolved their safety concerns, and they are able to re-engage in medically necessary treatment in accordance with their treatment plan. MaineCare will not reimburse for any time a provider is administering a restraint, or for any services delivered while the MaineCare member is being restrained. The fact that an individual provider may be involved in a restraint outside the scope of this guidance (service and/or time not billed to MaineCare; inpatient or residential service) does not disqualify that provider from being reimbursed by MaineCare for MaineCare-covered services delivered in an outpatient setting when delivered consistent with this guidance.

This guidance is specific to MaineCare behavioral health services provided in an outpatient setting and does not dictate what practices may or may not be appropriate in other settings, or for activities for which a provider is not seeking MaineCare reimbursement. In particular, this guidance does not dictate what may or may not be permissible in a school setting regulated by the Maine Department of Education (DOE) for activities that MaineCare does not reimburse. DOE and entities subject to its regulatory authority are governed by DOE's rules. Regardless of whether restraints may be employed in school settings under narrowly prescribed circumstances pursuant to DOE rules, MaineCare may not reimburse providers for services utilizing restraint that do not meet DHHS rules and/or MaineCare service delivery requirements. For more information, please see the notice issued by DHHS in March 2023.

For additional information, there is a [Frequently Asked Questions](#) document posted on [MaineCare's School Health-Related Services webpage](#).

MaineCare Seed Payments

Both SAUs and Child Development Services have an obligation to pay the state share cost to the Department of Education for the reimbursement of all MaineCare School Health-Related services provided through IDEA. This state share, referred to as “Seed,” is used to secure federal matching funds for the provision of MaineCare reimbursable services.

All services provided in accordance with an IEP or IFSP (referred to in this guide as “IDEA Services”) will be assessed Seed, regardless of whether a claim for the services is submitted from a school directly or by a contracted provider.

Services provided in School-Based Health Centers are not assessed Seed.

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

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

Medical Necessity

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

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

Transition from Child Member Services to Adult Member Services

MaineCare’s State Plan allows for children’s services to be provided through age 20. This means that MaineCare members age 21 and over in need of health-related services must access adult services. Although DHHS is aware that the Maine Department of Education recently updated guidance for all School Administrative Units in the state, requiring Special Education services to be provided through age 21, this update does not change federal or state regulations regarding the provision of Medicaid services.

Both Section 28 “Rehabilitative and Community Supports Services for Children with Cognitive Impairments and Functional Limitations” and Section 65 “Children’s Behavioral Health Day Treatment” services can only be provided to members under the age of 21.

Some other covered services may be provided to members age 21 as indicated in the appropriate policy section for other covered services. All providers must ensure that any services provided to members age 21 are done pursuant to the MaineCare Benefits Manual (MBM). For example, services such as Speech, Occupational, and Physical Therapies require Prior Authorization in addition to other requirements, which differs from the provision of services to children.

Covered Service Descriptions

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

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

The MaineCare Benefits Manual may be accessed online [here](#).

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

Service Descriptions:

- 28.04-1 **Treatment Services for Children with Cognitive Impairments and Functional Limitations** are medically necessary treatment services for members under the age of twenty-one (21). Treatment services are designed to retain or improve functional abilities which have been negatively impacted by the effects of cognitive or functional impairment, and are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills. Services include: problem solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs, learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self-awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.
- 28.04-2 **Specialized Services for Children with Cognitive Impairments and Functional Limitations** are medically necessary, evidence-based treatment services for members under the age of twenty-one (21), that utilize behavioral interventions designed to improve socially significant behaviors and developmentally appropriate skills to a measurable degree. Services include problem solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs, learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self-awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
 - ✓ Written member record
 - ✓ Comprehensive assessment (completed within thirty days of initiation of services)
 - ✓ Individual Treatment Plan (ITP)
 - ✓ Prior Authorization
 - ✓ Progress Notes
 - ✓ A "TL" or "TM" modifier must be added to the claim to identify an IDEA related service. *
- *Prior to April 1, 2022, MaineCare providers did not have the option to use "TL" or "TM" modifiers for services delivered through Sections 28 or 96. A change has been made which now allows this to occur.

Provider Staff Requirements:

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

For more information, please see: [MaineCare Benefits Manual, Section 28, Chapter II Policy \(Description of Services and Requirements\)](#). For rate information, please see page 15 of this guide as rates for this section were included in the recent rate reform process.

Section 65 Behavioral Health Services

Service Description:

65.06-13

Children's Behavioral Health Day Treatment

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

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

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Comprehensive assessment (completed within thirty days of initiation of services)
- ✓ Individual Treatment Plan (ITP) with crisis/safety and discharge plan
- ✓ Prior authorization
- ✓ Progress notes
- ✓ A "TL" or "TM" modifier must be added to the claim, in addition to any other modifiers as directed in bill to identify an IDEA related service

Provider Staff Requirements:

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

For more information, please see:

[MaineCare Benefits Manual, Section 65, Chapter II Policy \(Description of Services and Requirements\)](#)

For rate information, please see page 15 of this guide as rates for this section were included in the recent rate reform process.

Section 68 Occupational Therapy Services

Service Descriptions:

MaineCare reimburses providers for the following occupational therapy services:

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

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

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

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

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

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Personalized plan of service/plan of care
- ✓ Progress notes
- ✓ A "TL" or "TM" modifier must be added to the claim to identify an IDEA related service

Provider Staff Requirements:

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

For more information, please see:

[MaineCare Benefits Manual, Section 68, Chapter II Policy \(Description of Services and Requirements\)](#)

[MaineCare Benefits Manual, Section 68, Chapter III Allowances \(Reimbursement Rates\)](#)

Section 85 Physical Therapy Services

Service Descriptions:

MaineCare reimburses providers for the following physical therapy services:

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

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

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

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

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

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Personalized plan of service/plan of care
- ✓ Progress notes
- ✓ A "TL" or "TM" modifier must be added to the claim to identify an IDEA related service

Provider Staff Requirements:

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

For more information, please see:

[MaineCare Benefits Manual, Section 85, Chapter II Policy \(Description of Services and Requirements\)](#)

[MaineCare Benefits Manual, Section 85, Chapter III Allowances \(Reimbursement Rates\)](#)

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the child health component of Medicaid. EPSDT is a federally mandated entitlement which provides preventative and comprehensive health services for Medicaid-eligible children from birth up to age 21. The purpose of EPSDT is to discover and treat childhood health conditions before they become serious or disabling.

Services available to MaineCare members under age 21 include:

Health: well-child checks and doctor appointments, lead exposure screening, developmental screening, mental health services. Health screenings will include a comprehensive health history, physical exam, immunizations, laboratory testing, and health education.

Vision: vision tests, glasses

Dental: oral health assessments, teeth cleaning and checkups, fluoride treatments, x-rays and fillings, and other care the dentist says is necessary

Hearing: hearing tests, hearing aids

Other Medically Necessary Services: diagnostic services and services to help treat or ameliorate the symptoms of physical and mental conditions

EPSDT Treatment services are also covered services that are medically necessary and needed to correct or ameliorate defects and physical or mental conditions.* Providers should use the EP modifier when requesting these types of services in addition to modifiers “TL” or “TM.”

These can be 3 types:

1. A type of service not described in regulation.
2. The frequency exceeds regulation.
3. The duration exceeds regulation.

When a provider files a claim for an EPSDT covered service that is not the type, frequency, or duration usually covered by MaineCare, the claim will be reviewed to be sure that the service is:

- A. Documented scientifically, with valid clinical evidence of effectiveness.
- B. Not be considered investigational or experimental.
- C. Be the most cost-effective services that would provide the member with the same medically necessary outcome and intended purpose.
- D. Be “prior authorized” by MaineCare Services.
- E. Be medically necessary (as defined in policy).
- F. Not be custodial, academic, educational, vocational, recreational, or social in nature (as defined in policy).

For more information, please see:

[MaineCare Benefits Manual, Section 94, Chapter II Policy \(Description of Services and Requirements\)](#)

Section 96 Private Duty Nursing and Personal Care Services

Service Description:

- If a student is eligible for services under Section 96, Private Duty Nursing and Personal Care Services, and the services are listed on the IFSP/IEP, and have a prior authorization, reimbursement may be sought for Nursing Services.
- At this time, Private Duty Nursing services can be provided by (1) An agency, (2) an independent RN, or (3) an RN/LPN who is an employee of the school SAU.
- Under current policy, as employees of school SAUs, RNs or LPNs can perform tasks within the Nurses Practice Act, and under the scope of their individual licensures.
- An “Independent” RN has their own NPI number and bills directly with the correct Place of Service Code being 03. (The rate is lower because an Independent RN would not have the same overhead costs as an agency).
- Schools must ensure that their contracts do include Section 96 Services. To be considered an IDEA service, the nursing services must be listed on the member’s IFSP or IEP.
- A Prior Authorization must be obtained by the provider prior to the start of any nursing services.

Documentation Requirements:

- ✓ Prior authorization
- ✓ Medical service listed on member’s IEP or IFSP
- ✓ Written member record
- ✓ Authorized plan of care
- ✓ Nursing treatment plan of care
- ✓ Written progress notes
- ✓ A “TL” or “TM” modifier must be added to the claim to identify an IDEA related service*

*Prior to April 1, 2022, MaineCare providers did not have the option to use “TL” or “TM” modifiers for services delivered through Sections 28 or 96. A change has been made which now allows this to occur.

Provider Staff Requirements:

Nursing services may be provided by

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

For authorizations to be approved, there must be a documented need for skilled nursing. In addition, MaineCare must determine that the student member needs nursing services beyond what can be provided by school staff.

If a member has an IEP, MaineCare staff will review to see if the IEP team has determined there is a nursing need and lists it as a service in Section 7 of the IEP. MaineCare staff will review the IEP to ensure compliance with the joint guidance provided by MaineCare/DOE Special Services. If the IEP team determines there is not a nursing need listed in Section 7, that will also be a consideration in determination of services.

For more information, please see:

[MaineCare Benefits Manual, Section 96, Chapter II Policy \(Description of Services and Requirements\)](#)

[MaineCare Benefits Manual, Section 96, Chapter III Allowances \(Reimbursement Rates\)](#)

Section 109 Speech and Hearing Services

Service Description:

The following services are covered for all members:

Speech, Voice and Language Evaluation, Diagnosis and Plan of Care by Speech-Language Pathologist

A direct encounter between a licensed speech-language pathologist and the member to determine the status of both receptive and expressive communication skills.

Speech, Voice and Language Therapy and/or Aural Rehabilitation, Individual

The process of producing behavioral change in the member with a communication disorder involving a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

Speech, Voice and Language Therapy and/or Aural Rehabilitation, Group

The process of producing behavioral change in the member with a communication disorder involving other than a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

Speech and Language Periodic Re-Evaluation

A direct encounter between member and speech-language pathologist to determine current status with periodicity determined by plan of care.

At minimum, re-evaluations will occur, and plans shall be updated within six (6) months of the date of the plan of care.

Speech Pathology Diagnostic Services at Physician or PCP's Request

Specialty testing by speech-language-pathologist to assist in diagnosis and development of a medical plan of care. Report will include speech-language pathologist's recommendations. Currently acceptable medical tests and procedures are to be utilized as medically necessary.

Hearing Screening by a Speech-Language Pathologist

Pure tone air conduction testing by a speech-language pathologist as part of a hearing screening program.

Speech, Voice and/or Language Screening

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

Augmentative and Alternative Communication Evaluation Services

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

Therapeutic Adaptations and Set-Up for Assistive/Adaptive Equipment

This shall include customizing the operational characteristics of an AACD to meet the needs of the individual member and to maximize the use and effectiveness of the device. This service shall be performed by a licensed speech-language pathologist who is familiar and has experience with augmentative communication devices.

Reprogramming

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

Audiologic Evaluation, Diagnosis and Plan of Care, by Audiologist

A direct encounter between a member and an audiologist to determine the member's hearing status.

Audiologic Evaluation for Persons Difficult to Test

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

Audiologic Evaluation for Site of Lesion

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

Audiologic Evaluation as a Result of Change in Hearing Status Because of Disease, or Trauma

Audiologic evaluation necessitated by an observed or suspected change in a member's hearing status because of disease or injury, on referral from a physician or PCP.

Audiologic Diagnostic Services at Physician or PCP's Request

Specialty testing performed by an audiologist to assist in diagnosis and developing a medical plan of care. The report shall include audiologist's recommendations.

Aural or Language Rehabilitation (including speech reading), Individual, by Audiologist

The process of producing behavioral change in the member presenting communication disorders related to auditory function, involving a one-to-one relationship, and following a plan of care. This includes cochlear implant follow-up aural rehabilitation services.

Aural or Language Rehabilitation (including speech reading), Group, by Audiologist

The process of producing behavioral change in the member presenting a communication disorder related to auditory function involving other than a one-to-one relationship and following a plan of care.

Hearing Aid Evaluation and Related Procedures, by Audiologist

Covered services must be provided by an audiologist and include evaluating members for hearing aid and demonstrating the basic features of hearing aids to the member. For each evaluation of a member, the audiologist will provide a written report.

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

Hearing and/or Hearing Aid Periodic Recheck

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

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

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

Documentation Requirements:

- ✓ Medical service listed on member's IEP or IFSP
- ✓ Written member record
- ✓ Personalized plan of service/plan of care
- ✓ Progress notes
- ✓ Re-evaluation every six months
- ✓ A "TL" or "TM" modifier must be added to the claim to identify an IDEA related service

Provider Staff Requirements:

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

Additional Note:

- MaineCare policy requires that re-evaluations occur and plans of care be updated within six months of the date of the plan of care.
- A re-evaluation is not defined in the MaineCare Benefits Manual policy the same way as described in MUSER. MaineCare expects providers to comply with the service as described in the MBM.

For more information, please see:

[MaineCare Benefits Manual, Section 109, Chapter II Policy \(Description of Services and Requirements\)](#)

[MaineCare Benefits Manual, Section 109, Chapter III Allowances \(Reimbursement Rates\)](#)

Section 113, Non-Emergency Transportation (NET) Services

Service Description:

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

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

- Special needs transportation includes the following:
 1. Transportation from the member's place of residence to school (where the member receives medically necessary services covered by MaineCare's School Health-Related services program, provided by the school, and/or return to the residence).
 2. Transportation from the school to the office of a medical provider who has a contract with the school to provide medically necessary services covered by MaineCare's School Health-Related services program.
 3. In most cases, members with special education needs who ride the regular school bus to school with other non-disabled children will not have a medical need for transportation services and will not have transportation listed in their IEP. The fact that members may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.
 4. The primary purpose for transportation must be to access a medical service for more than 50% of the school day.

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

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

- School Health-Related Transportation involves utilization of MaineCare's Non-Emergency Transportation system. All providers must adhere to policy requirements in Section 113 of the MaineCare Benefits Manual.
- This is a shared-ride system. This means that rides are shared within the transportation broker system by all MaineCare members in need of rides to access medical services. In some cases that means adult MaineCare members may be traveling in the same vehicles as child MaineCare members.
- Complaints regarding transportation should first be directed to the appropriate transportation broker. MaineCare members may also call MaineCare Member Services.
- School Administrative Units (SAUs) have two options for seeking reimbursement for services provided through MaineCare brokers:

1. SAUs may work with Brokers directly to set up reimbursement on an individual trip basis using the broker's rate through the Friends, Family, Neighbors program, or
2. An SAU may opt to set up a larger reimbursement program for students in their district at a negotiated rate.

In either case, the SAU must contact the Broker directly to work out these arrangements. MaineCare does not directly reimburse providers for transportation outside of the broker system.

Documentation Requirements:

- ✓ All transportation request forms as mandated by broker being utilized,
- ✓ Consent to bill Medicaid for both transportation and medical service must be on file.

Documentation Requirements

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

Authorized Plan of Care

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

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

Comprehensive Assessment

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

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

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

- A clinician must complete a Comprehensive Assessment that integrates co-occurring mental health and substance use issues within thirty (30) days of the day the member begins services. The Comprehensive Assessment must be

included in the member's record. The Comprehensive Assessment process must include a direct encounter with the member and if appropriate, family members, parents, friends, and guardian. The Comprehensive Assessment must be updated at a minimum, when there is a change in level of care, or when major life events occur, and annually.

- The Comprehensive Assessment must contain documentation of the member's current status, history, strengths and needs in the following domains: personal, family, social, emotional, psychiatric, psychological, medical, drug and alcohol (including screening for co-occurring services), legal, housing, financial, vocational, educational, leisure/recreation, potential need for crisis intervention, physical/sexual and emotional abuse.
- The Comprehensive Assessment may also contain documentation of developmental history, sources of support that may assist the member to sustain treatment outcomes including natural and community resources and state and federal entitlement programs, physical and environmental barriers to treatment and current medications. Domains addressed must be clinically pertinent to the service being provided.
- Additionally, for a Comprehensive Assessment for a member with substance use, the documentation must also contain age of onset of alcohol and drug use, duration, patterns and consequences of use, family usage, types, and response to previous treatment.
- The Comprehensive Assessment must be summarized, and include a diagnosis using all current *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) criteria or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC 0-5) diagnosis, as appropriate. The Comprehensive Assessment must be signed, credentialed, and dated by the clinician conducting the Comprehensive Assessment. A Comprehensive Assessment for a member with a substance use diagnosis must also contain ASAM level of care criteria. If the Comprehensive Assessments for a member receiving integrated treatment for co-occurring disorders, the Comprehensive Assessment must contain both the DSM and ASAM criteria.
- If a provisional diagnosis is made by an MHRT or CADC providing the direct service, the diagnosis will be reviewed within five (5) working days by the supervising licensed clinician and documented in the record.
- Historical data may be limited in crisis services. The Comprehensive Assessment must contain documentation if information is missing and the reason the information cannot be obtained or is not clinically applicable to the service being provided.

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

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

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

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

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

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

For information on how to document these services on an IEP, please review the [Joint DHHS/MDOE guidance](#). There is also a [training presentation](#) posted for additional detail.

Using the IEP as both a Plan of Care and ITP

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

MaineCare understands that the Department of Education and federal IDEA regulations have different requirements than MaineCare. Therefore, MaineCare recommends that SAUs develop separate ITP and IEP/IFSP documents to ensure that all MaineCare required information is included pursuant to the MBM. After reviewing instances where SAUs are utilizing one document instead of two, here are three examples of areas that need to be considered when deciding whether to use an IEP as an ITP or Plan of Care.

Staff Required to Participate in development of IEPs and ITPs.

For example, IDEA and MUSER stipulate participants necessary in the development of IEPs. When providing services through Section 65, Children’s Behavioral Day Treatment, there is a requirement that “Qualified Staff must assume clinical responsibility for medical necessity and the ITP development.” If one document is being used to fulfill both IDEA and MUSER requirements for an IEP and MaineCare requirements regarding an ITP, a SAU could potentially meet both requirements by ensuring that “Qualified Staff” as defined in the MaineCare Manual are a part of the child member’s IEP team. If that is not possible, the SAU would need to consider using two separate documents so that the Qualified Staff is part of the development of the ITP even if they are not part of the IEP/IFSP team.

Signature Requirements

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

A notice was issued on [May 26, 2023](#) providing an update on verbal consent in place of signatures. During the COVID-19 PHE, the Department issued [guidance](#) to providers allowing verbal consent in place of wet signatures, except where a signature is specifically required through federal regulation.

As of May 12, 2023, the federal PHE ended. The Department plans to continue the flexibility to allow verbal consent, consistent with the original guidance, and will engage in rulemaking to update specific provisions of the MaineCare Benefits Manual (MBM) accordingly.

Consistent with the July 2020 guidance, providers continue to be responsible for complying with substantive consent and approval requirements and for maintaining documentation in the member’s record of the verbal consent. Until such time as rule updates are complete, the Department will exercise enforcement discretion with respect to requirements for a member signature that are solely based on Departmental rule. The Department cannot waive signature requirements based on state or federal statute or based on federal regulation.

90 Day Reviews

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

Individualized Treatment Plan (ITP) Document Requirements

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

- Within thirty (30) days of initiation of services, the treatment team must develop an ITP. The ITP is based on the comprehensive assessment and is appropriate to the member's developmental level. The ITP **must** contain the following:
 1. The member's diagnosis and reason for receiving the service.
 2. Specific medically necessary treatment services to be provided with methods, frequency and duration of services and designation of who will provide the service.
 3. Objectives with target dates that allow for measurement of progress toward meeting identified developmentally appropriate goals.
 4. Special accommodations needed to address barriers to provide the service.
 5. The parent or guardian and the member, if applicable, must sign and date the ITP.
 6. Be reviewed every ninety (90) days by the treatment team.
 7. If indicated, the member's needs may be reassessed, and the ITP revised.
 8. The provider will provide the member with a copy of the initial and reviewed ITP within ten (10) days of signing.

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

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

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

- The clinician, member, and other participants (service providers, parents, or guardian) must develop an ITP based on the comprehensive assessment that is appropriate to the member's developmental level within thirty days of the day the members begin services.
- When an ITP is required, it must contain the following, unless there is an exception:

1. The member's diagnosis and reason for receiving the service.
 2. Measurable long-term goals with target dates for achieving the goals.
 3. Measurable, short-term goals, with target dates for achieving the goals, with objectives that allow for measurement of progress; specific services to be provided with amount, frequency, duration and practice methods of services; and designation of who will provide the service, including documentation of co-occurring services and natural supports, when applicable.
 4. Measurable Discharge criteria.
 5. Special accommodations needed to address physical or other disabilities to provide the service; and
 6. All participants must sign, credential (if applicable) and date the ITP. The first ninety (90) day period begins with date of the initial, signed ITP. The ITP must be reviewed at all major decision points but no less frequently than ninety (90) days, or as described in 65.09-3.B.7. If clinically indicated, the member's needs may be re-assessed, and the ITP may be reviewed and amended more frequently than every ninety (90) days. Changes to the ITP are considered to be in effect as of the date it is signed by the clinician and member or, when appropriate, the parent or guardian. All participants must sign, credential (if applicable) and date the reviewed ITP.
- For members receiving crisis resolution services, a written plan of care is substituted for the ITP.
 - For members receiving family psychoeducation, no comprehensive assessment is required. For members receiving psychological testing, no comprehensive assessment or ITP is required. For members receiving a neurobehavioral status exam, no ITP is required.
 - If a member receives covered case management services (MaineCare Benefits Manual, Section 13) or services under MaineCare Benefits Manual Section 17, the member's mental health provider's ITP will coordinate with the appropriate portion of the member's ITP described in MaineCare Benefits Manual Section 13 or MaineCare Benefits Manual Section 17.
 - MaineCare will reimburse for covered services provided before the ITP is approved as long as the ITP is completed within prescribed time frames from the day the member begins treatment.
 - The ITP must be completed and reviewed every ninety days.
 - If a member is assessed by appropriate staff, but an ITP is not developed because there is at least a sixty-day waiting list to enter treatment, reimbursement may be made for the assessment only.
 - Comprehensive assessments must be updated before treatment begins if, in the opinion of the professional staff assigned to the case, this would result in more effective treatment. If an update is necessary, additional units for the comprehensive assessment may be authorized by DHHS or an Authorized Entity.
 - Crisis/safety plan must:
 1. Identify the precursors to the crisis.
 2. Identify the strategies and techniques that may be utilized to stabilize the situation.
 3. Identify the individuals responsible for the implementation of the plan, including any individuals whom the member (or parents or guardian, as appropriate) identifies as significant to the member's stability and well-being; and
 4. Be reviewed every ninety days or as part of the required review of the ITP.

Member Written Record

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

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

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

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

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

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

- Providers must maintain a specific record for each member, which shall include, but not necessarily be limited to:
 1. Member's name, address, birthdate, and MaineCare ID number.
 2. The member's social and medical history, and medical diagnoses indicating the medical necessity of the service or services.
 3. A personalized plan of service
 4. Written progress notes

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

- Providers must maintain a specific record for each member, which shall include, but not necessarily be limited to:
 1. Member's name, address, birthdate, and MaineCare ID number
 2. The member's social and medical history and medical diagnoses indicating the medical necessity of the service or services
 3. A personalized plan of service
 4. Written progress notes each day the member is seen (also referred to as the treatment or session note)

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

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

1. Member's name, address, phone number, emergency contact, birth date.
2. The member's medical eligibility determination form, release of information, authorized plan of care and copies of the eligibility determination notice and service authorizations issued by the Service Coordination Agency for members over age 21.

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

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

- The provider will maintain an individual record for each member eligible for MaineCare reimbursement, including but not limited to:
 1. Name, birthdate, MaineCare ID Number.
 2. Referral from a practitioner of the healing arts as allowed by the respective licensing authority and their scope of practice, made in writing or by telephone prior to the delivery of service. Written referral confirming a telephone referral must be included in the record within thirty (30) days of the original order.
 3. Pertinent medical information, as available, regarding the member's condition.
 4. Appropriate hearing and/or speech-language evaluation and diagnosis.
 5. A plan of care which includes identified problems, treatment in relation to the problems, and obtainable goals. This plan shall be updated in relation to the member's progress in reaching the goals.
 6. Documentation of each visit, showing the date of service, the service performed, the start time and stop time of the service, indicating the total time spent in delivering the service, and the signature of the individual performing the service.
 7. Progress notes written regularly, (at least quarterly), which state the progress which the member has made in relation to the plan of care.
 8. A discharge summary with a copy sent to the referring practitioner of the healing arts.
 9. Copies of prior authorization or any other pertinent information concerning the member.
- Members' records will be kept current and available to the Department as documentation of services included on invoices.

Nursing Treatment Plan of Care

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

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

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

Plan of Service

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

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

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

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

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

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

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

Prior Authorization

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

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

Frequency: Prior authorizations for ongoing services must be resubmitted quarterly except for transportation. Documentation submitted in support of a prior authorization request must be sufficient to establish medical necessity, as opposed to educational necessity.

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

Prior Authorizations

Pre-Review of IEP Documentation

Effective January 1, 2022, an update was made to the Prior Authorization process for Section 28 and 65 services. As communicated in [joint guidance](#) from the Maine Department of Health and Human Services (MDHHS) and MDOE, Section 1903(c) of the federal Social Security Act permits Medicaid payments for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) through a child's IEP. Documentation that health-related services are being provided as part of a member's IEP is required under federal law to ensure the services are Medicaid reimbursable.

As part of Acentra Health's (formerly Kepro) review process, providers will be asked to indicate if the requested service is being provided pursuant to IDEA regulations. If the answer is yes, the provider must submit the IEP cover page, along with Sections 6 and 7 of a member's IEP.

Acentra Health will review the submitted IEP documents to ensure services are documented in accordance with the DHHS/MDOE [joint guidance](#). Providers will be notified if documentation is not in compliance. They will then be asked to correct and update the member's IEP. Service authorizations will be placed on hold until providers upload the updated IEP. The review process helps providers ensure documents are in alignment with IDEA and federal requirements prior to the provision of services. **As reminder, IEP services must be a determination of the IEP team and cannot be altered or added solely for the purpose of MaineCare authorization of payment.**

Additional information regarding the provision of MaineCare-covered services in schools is available on the [MaineCare in Education](#) website. Providers will also find a [recording](#) of the joint OMS/MDOE presentation from June 2, 2021.

Requests for Prior Authorization of IDEA Services

It is important to remember that requests for School Health-Related services are only for members age three (3) and older.

For example, if a member who is less than three years old needs Section 28 services, Acentra Health staff would expect to see a request for Home and Community Based Services, not for Section 28 services delivered in a school setting.

This is because the providers are approved through the Department of Education to serve students ages three (3) and older, as either a Special Purpose Private School or a Regular Education Public School Program and when services are delivered in a school/center-based setting.

Progress Notes

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

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

For Section 65 Behavioral Health Services (65.05 MBM)

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

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

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

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

- Written progress notes each day the member is seen, (also referred to as the treatment or session note) shall contain: Identification of the nature, date, and provider of any service given; the start time and stop time of the service, indicating the total time spent delivering the service; any progress toward the achievement of

established long and short range goals; the signature of the service provider for each service provided; and a full account of any unusual condition or unexpected event, including the date and time when it was observed and the name of the observer.

- Entries are required for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify why more, less, or different care than that specified in the plan of care was provided.

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

- Written Progress Notes for Services Delivered by a Direct Care Provider must contain: The service provided, date, and by whom; entrance and exit times of nurse's, home health aides, certified nursing assistants and personal care assistant' visits and total hours spent in the home for each visit. Exclude travel time, (unless provided as a service as described in this Section); a written service plan that shows specific tasks to be completed and the schedule for completion of those tasks; progress toward the achievement of long and short-range goals. Include explanation when goals are not achieved as expected; signature of the service provider; and full account of any unusual condition or unexpected event, date and documented.
- Written Progress Notes for the Service Coordination Agency must contain: Date and time of every contact with the member and by whom, and progress toward the achievement of long- and short-range goals. Include explanation when the goals are not met as expected; signature and date of the Service Coordination Agency staff member entering the note; full account of any unusual condition or unexpected event, dated and documented; and all entries must be signed by the individual who performed the service. Authorized and valid electronic signatures are acceptable.

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

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

Audit Guidance: Historical Findings Summary

Below is a summary of major findings from audits conducted 2016 through 2020 for review. Due to various confidentiality concerns, the Office of MaineCare Services is not able to disclose specific details on past Program Integrity (PI) audits or reviews conducted, or those currently in process. PI provides appeals information during the audit process.

It is important to understand that the Office of MaineCare Services is required under federal Medicaid law to ensure that all services provided are medically necessary. As outlined above, providers must maintain documentation reflecting the provision of all services as outlined in the MaineCare Benefits Manual. As always, if a SAU or contracted provider has any questions about compliance with MaineCare’s rules, they should contact MaineCare directly. If they outreach DOE with a MaineCare-related question, DOE staff should redirect them to MaineCare.

➤ Summary of Major Audit Findings



Billing	Claims billed at the master’s level for services provided by a bachelor’s level professional
	Claims billed for 1:1 when notes describe a group session was provided.
Comprehensive Assessments	No comprehensive assessment was found covering the date of service provided.
	Parent/guardian signatures were missing from the Comprehensive Assessment provided.
IEP Review	The IEP provided was completely blank.
	The IEP provided did not list the MaineCare reimbursable service or listed a wrong MaineCare reimbursable service.
Individual Treatment Plans	There was no treatment plan for the date of service
	The Individual Treatment Plan was not signed by any member of the treatment team.
	The Individual Treatment Plan was not signed by a parent or legal guardian.
	There were no goals or objectives listed on the Individual Treatment Plan.
	The Individual Treatment Plan was outdated.
Prior Authorizations	There was no Prior Authorization for the service provided where Prior Authorization is required.
Progress Notes	No progress notes were provided as requested.
	Progress notes did not contain duration of service
	Progress notes did not contain a description of the service being provided.
	Progress notes state member was “sick” and did not attend session.
	Progress notes state “staff not present.”
90 Day Review	No review was completed.

	Review was not completed in a timely manner.
Modifiers	The “TM” modifier was not used when services were provided in conjunction with an IEP.

- It is important to note that there are often overlapping violations that PI identifies in an audit/review. It is not uncommon to identify more than one of the errors identified above on a single claim.

Additional Information

IDEA vs. Non-IDEA Related Claim Submissions

If there is clear documentation for each session showing that separate services are being provided, and if overall limits for services are not exceeded, (even if services are provided by the same person/agency), concurrent billing is allowable when a member is provided services in more than one setting, on the same day. Providers can also provide services in more than one setting, pursuant to any limitations on the service outlined in the [MaineCare Benefits Manual](#).

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

Claims submitted for School Health-Related services provided in connection with an IFSP or an IEP must indicate the correct Place of Service Code as “03,” along with a modifier of either TL or TM for us to differentiate between the IDEA and non-IDEA service provided.

Reminder- Modifiers

For all services provided pursuant to IDEA, providers are required to utilize the modifiers below. The claims that should match a student’s IFSP or IEP. These global modifiers are in addition to any other modifiers as instructed to bill for the covered service. Modifiers do not need to be used for the prior authorization; however, they **must be included when the claim is submitted**.

“**TL**” - Services delivered under an Individualized Family Service Plan (IFSP)

“**TM**” - Services delivered under an Individualized Education Plan (IEP) with MaineCare addendum denoting medical necessity of the service.

- The TL or TM modifiers should always come after any other modifiers necessary as listed in the MBM, Chapter III Allowance schedules.
- Prior to April 1, 2022, MaineCare providers did not have the option to use “TL” or “TM” modifiers for services delivered through Sections 28 or 96. A change has been made which now allows this to occur.
- If a provider delivers services in addition to what is listed on an IFSP or IEP, those services must be submitted separately without the “TL” or “TM” modifier.

Place of Service Code

All schools will need to make sure that the Place of Service Code on the claim is “03” when a School Health-Related Service claim is submitted if the service is delivered in school.

Here are some other common Place of Service Codes where services may be delivered:

Community Mental Health Center	53	On-Campus, Outpatient Hospital	22
Federally Qualified Health Center (FHQC)	50	Off-Campus, Outpatient Hospital	19
Home	12	School	03
Office	11	Telehealth	02

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

Record Retention

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

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

Review and Submission of Claims

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

- Claims may be filed using Direct Data Entry on the MaineCare portal. This is the preferred method of billing.
- Paper claims may be mailed to: MaineCare Claims Processing, M-5500, Augusta, ME 04333.
- The Maine Integrated Health Management Solution (MIHMS) website is available [here](#).

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

Part VI: School-Based Health Centers

School-Based Health Centers

School-Based Health Centers (Clinics) are defined in Chapter II, Section 3 of the MBM. These centers are an option for SAUs who would like to provide a specific array of services to MaineCare members.

Covered services include preventive, diagnostic and/or therapeutic services for acute, episodic, and chronic conditions furnished by the center's professional staff; supplies commonly furnished for the provision of these services; and basic laboratory services essential for immediate diagnosis and treatment. Providers can choose what services are delivered based on the members' needs. Providers do not have to provide all these services listed in this policy.

Professional Staff qualified to provide services through a School Based Health Center include: Physician, Nurse Practitioners, Physician Assistants, Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors, Alcohol and Drug Counselors, Registered Nurses, Licensed Clinical Professional Counselors (LCPS), Psychologists, Respiratory Therapists, Nurse-Midwives, and Other Qualified Staff as defined in 3.06 MBM.

Medical services rendered under this policy must be provided under the supervision of a physician. Nurse practitioners who have completed a minimum of 24 months supervision by a licensed physician and nurse-midwives are not subject to supervision by a physician. Psychologists, LCSWs, LCPCs and other non-medical staff are also not subject to the supervision of the physician. Physician supervision must be performed in accordance with the Maine Board of Licensure in Medicine or the Maine Board of Licensure in Osteopathy and the Maine State Board of Nursing requirements (3.06-2 MBM).

Patient Records should include the following information as listed in 3.06-3 MBM:

- A. The patient's name, address, and birth date.
- B. The patient's social and medical history, as appropriate.
- C. Long and short-range goals, as appropriate.
- D. A description of any tests ordered and performed and their results.
- E. A description of treatment or follow-up care and dates scheduled for revisits.
- F. Any medications and/or supplies dispensed or prescribed.
- G. Any recommendations for and referral to other sources of care.
- H. The dates on which all services were provided.
- I. Written progress notes, which shall identify the services provided and progress toward achievement of goals; and
- J. A description of the findings from the physical examination.

Entries are required for each service billed and must include the name, title, and signature of the service provider.

For more information, please see:

[MaineCare Benefits Manual, Section 3, Chapter II Ambulatory Care Clinics Provider Fee Schedule](#) (Allowance Chart)