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1.01 INTRODUCTION AND STATUTORY AUTHORITY

The following laws of the United States and the State of Maine provide statutory authority for benefits governed by this *MaineCare Benefits Manual* (MBM):

A. Medicare: Title XVIII of the *Social Security Act,* as amended; 42 U.S.C.A. §1395 *et seq.*

B. Medicaid: Title XIX of the *Social Security Act*, as amended; 42 U.S.C.A. §1396 *et seq*.

C. 22 M.R.S. §3173 *et seq*.

D. Family Planning Services: 22 M.R.S. §1901, *et seq*.

E. State Children's Health Insurance Program (CHIP): Title XXI of the *Social Security Act*, as amended; 42 U.S.C. §1397.

F. Cub Care Program: M.R.S. §3174-T as enacted by Public Law 1998, Chapter 777, approved by the Governor, April 16, 1998.

1.02 MAINECARE ADMINISTRATION

1.02-1 General

The Maine Department of Health and Human Services (the Department) is responsible for administering MaineCare in compliance with federal and state statutes, and for administrative policies.

A. **Federal Authority**

Federal authority for Medicare, Medicaid, and CHIP rests with the Secretary of the Federal Department of Health and Human Services. Primary responsibility within the Department of Health and Human Services in turn rests with the Centers for Medicare and Medicaid Services (CMS).

B. **State Authority**

Authority for the Department of Health and Human Services to accept and administer any funds which may be available from private, local, state, or federal sources for the provision of the services set forth in this Manual is established by 22 M.R.S., §§ 10, 12 and 3173. The regulations themselves are issued pursuant to authority granted to the Department of Health and Human Services by 22 M.R.S. §§ 42 (1), and 3173.

1.02-2 Departmental

The Commissioner of the Department of Health and Human Services has delegated authority for administering the MaineCare Programs as follows:

1.02 MAINECARE ADMINISTRATION (cont.)

A. The Department of Health and Human Services, Office for Family Independence, determines eligibility for MaineCare.

B. The Department of Health and Human Services, Program Integrity Unit and Division of Audit, monitors the MaineCare Program for fraud, abuse, and inefficient use of funds, and also administers sanctions, recovers overpayments and applies penalties.

C. The Office of MaineCare Services performs numerous functions related to the delivery of MaineCare services, including, but not limited to, the following:

1. Clinical and quality management including,

   a. Prior authorization;
   b. Classification Review/Case Mix;
   c. Pharmacy management;
   d. Provider resource/development;
   e. Care management; and
   f. Quality assurance;

2. MaineCare operations, including provider and member services, claims research and adjustment, and claims processing;

3. Policy development and revision, including development and revision of MaineCare rules regarding the amount, duration and scope of services and the management of the Medicaid State Plan and related federal waivers;

4. Identifying and collecting reimbursement from legally liable parties for medical expenditures paid by the Department, including estate recovery, casualty recovery, drug rebates, and private health insurance premiums;

5. Customer Service, including provider and member services and claims research and adjustments.

Some functions of MaineCare Services may be provided by agents under contract to the Department.

1.02-3 Agency Rulemaking

In the event that any requirement of this Chapter I is inconsistent with the requirements of any other Chapter of the MBM, the requirements of this Chapter I shall control.

The Department publishes Notices of Agency Rulemaking in the major newspapers to cover the entire State. Copies of proposed rules regarding MaineCare benefits are made available upon request prior to the adoption of any rule, by contacting MaineCare Services, Division of Policy.

1.02 MAINECARE ADMINISTRATION (cont.)

Copies of all rules, including proposed, emergency and final rules are also available on the MaineCare Services web site at no cost. The website address is: http://www.maine.gov/dhhs/oms/rules/index.shtml. All rules are promulgated in accordance with the provisions outlined in the *Maine Administrative Procedure Act* (APA) and all other applicable statutes and executive orders. Interested parties may also subscribe with MaineCare Services to receive electronic notices of proposed rulemaking. Printed copies are available for a fee. Members, other state agencies, providers of the particular administrative units, contractors with the administrative unit, public or private non-profit organizations, and agencies or groups representing constituent populations who may be impacted by the printed materials being requested, and selected legislative offices may receive one (1) *MaineCare Benefits Manual* at no charge upon request. A fee will be charged for additional requests for policies. A sixty-five dollar ($65.00) fee will be charged for additional requests for the entire *MaineCare Benefits Manual*.

The Department must give notice of proposed rulemaking to the following interested parties before a hearing or before the deadline for comments, if no hearing is scheduled:

A. Any person specified in the statute authorizing the rulemaking;

B. Any person who, within the past year, has filed a written request with the Agency for notice of rulemaking. The Department may charge a fee reasonably related to the cost of this service; and

C. Any trade, industry, professional interest group or regional publication that the Department deems effective in reaching affected persons.

1.02-4 General Definitions

A. **Authorized Entity** means an organization, entity or individual authorized by the Department to perform specified functions pursuant to a signed contract or other approved signed agreement.

B. **"Covered Health Care Provider"** means a health care provider, as defined in 45 C.F.R. §160.103, specifically, a provider of medical or health services and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business.

C. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child);

2. Serious impairment to bodily functions; or

1.02 MAINECARE ADMINISTRATION (cont.)

3. Serious dysfunction of any bodily organ or part.

D. **Emergency Medical Condition for Undocumented Non-Citizens** means a medical condition (including emergency labor and delivery) characterized by sudden onset, and manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to the member's health;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

MaineCare will not cover any services after stabilization of the emergency condition for undocumented non-citizens. Examples of services that are not considered an emergency medical condition include, but are not limited to: dialysis, organ transplants, school based services, personal care services, waiver services, nursing facility services and hospice services.

E. **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 (EPSDT) requirements as detailed in Chapter II, Section 94 of this Manual);

5. Performed by enrolled providers within their scope of licensure and/or certification; and

6. Provided within the regulations of this Manual.

F. **Member** means any person enrolled in the MaineCare program.

1.02 MAINECARE ADMINISTRATION (cont.)

G. **National Provider Identifier** (NPI) is a unique, 10 digit, intelligence free, identification number issued by CMS to covered health care providers. Intelligence free means that the numbers do not carry other information about healthcare providers such as the state in which they live or their medical specialty.

H. **Provider** means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group association, corporation, institution, or entity that is enrolled in the MaineCare program as one of the following:

1. **Rendering Provider (also known as a Servicing Provider)** is defined as an individual MaineCare provider who performs services for eligible MaineCare members through a Group or Facility/Agency/Organization (FAO). A rendering provider does not bill MaineCare directly. The billing provider submits claims and receives payment on behalf of the rendering provider.

2. **Billing Provider** means the MaineCare provider submitting claims and receiving MaineCare payment for services. Billing providers perform these functions on behalf of the rendering provider.

3. **Non-Billing, Ordering, Prescribing and Referring (NOPR) Provider** – A physician or non-physician practitioner who is eligible to enroll in MaineCare, qualified to order, prescribe and/or refer services or supplies for MaineCare-eligible members, and has an NPI, but may not submit claims for payment for services provided to Medicaid Members. In order for MaineCare to reimburse for orders, prescriptions and/or referral of services or supplies resulting from the order of an NOPR Provider, the NOPR Provider must be enrolled in MaineCare as a MaineCare NOPR Provider.

1.02-5 **Department/Provider Notices and Information Dissemination**

A. Unless otherwise specified by statute or regulation the Department may provide notices or disseminate information to the provider by any of the following methods:

1. In person by a person authorized by MaineCare Services who signs a proof of service.

2. Regular U.S. mail, with proper postage, to the address on file with the Provider Enrollment Unit.

3. Certified mail, return receipt, to the last known address.

4. Facsimile to the number on file with the Provider Enrollment Unit.

1.02 MAINECARE ADMINISTRATION (cont.)

5. Electronic mail to the e-mail address on file with the Provider Enrollment Unit.

B. When sent to the "pay-to" addresses on file with the Provider Enrollment Unit, notices and/or information will be presumed to have been received by the provider:

1. By facsimiles and e-mails, the same day they were sent.

2. By regular U.S. mail, the third (3rd) day after the notice or information was deposited in the mail.

3. By certified mail, return receipt, the date the mail receipt is signed by the provider, its agent, or employees.

C. Except as required by other sections of the MBM, notices or information provided to the Department may be sent to the Director, MaineCare Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine, 04333-0011.

D. Notices or information dissemination must be provided within the timeframes outlined in the MBM and the provider agreement.

1.03 PROVIDER PARTICIPATION

1.03-1 Enrollment Process

A. All providers must complete an initial enrollment application followed by subsequent enrollment applications to take place at various intervals as follows:

1. Every three (3) years for providers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS);

2. Every five (5) years for all other providers; and

3. Upon request by the Department.

B. Providers should enroll online through the Department's Health PAS portal, located at https://mainecare.maine.gov.

Consistent with 42 C.F.R. §431.107, the provider understands and agrees that an executed Provider Agreement by and between the provider and MaineCare is mandatory for participation or continued participation in the MaineCare Program. If upon request, a provider fails to timely furnish an executed Provider Agreement to MaineCare, the provider will be out of compliance. No reimbursement for claims submitted shall be paid to the provider until compliance is established.

1.03 PROVIDER PARTICIPATION (cont.)

Providers have a continuing obligation to supply the Department with complete, accurate, and updated information as required by the MBM and the Provider Agreement.

The Department may request additional information beyond the Provider Application from an applicant. The Department may require the applicant to provide documentation demonstrating the applicant's ability to provide high-quality care, services, and supplies and to be financially responsible.

All providers are required to update any changes to their NPI information or any other enrollment information within ten (10) days of the change.

1. New MaineCare Provider Agreement Required

   In the event of any of the following changes, the provider will be required to sign a new provider agreement.

   a. New enrollment application submitted;
   b. Subsequent enrollment application submitted;
   c. Reactivation application submitted.

2. Requirements for Updated MaineCare Provider Agreement

   Under the following circumstances, the provider is required to change their MaineCare Provider Agreement (rather than sign a new provider agreement):

   a. New service location;
   b. Change of physical address to a service location;
   c. Existing service location is terminated;
   d. Change of provider name or “doing business as” (DBA) name.

In the event that any requirement of this Chapter governing provider participation is inconsistent with the requirements of any other Chapter of the MBM, the requirements of this Chapter shall control.

C. **Enrollment Fee**

1. A prospective or re-enrolling provider must submit the applicable application fee established in 42 CFR 424.514(d) to MaineCare prior to executing a MaineCare Provider Agreement, except for the following providers:

   a. Individual physicians or non-physician practitioners; and
   b. Providers that are enrolled in either of the following:

1.03 PROVIDER PARTICIPATION (cont.)

i. Title XVIII of the *Social Security Act*; or
ii. Another State's Title XIX or XXI plan; and

c. Providers that have paid the applicable application fee to:
i. A Medicare contractor; or
ii. Another State Medicaid Agency.

2. Institutional providers that submit an application to establish a new practice location must submit the applicable application fee prior to executing a MaineCare Provider Agreement.

3. MaineCare will reject the enrollment application from a newly-enrolling institutional provider, or an institutional provider that is applying to establish a new practice location, that is submitted without the application fee or documentation that CMS has granted the provider a hardship waiver for the application fee.

4. Requests for hardship waivers must be submitted to CMS pursuant to 42 CFR 424.514.

D. MaineCare does not reimburse in-state providers, including rendering providers, for services provided to members prior to enrollment approval or after a provider's enrollment has been terminated (end-dated).

E. Once the enrollment application has been submitted online through the Department's Health PAS portal, notification of MaineCare's decision will be sent to providers via electronic notification or U.S. mail. The effective enrollment date is the effective date of the Provider Agreement.

F. In the case of retroactive enrollment for Federally Qualified Health Centers (FQHCs), the retroactive FQHC enrollment will be effective on the date of the FQHC's Health Resources and Services Administration (HRSA) or CMS approval, not before. In the case of retroactive enrollment for Rural Health Clinics (RHC), retroactive enrollment will be effective on the date of the Medicare approval. In the case of retroactive enrollment for Indian Health Centers (IHCs), the retroactive IHC enrollment will be effective on the date of the HRSA grant.

Retroactive enrollment for all other providers is subject to review and approval by the Department in accordance with 42 C.F.R. §431.108. The provider must supply all information requested by the Department, including all reasons justifying the request for retroactive enrollment, as well as proof of any required licensure or certification for the period. A request for retroactive enrollment is subject to the Department's review and discretion and is not a guarantee of claim payment or prior authorization. The Department may grant retroactive enrollment back to the Medicare certification date, but will not grant a retroactive enrollment date that is more than three hundred and sixty-five (365) days prior to the date of the provider's MaineCare application submission.

1.03 PROVIDER PARTICIPATION (cont.)

G. The Department will pay for MaineCare covered services provided only to the following members:

1. Those who are eligible for the specific services on the date the services are actually provided, unless otherwise specified in the MBM; or

2. Those who have been granted retroactive MaineCare eligibility after services have been provided. For more information on retroactive eligibility see Section 1.04-1.

H. Certain providers will be required to use rendering provider NPI in accordance with the appropriate billing instructions. For some types of new providers not previously reimbursed under MaineCare, reimbursement rates must be established before the provider may be enrolled and reimbursed for covered services.

Chapter II outlines additional requirements that may apply in specific instances including state contracts, and certification of state share. Certain providers will be required to: attend provider education sessions; have prior authorization of services; and/or have one hundred (100%) percent review of claims prior to payment.

I. **National Provider Identifier**

In order to enroll with MaineCare, providers must obtain a NPI. If a provider is not eligible for an NPI, the Provider Enrollment Health PAS portal will assign an Atypical Provider Identifier (API) to qualified providers. In addition, this system will assign three-digit identifiers to each service location enrolled by the provider.

These identifying numbers must be used in submitting all claims for payment.

J. **Fingerprint-based Criminal Background Checks**

1. Any provider or provider applicant whose categorical risk level is high, as defined below, must consent to a fingerprint-based criminal background check (FCBC) and submit fingerprints to the Department or its vendor in the form and manner required by the Department. The provider or provider applicant and any person with a five (5) percent or greater direct or indirect ownership interest in the provider or provider applicant must submit fingerprints as directed by the Department and shall be responsible for the costs of the FCBC.

The Department shall terminate or deny enrollment of a provider if the provider, provider applicant, or any person with a five (5) percent or greater direct or indirect ownership interest in the provider or provider applicant who is required to submit fingerprints:

1.03 PROVIDER PARTICIPATION (cont.)

a. Fails to submit them within thirty (30) days of the Department's request;
b. Fails to submit them in the form and manner requested by the Department; or
c. Has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or CHIP programs in the last ten (10) years.

The Department may rely upon a provider or provider applicant's Medicare enrollment if that provider or provider applicant is considered high risk by Medicare, has been enrolled by Medicare, has undergone an FCBC, and if the provider or provider applicant has passed or failed the FCBC.

The Department may also rely upon the results of an FCBC conducted by another state's Medicaid program if the provider or provider applicant is enrolled in the other state's Medicaid or CHIP program and has met the revalidation requirement of 42 CFR § 455.414.

2. **High Categorical Risk**

a. In accordance with 42 CFR 424.518, the following provider types have high categorical risk:

i. Prospective (newly enrolling) home health agencies;
ii. Prospective (newly enrolling) DME suppliers;
iii. Prospective (newly enrolling) Medicare Diabetes Prevention Program suppliers; and
iv. Prospective (newly enrolling) opioid treatment programs that have not been fully and continuously certified by SAMHSA since October 23, 2018.

b. The categorical risk for a provider or supplier shall be adjusted to high if the following occurs:

i. MaineCare has imposed a payment suspension on a provider based on credible allegations of fraud, waste or abuse within the past ten years;
ii. The provider has an existing Medicaid overpayment of $1,000 or more owed to the Department which is not currently under appeal or in a payment plan;
iii. The provider has been excluded by the Office of the Inspector General or another State's Medicaid program within the previous 10 years;
iv. MaineCare or CMS in the previous six (6) months lifted a temporary moratorium for a particular provider or supplier type, and a provider or supplier that was prevented from enrolling based on the moratorium applies for enrollment as a MaineCare provider or

1.03 PROVIDER PARTICIPATION (cont.)

supplier at any time within 6 months from the date the moratorium was lifted; or

v. The provider or supplier:
   A. Has been excluded from Medicare by the Office of the Inspector General;
   B. Had billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to:
      1. Enroll as a new provider or supplier; or
      2. Establish billing privileges for a new service location;
   C. Has been terminated or is otherwise precluded from billing Medicaid;
   D. Has been excluded from any federal health care program; or
   E. Has been subject to any final adverse action within the previous ten (10) years, which includes the following:
      1. A Medicare-imposed revocation of any Medicare-imposed privileges;
      2. Suspension or revocation of a license to provide health care by any State licensing authority;
      3. Revocation or suspension by an accreditation organization;
      4. A conviction of a Federal or State felony offense (as defined in 42 CFR § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
      5. An exclusion or debarment from participation in a Federal or State health care program.

1.03-2 **Additional Enrollment Requirements for Out-of-State Providers**

A. All out-of-state providers, with the exception of NOPRs, must be fully enrolled with MaineCare, including those providers that provide emergency services. Out-of-state providers are subject to all requirements as described in 1.03-1. Out-of-state NOPRs must follow the same enrollment requirements as in-state NOPRs.

B. Out-of-state providers may enroll after services have been provided but must do so before billing for the services rendered. The Department may terminate the enrollment status of an out-of-state provider at any time there are no MaineCare members receiving authorized services from that provider.

C. Out-of-state providers that only provide emergency services to MaineCare members traveling out-of-state may bill MaineCare for those services. These providers must notify the Department, or its Authorized Entity, within one business day of an emergency admission for a MaineCare member. Inpatient emergency admissions will be reviewed for medical appropriateness. Length of stay will be authorized by the Department, or its Authorized Entity, and will be based upon medical documentation supporting the member's need for services. In order to be reimbursed by MaineCare for emergency inpatient services provided, the provider must receive and submit an authorization number on the claim form

1.03 PROVIDER PARTICIPATION (cont.)

submitted to the Department.

For emergency services that do not result in an inpatient admission, the provider must notify the Department, or its Authorized Entity, of the treatment provided to the member, also within one (1) business day.

In cases where the provider is unable to confirm proof of MaineCare coverage (e.g., member is unconscious or the member does not have a MaineCare card readily available), the provider may exceed the one-day requirement by providing a sufficient explanation of the case.

D. Other instances in which an out-of-state provider may enroll in MaineCare include, but are not limited to the following:

1. Services and equipment provided to a member who is residing out-of-state, at the discretion of the Department, taking into account cost-effectiveness and medical necessity;

2. A provider that is the sole provider of a type of cost-effective medically necessary item or service may be enrolled only for the purpose of providing that item or service with prior authorization. An example would be an out-of-state laboratory that conducts a test, or a manufacturer of a highly specialized item, not provided by any in-state provider; and

3. An out-of-state provider of services to a MaineCare member who is eligible for services as a Qualified Medicare Beneficiary (QMB) may enroll as a MaineCare provider only for the purpose of billing Medicare coinsurance and deductibles.

E. The Department reserves the right to issue a request for proposals for provision of any service, pharmaceutical, supply, or piece of equipment. The resulting contract may be awarded to an out-of-state provider.

F. Out-of-state providers located within fifteen (15) miles of the Maine/New Hampshire border are treated the same as Maine providers in all aspects of policy requirements, enrollment, rates of reimbursement, and payment methodologies with the exception of out-of-state hospitals, which are excluded from in-state reimbursement methodology as described in Chapter III, Section 45. MaineCare will not provide payment to any entity outside the United States.

G. Maine-based providers that are providing services out-of-state are considered out-of-state providers and as such are bound by the same requirements as out-of-state providers, including prior authorization and proper licensure within the state in which services are being provided.

1.03 PROVIDER PARTICIPATION (cont.)

1.03-3 Denial of Enrollment and Subsequent Enrollment Applications

A. MaineCare shall deny enrollment or subsequent enrollment of any individual or entity that meets any of the following conditions:

1. The provider is currently excluded by MaineCare;

2. The provider has been terminated on or after January 1, 2011, by Medicare or by the Medicaid program or CHIP of any other state, and remains excluded;

3. The provider or any person with a five percent (5%) or greater direct or indirect ownership interest in the provider fails to submit timely and accurate information and cooperate with any screening methods required under 42 CFR PART 455, Subpart E;

4. Any provider or any person with a five percent (5%) or greater direct or indirect ownership interest in the provider who has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years;

5. Any provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information; or

6. The provider fails to permit access to provider locations for a site visit.

B. MaineCare may deny enrollment of any individual or entity that meets any of the following conditions:

1. The provider has falsified any information or omitted any material fact on the application;

2. The Department is unable to verify the identity of the provider;

3. The provider has any previous suspension, exclusion or involuntary withdrawal from participation in MaineCare, Medicare, or the Medicaid program of any state;

4. The provider is, has been previously, or is currently suspended, excluded, or has involuntarily withdrawn from participation in any private medical insurance program;

5. The provider is in receipt of, but has not made restitution for, a MaineCare, Medicare, or other state Medicaid program’s overpayment, as determined to have been made pursuant to a final decision or determination of an agency

1.03 PROVIDER PARTICIPATION (cont.)

having the powers to conduct the proceeding and after an adjudicatory proceeding in which no appeal is pending or after resolution of the proceeding by stipulation or agreement; however, if a provider has entered into a plan of restitution of such overpayments, an application will not be denied solely on this factor unless the provider has defaulted in repayment;

6. The provider has made any false representation or omission of a material fact in making application in any state for any license, permit, certificate, or registration related to a profession or business;

7. The provider has failed to correct deficiencies in the operation of a business or enterprise after having received written notice of the deficiencies from a state or federal licensing or auditing agency;

8. The provider fails to supply further information concerning the application after receiving a written request for such further information;

9. The provider submits an application which conceals an ownership or control interest of any person who would otherwise be ineligible to participate;

10. The provider has been indicted for or convicted of any crime relating to the furnishing of, or billing for, medical care, services, or supplies which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals;

11. The provider has a prior finding by a licensing, certifying, or professional standards board or agency of the violation of the standards or conditions relating to licensure or certification or as to the quality of services provided;

12. The provider has a prior history of excessive claims or furnishing of unnecessary or substandard services and/or items, or any prior improper conduct under any private or publicly funded program or insurance policy;

13. The provider demonstrates any other factor having a direct bearing on the applicant's ability to provide high-quality medical care, services or supplies to recipients of MaineCare benefits, or to be fiscally responsible to the program for care, services or supplies to be furnished under the program, including actions by persons affiliated with the applicant;

14. Any other factor which may affect the effective and efficient administration of the program, including, but not limited to, the current availability of medical care, services or supplies to members, or the inability to bill appropriately for services rendered.

1.03 PROVIDER PARTICIPATION (cont.)

1.03-4 Notice of Denial of Application

Upon completion of its review of an enrollment application, including consideration of the above factors, the Department will notify any provider applicant of the Department's denial of the application by issuing a written notice of denial to the provider or provider applicant. The notice will specify the reasons for the denial. Department denials may be appealed in accordance with this regulation.

1.03-5 Claims Submittal Following Termination of Enrollment

Providers that are terminated, either voluntarily or involuntarily, from MaineCare enrollment, will have one (1) year from the end date of their enrollment to submit claims for services provided during the period of active enrollment (that is, for services delivered prior to the end date of enrollment). Claims for services delivered during the period of active enrollment will not be reimbursed if the claims are submitted beyond one (1) year of the date of the service.

1.03-6 Changes of Ownership, Closures, and Disenrollment

A. Providers must notify the Provider Enrollment Unit of any Change in Ownership (CHOW), closure, or intention to disenroll from the MaineCare program no less than thirty (30) days prior to the intended change, except in the case of reasonably unforeseen circumstances. Providers must take all reasonable and appropriate steps requested by the Department to transition members before the intended change and, upon request, submit a transition plan to the Department for review and approval.

B. Providers undergoing a CHOW must update the change on the Health PAS portal. As part of that process, the providers will be required to complete the CHOW questionnaire and follow the online instructions for submission. Depending on the questionnaire responses, the provider may be required to submit a new application.

1.03-7 Automatic Disenrollment

The Department will terminate the enrollment of any provider (other than NOPR providers) that has not submitted a claim within three hundred and sixty-five (365) days of enrollment. Such providers are eligible to re-enroll at any time.

1.03-8 Requirements of Provider Participation

Enrolled providers must:

A. Maintain current licenses, as applicable, and must submit copies of license renewals to the Provider Enrollment Unit to ensure continuity of services through license expiration dates. Providers that are "covered health care providers" are

1.03 PROVIDER PARTICIPATION (cont.)

required to obtain an NPI from the CMS National Provider System. Providers must write their NPI and API ID number(s) and the three (3) digit service location identifier, if applicable, on the copy of their license renewals to ensure accurate data entry.

License renewals or updates must be submitted to and received by the Department at least thirty (30) days prior to the date of the license expiration or change. If the provider has not received the renewed or updated license in sufficient time, the provider must submit proof of application for the license renewal or update at least thirty (30) days before the license expiration and then provide the license renewal or change with the numbers required above within ten (10) days of receipt.

B. Notify the Department whenever there is a change in any of the information that the provider previously submitted to the Department using the MaineCare Services portal at https://mainecare.maine.gov. An example would be: a change in address, or the addition or deletion of staff from the practice. This must be done within ten (10) days of each occurrence. Failure to provide complete and accurate information in a timely fashion will constitute good cause for the Department to terminate the agreement.

C. Not interfere with a member's freedom of choice in seeking medical care from any institution, agency, pharmacy or person who is qualified to perform a required service and is a MaineCare provider.

D. Not discourage or interfere with a MaineCare member accessing medically necessary MaineCare services for which the member is eligible.

E. Allow members the freedom to reject medical care and treatment.

F. Not discriminate against any member, because of race, color, sex, gender identity, sexual orientation, religious creed, ancestry, national origin, age, or physical or mental handicap or disability, or any other factor as specified in the *Maine Human Rights Act*, 5 M.R.S. §4551 *et seq*., the *Federal Civil Rights Act*, 42 U.S.C. §1981 *et seq*., *The Americans With Disabilities Act of 1990*, 42 U.S.C. §12101, or the *Federal Rehabilitation Act*, 29 U.S.C. §504 *et seq*. The provider will comply with 5 M.R.S. §784(2) and any and all appropriate federal and state laws and regulations regarding non-discrimination.

G. Provide services and supplies to members in the same quality and mode of delivery as they are provided to the general public.

H. Charge and bill MaineCare for the provision of services and supplies to members in an amount not to exceed the provider's usual and customary charges to the general public or, the contractual agreement for a member with a liable third party.

1.03 PROVIDER PARTICIPATION (cont.)

I. Accept as payment in full the MaineCare rate as specified in Section 1.08-1.

Section 1.03-8(J) immediately below will be effective until December 31, 2022

J. Bill only for covered services and supplies delivered. In cases where services provided include less than a whole unit of a service, the unit shall be rounded up only if equal or greater than fifty per cent (50%) of the unit of service, e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service.

The procedure code for the smallest unit of service must be used. Specific provisions in any other Chapters or Sections of this Manual will supersede this rounding requirement.

Section 1.03-8(J) immediately below will be effective on January 1, 2023

J. Bill only for covered services and supplies delivered. In cases where a partial unit of service is delivered, the provider may bill for the partial unit. A provider also has the option to round up a partial unit and bill for the nearest whole unit, if the partial unit of service provided is equal to or greater than eighty percent (80%) of the unit of service: e.g. providers may round 1.8 units of service up to two (2) units of service; the provider may bill 1.7 units of service provided either as 1.7 units of service if it bills the partial unit or as 1.0 unit of service if it does not. If the provider rounds up to the next unit from eighty percent (80%) or greater, the provider must document the actual units of service delivered in the member's record.

Providers may bill partial units of service delivered to one or two decimal places, and providers may round partial units of service to the first or second decimal place. For example, to bill ten minutes of a 15-minute service (.667 units), providers may choose to use the first decimal place, not round, and bill .6 units; use the second decimal place, not round, and bill .66 units; round to the second decimal place and bill .67 units; or round to the first decimal place and bill .7 units. Providers shall not round up to .8 units and then round up again to bill the whole unit.

In cases where an unforeseen and uncontrollable circumstance prevents a provider from delivering a whole unit of service, the provider may round up the partial unit to the nearest whole unit if the partial unit is equal to or greater than fifty percent (50%) of the unit of service: e.g. providers may round 1.5 units of service up to two (2) units of service in the case of an unforeseen and uncontrollable circumstance; 1.4 units of service provided would be billed at either 1.4 units of service if the provider bills a partial unit or 1.0 unit of service if it does not. Unforeseen and uncontrollable circumstances may include, but are not limited to, a power outage, a fire or other event that necessitates evacuation from the place of

1.03 PROVIDER PARTICIPATION (cont.)

service, or a medical emergency. If rounding up from 50% or greater, the provider must document the actual units of service provided and fully describe the unforeseen and uncontrollable circumstance in the member's record.

The procedure code for the smallest unit of service must be used. Specific provisions in any other Chapters or Sections of this Manual will supersede this rounding requirement.

K. Accept assignment of Medicare benefits for eligible MaineCare members (as set forth in Section 1.07-5).

L. Use designated Health Insurance Portability and Accountability Act (HIPAA) compliant billing forms, or accepted 837 transactions, for submission of charges and follow the appropriate MaineCare billing instructions. 837 filings are transactions using the HIPAA standard format for submission of electronic claims. There are three (3) versions of the 837: the Institutional (similar to the UB-04 paper claim); the Professional (comparable to the CMS 1500 paper claim) and the Dental (comparable to the ADA paper claim).

M. Maintain and retain contemporaneous financial, provider, and professional records sufficient to fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member.

1. 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.

2. If a service is billed on a fifteen (15) minute unit basis, a notation for each visit is sufficient.

3. 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 (5) 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.

4. At all reasonable times during the prescribed retention period, persons duly authorized by the Department or the federal government, whether employees or contractors, shall be given the right to full access to inspect,

1.03 PROVIDER PARTICIPATION (cont.)

review, or audit all medical, quality assurance documents, financial, administrative records, and other documents and reports required to be kept under federal and state laws and regulations. Those duly authorized shall also have the right to obtain copies of such records at no expense to the Department, federal or state government.

The provider and any approved subcontractor shall give the Department or the Federal government complete and private access to the Provider's staff and to any resident or member for the purpose of reviewing the provider's compliance with the provider agreement, and other applicable federal and state laws and regulations, including laws and regulations governing licensing and certification.

5. MaineCare providers, all rendering providers, and any subcontractors shall make available, during regular business hours, all pertinent provider financial records, all records of the requisite insurance coverage, all records concerning the provision of health care services to MaineCare members, and all financial records of MaineCare members, to any duly authorized representative of DHHS, the Department's Authorized Entity, the Maine Attorney General's MaineCare Fraud Unit, and the Director of the United States Centers for Medicare and Medicaid Services. MaineCare providers, all rendering providers, and any subcontractors shall provide, if requested by any of the above, copies of records and documentation, including copies of consolidated financial statements of all related corporations. Failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension from participation in the MaineCare program.

6. MaineCare providers, all rendering providers, and any subcontractors will make their premises available to any of the above, for announced visits or unannounced visits, for the purpose of determining whether enrollment or continued enrollment in the MaineCare program is warranted, to investigate and prosecute fraud against the MaineCare program, to investigate complaints of abuse and neglect of MaineCare members, and as necessary for the administration of the MaineCare program. Failure to permit inspection by DHHS, the Maine Attorney General's MaineCare Fraud Unit, or the Secretary of the United States Centers for Medicare and Medicaid Services shall be grounds for immediate suspension from participation in the MaineCare program.

N. Have safeguards and security measures in place that allow only authorized persons to enter information into electronic records. Passwords or other secure means of authorization must be used that will identify the individual and the date and time of entry. Such identification will be accepted as an electronic "signature." With security measures in place, limited access may be allowed for certain individuals

1.03 PROVIDER PARTICIPATION (cont.)

for changes such as member demographic information. There shall be a signature of record on file.

O. Maintain and retain contracts with subcontractors for a period of at least five (5) years after the expiration date of the contract. In addition, records of contractors or subcontractors shall be subject to the same record maintenance and retention rules as are all enrolled providers (refer to Section 1.03-8 M).

Providers must submit within thirty-five (35) days of the Department's request, full and complete information regarding the ownership of any subcontractor with whom the provider has had business transactions totaling twenty-five thousand dollars ($25,000.00) or more, during a twelve (12) month period prior to the date of the request. Updates to ownership information will be required on an annual basis.

P. Transfer at no charge clinical records and other pertinent information to other clinicians involved in the member's case, upon request and, when necessary, with the member's signed release of information. Members may only be charged for copies of their own records if the member is requesting that the copies be given directly to them. Charges to the MaineCare member must be in a manner comparable to any charges providers may require from private pay patients.

Enrolled providers must furnish to the Department or its Authorized Entity without charge, in the form and manner requested, pertinent information, including clinical, professional and financial records, regarding services for which charges are made. Where appropriate, as determined by the Department, this will include information necessary to support requests for exemption from managed care requirements and correspondence that substantiates services billed by providers. A release of information signature is not required in order to send records to the Department or its Authorized Entity.

Q. Comply with the requirements of the Department regarding faxed and e-signatures. The Department will accept e-signatures and faxed (facsimile) copies of signatures as evidence of compliance with MaineCare documentation requirements only when the original signature is subsequently forwarded to the Department within (30) calendar days of the date of service or is already on file.

1. Providers must maintain evidence of the faxed and e-signatures in the member's record;

2. A faxed signature by itself without the original signature on record will not be acceptable proof of signature.

R. Hold confidential, and use for authorized program purposes only, all MaineCare information regarding members. In situations where it is medically necessary for the member's well-being, information may be shared between providers. The

1.03 PROVIDER PARTICIPATION (cont.)

rules of confidentiality apply to all providers involved as referenced in Section 1.03-9 of this Manual. Confidentiality requirements described in 22 M.R.S. §1711-C also apply.

S. Comply with requirements of applicable federal and state law, and with the provisions of this Manual.

T. Enter into a MaineCare Provider Agreement with the Department, including any necessary Riders.

U. Providers, contractors and intermediaries in public, private or voluntary agencies that have Provider agreements with the Department, are obligated to:

1. Report any suspected or identified fraud or abuse by providers or members and submit supporting documentation to the Program Integrity Unit, Division of Audit;

2. Furnish available information, when requested, on excluded individuals and entities requesting reinstatement into the MaineCare Program; and

3. Ensure that the provisions of 42 C.F.R. 1000, *et seq*., pertaining to the exclusions of individuals and entities are abided by at all times.

V. **Disclosure of ownership or control**

Provider must disclose the following information to the department upon enrollment and within thirty (30) days of any change.

1. Providers other than individual practitioners or groups of practitioners must disclose all persons with an ownership or control interest in the provider. Persons with an ownership or control interest include the following:

   a. Those with an ownership interest totaling five percent (5%) or more in the provider;
   b. Those with an indirect ownership interest equal to five percent (5%) or more in the provider;
   c. Those with a combination of direct and indirect ownership interest equal to five percent (5%) or more in the provider;
   d. Those with an interest of five percent (5%) or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals five percent (5%) or more of the value of the property or assets of the provider;
   e. Individuals who are officers or directors if the provider organization of the provider is organized as a corporation; and
   f. Individuals who are partners in the provider's partnership.

1.03 PROVIDER PARTICIPATION (cont.)

2. Providers other than individual practitioners or groups of practitioners must disclose all corporations or other forms of business entities with an ownership or control interest in the provider. Corporations or other forms of business entities with an ownership or control interest include the following:

    a. Those with an ownership interest totaling five percent (5%) or more in the provider;
    b. Those with an indirect ownership interest equal to five percent (5%) or more in the provider;
    c. Those with a combination of direct and indirect ownership interest equal to five percent (5%) or more in the provider;
    d. Those with an interest of five percent (5%) or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals five percent (5%) or more of the value of the property or assets of the provider;
    e. Entities who are officers or directors of the provider organization if the provider is organized as a corporation; and
    f. Entities who are partners in the provider's partnership.

3. Providers other than individual practitioners or groups of practitioners must disclose all subcontractors in which the provider has an ownership interest of five percent (5%) or more.

4. Providers other than individual practitioners or groups of practitioners must disclose any individual owners of the provider who is related to other individual owner as a spouse, parent, child, or sibling. Providers must also disclose any individual owners of the provider's subcontractor in which the provider has an ownership interest who is related to other individual owner as a spouse, parent, child, or sibling.

5. Providers other than individual practitioners or groups of practitioners must disclose any ownership or control interest in any "other disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but if required to disclose certain ownership and control information because of participation in any program established under Title V, XVIII, or XX of the *Social Security Act*. This includes:

    a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII)
    b. Any Medicare intermediary or carrier; and

1.03 PROVIDER PARTICIPATION (cont.)

c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the *Social Security Act.*

W. Provide adequate access to medically necessary covered health care services for MaineCare members.

X. Refer to the Department any evidence demonstrating fraudulent or abusive provider and/or employee practice or overuse of member services by contacting the Program Integrity Unit.

Y. Abide by the provisions of 42 C.F.R. 1000, *et seq*., pertaining to the exclusions of individuals and entities from participation in Medicare or MaineCare and ensure that excluded individuals or entities are not employed or utilized to provide services, receive payments, or submit claims, to the MaineCare Program. Excluded provider information can be referenced at the Health and Human Services Office of Inspector General web site: http://exclusions.oig.hhs.gov and the Division of Audit, Program Integrity Unit web site: https://mainecare.maine.gov/mhpviewer.aspx?FID=MEEX.

Z. Maintain accurate, auditable and sufficiently detailed financial and statistical records to substantiate cost reports, negotiated rates, by report items, or any other fee for service rate for a period of at least five (5) years following the date of final settlement or established rate with the Department. These records must include, but not be limited to: matters of provider ownership; organization; operation; fiscal and other record-keeping systems; federal and state income tax information; asset acquisition; lease, sale or other action; cost of ownership information on leased property even if the property is leased from an unrelated party; franchise or management arrangement; patient service charge schedule; matters pertaining to cost of operation; amounts of income received by service and purpose; and flow of funds and working capital.

AA. Attend provider education sessions when required by the Department.

BB. Submit all claims for review prior to payment, when required by the Department.

CC. Comply with the requirements of the *Federal False Claims Act* as referenced in Appendix 2 of this Chapter.

DD. Comply with this Chapter and all other applicable Chapters and Sections of the MBM.

The Department may sanction providers that fail to comply with these requirements.

1.03 PROVIDER PARTICIPATION (cont.)

1.03-9 Confidentiality

Providers may disclose information regarding individuals participating in MaineCare only for purposes directly connected with the administration of MaineCare. Providers must maintain the confidentiality of information regarding MaineCare members in accordance with 42 C.F.R. 431, *et seq*. and other applicable sections of state and federal law and regulations, including compliance with the privacy and security requirements of HIPAA.

The Department will ensure that criteria exist specifying the conditions for release and use of information about MaineCare members. Access to information concerning members is restricted to persons or Department representatives who are subject to standards of confidentiality set by the Department.

The Department may not publish or disseminate, in any way, names of members. Permission must be obtained from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of a MaineCare payment.

Parents or guardians of minors may be required to provide annual reauthorization regarding the release of confidential information.

1.03-10 Requirements for Persons Acting on Behalf of a Provider

All persons acting on behalf of a provider, such as employees, agents, volunteers or family members, are bound by and must adhere to MaineCare rules and regulations. Violations committed by any of the above named parties may result in sanction actions as defined in Section 1.20 of this Manual.

1.03-11 MaineCare Managed Care

MaineCare managed care providers are primary care providers when all parties have completed and signed a MaineCare provider Agreement and have received approval from MaineCare to provide comprehensive health care to members receiving managed care benefits. Such providers must comply with Chapter VI, Section 1, Primary Care Case Management and other appropriate sections of the MBM.

Unauthorized use of a primary care provider's NPI identification number by any provider will be deemed to be fraud and may result in the sanctions described in Section 1.20 of this Chapter.

1.03-12 Requirements for Agencies Hiring Certified Nursing Assistants (CNAs) and Direct Care Workers (DCWs)

MaineCare providers that hire CNAs or DCWs must check the Maine Certified Nursing Assistants and Direct Care Worker Registry to ensure CNAs and DCWs are eligible for

1.03 PROVIDER PARTICIPATION (cont.)

employment in Maine and must comply with all requirements stipulated in the Department's Certified Nursing Assistants and Direct Care Worker Registry Rule, 10-144 *Code of Maine Rules*, Chapter 128.

1.03-13 License Verification for Registered Nurses

Providers shall verify that all registered nurses they hire or employ are currently and validly licensed as a registered professional nurse by the Maine State Board of Nursing or hold a current, unencumbered compact license from another compact state that they claim as their legal residence.

1.04 MEMBER PARTICIPATION

The Office for Family Independence defines a member as a person determined to be financially eligible in accordance with the eligibility standards published in the *MaineCare Eligibility Manual*.

The *MaineCare Eligibility Manual* is published and maintained by the Office for Family Independence. Detailed information regarding financial eligibility standards can be obtained by contacting the Regional Offices of the Department of Health and Human Services. If there are any conflicts or inconsistencies between financial eligibility guidelines described in this Manual and the *MaineCare Eligibility Manual*, the *MaineCare Eligibility Manual* governs.

Members are also subject to eligibility requirements to determine need for specific services as detailed in other Chapters and Sections of this Manual. The Department may reassess a member's medical eligibility at any time. Pursuant to 42 C.F.R. §435.916, if the Department has information about anticipated changes in a member's circumstances, the Department must re-determine eligibility at the appropriate time based on those changes.

The Department issues an identification card to all members. Providers must verify an individual's eligibility for MaineCare prior to providing services. Eligibility may be verified by point of service systems and web-based systems available to providers. MaineCare eligibility verification can also be checked by calling the Department's Interactive Voice Response System. Providers that do not have access to a touch-tone telephone may contact Provider Services as described in Section 1.13. Verification of financial eligibility does not assure reimbursement if any requirements for medical eligibility and prior authorization have not been met. The Department reserves the right to change the frequency of card issuance; to provide separate cards for members restricted to seeing certain providers (See Chapter IV of the MBM); and to change the card format and content.

1.04-1 Additional Eligibility Considerations

A. Retroactive Eligibility for Services

The following retroactive reimbursement procedure does not apply to situations where a person has knowingly misrepresented his or her status to a provider as a MaineCare applicant or member.

1.04 MEMBER PARTICIPATION (cont.)

In some cases, MaineCare eligibility may be determined retroactively. If covered services were provided during a period of retroactive eligibility and if the member made any payment toward those retroactively-covered services, the provider, if requested to do so by the member within nine (9) months of the date of the original written notification of MaineCare eligibility, must reimburse the member the full amount paid by the member within fourteen (14) days of being notified by the member. Failure to reimburse the member will result in sanctions as defined in Section 1.20. The provider may then bill MaineCare for those same services. If covered services were provided during a period of retroactive eligibility and the member has not made payments towards those covered services, the provider has one (1) year from the date the eligibility was granted to file a claim correctly with the Department.

B. **Individuals Residing in Public Institutions**

For inmates involuntarily confined in a public institution, state or federal prison, jail, detention facility or other penal facility, who are MaineCare members, MaineCare will pay only for covered inpatient medical institution services provided to the inmate while an inpatient in a hospital, nursing home, ICF/IID Intermediate Care Facility for Individuals with Intellectual Disability or juvenile psychiatric facility. MaineCare will not pay for any other services.

MaineCare will pay for all MaineCare coverable services for individuals admitted to and residing in an Institution for Mental Diseases (IMD) for over thirty (30) days, if the individual is under twenty-one (21) years of age or over sixty-five (65) years of age. MaineCare will not cover the cost of
services for individuals who are age twenty-one (21) and over and under sixty-five (65) years of age while residing in an IMD.

C. **Undocumented Non-Citizens**

MaineCare coverage for emergency services for undocumented non-citizens extends only to those services necessary to stabilize the emergency condition. MaineCare does not cover any further treatment or rehabilitation resulting from the emergency even though such treatment may be necessary.

Please refer to Chapter I, Section 1.02-4 (D) of this Manual for the complete definition of emergency services for undocumented non-citizens.

D. **Other Categories**

The Office for Family Independence may establish other categories in accordance with the *MaineCare Eligibility Manual*. These special categories define or limit the particular services a person may be eligible to receive. For example, in the

1.04 MEMBER PARTICIPATION (cont.)

category of "Qualified Medical Beneficiary (QMB) eligible only," MaineCare covers only the Medicare coinsurance and deductible. If Medicare does not allow the service, the member is responsible.

1.05 SUPPLEMENTATION BY MEMBERS

MaineCare providers must accept the allowances for covered services established by the Department as payment in full. Providers must also comply with state and federal law as well as the provisions of the MBM, Chapter I, Section 1.03-8.

Providers that request or require supplementary payment for MaineCare covered services are in violation of MaineCare rules and are subject to administrative sanctions. Private supplementary payment includes, but is not limited to, charging fees for referrals to other providers or consultants, charging a fee to request prior authorization, or charging fees for any other administrative services required in the process of providing MaineCare services.

Title 42 U.S.C. §1320a-7(b) specifically provides, in part, for criminal penalties as follows:

"Whoever knowingly and willfully; (1) charges, for any services provided to a patient under a State Plan approved under subchapter XIX of this title, money or other consideration at a rate in excess of the rates established by the state shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty-five thousand dollars $25,000 or imprisoned for not more than five (5) years, or both."

Payment may be made by the Department only for MaineCare covered services provided to individuals who are eligible for services on the date the services are actually provided unless otherwise specified in the MBM, or who have been granted retroactive MaineCare eligibility after services have been provided.

Members may not be charged for covered services provided during any period of eligibility unless a member has knowingly misrepresented, in writing, his or her MaineCare status. Enrolled providers must bill the Department for covered services provided to a member during any period of eligibility for which the provider expects to be reimbursed. Nothing in this paragraph shall be construed as prohibiting a provider from providing free care.

1.06 COVERED AND NON-COVERED SERVICES

1.06-1 **Covered Services**

All covered services reimbursable by MaineCare must be medically necessary and described in the MBM. MaineCare members are eligible for as many covered services as are medically necessary and within the limitations outlined in applicable sections of this Manual. The Department reserves the right to require additional medical opinions or evaluations by appropriate professionals of its choice concerning medical necessity or expected therapeutic benefit of any requested service.

1.06 COVERED AND NON-COVERED SERVICES (cont.)

Covered services include those services described in other Chapters of this Manual and other medically necessary health care, diagnostic services, treatment, and other measures, as required by the *Omnibus Reconciliation Act of 1989*.

These services are intended to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services described in the Manual sections applicable to EPSDT for members under age twenty-one (21), whether or not such services are (otherwise) covered under the Medicaid State Plan as long as they would otherwise be federally allowable under the State Plan.

1.06-2 Interpreter Services

A. Providers must ensure that MaineCare members are able to communicate effectively with them regarding their medical needs. MaineCare will reimburse providers for interpreters required for limited and non-English speaking members and/or deaf/hard of hearing members, when these services are necessary and reasonable to communicate effectively with members regarding health needs. Interpreter services can only be covered in conjunction with another covered MaineCare service or medically necessary follow-up visit(s) to the initial covered service.

MaineCare will pay for two (2) interpreters for deaf MaineCare members who use a sign language other than American Sign Language or who use a unique non-spoken method of communication and require a relay interpreting team including a deaf interpreter working with a hearing interpreter.

B. Family members or personal friends may be used as interpreters, but cannot be paid. "Family" means any of the following: husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit.

Family members or friends, with the exception of those individuals under the age of 18, may be used as non-paid interpreters if:

1. requested by the member; and

2. the use of this friend or family member does not compromise the effectiveness of services or violate the member’s confidentiality; and

3. the member is advised that an interpreter is available at no charge to the member.

1.06 COVERED AND NON-COVERED SERVICES (cont.)

C. If a paid interpreter is hired, providers can select the interpreter. However, should the interpreter provide transportation to the member, MaineCare will not reimburse the interpreter for transporting the member while concurrently billing for interpreter services. All interpreter services must be provided in accordance with the *Americans with Disabilities Act*.

D. A provider may not bill MaineCare for an interpreter service supplied by an entity in which the provider, any owner of the provider, or an immediate family member of the provider or any of its owners has any direct or indirect ownership or financial interest, unless:

1. The provider also reimburses other entities for the provision of interpreter services; and

2. The entity providing the interpreting service makes those services commercially available to MaineCare providers or other businesses that do not share a direct or indirect familial ownership interest with the interpreting entity.

E. When providers request reimbursement for any interpreter services, the services must be included in the member record. Documentation must include a statement verifying the interpreter qualifications, date, time and duration of service, language used, the name of the interpreter, and the cost of performing the service.

F. Providers are responsible for ensuring that interpreters protect patient confidentiality and adhere to an interpreter code of ethics. Providers shall document that interpreters have provided evidence of having read and signed a code of ethics for interpreters equivalent to the model included as Appendix #1. This shall be deemed as compliance with this requirement.

G. Providers of interpreter services must be licensed by the Maine Department of Professional and Financial Regulation as Certified Interpreters/Transliterators, Certified Deaf Interpreters, Limited Interpreters/Transliterators, or as Limited Deaf Interpreters.

H. Providers must use the following code when billing for interpreter services for deaf/hard of hearing members and non-English speaking members:

T1013 Sign language or oral interpreter services per fifteen minutes.

The actual billable amount should be the lesser of the interpreter's usual and customary charge and the rate authorized by the Department.

Any other codes for interpreter services listed in the specific service sections of the MBM are no longer valid.

1.06 COVERED AND NON-COVERED SERVICES (cont.)

I. Providers may use language interpreter services conducted via telephone or other audio/video means. These services may come from local resources, national language interpreter services such as LanguageLine Solutions or comparable services. Wherever feasible, providers should use local and more cost-effective interpreter services.

When billing for language interpreter services conducted via telephone or other audio/video means, providers should use the T1013 procedure code with a GT modifier and include copies of the invoice with the claim. Reimbursement is by invoice.

J. **Exceptions and Limitations**

1. Hospitals, ICF/IID Intermediate Care Facility for Individuals with Intellectual Disabilities, and nursing facilities may not bill separately for either language or deaf/hard of hearing interpreter services. For hospitals, ICF/IIDs, and nursing facilities, these costs will be allowable and are included in the calculation of reimbursement.

2. The Department will not pay for interpreter services when there is a primary third party payer if the primary third party payer is required to cover the interpreter services.

3. The Department will not reimburse for interpreter travel time or wait time.

1.06-3 **Presumptive Eligibility for Services for Pregnant Women**

A. Presumptive eligibility can only be determined by qualified providers. The term "qualified provider" is defined in 42 U.S.C. §1396r-1. Examples of qualified providers to determine eligibility are: Federally Qualified Health Centers; Indian Health Centers; Rural Health Clinics; Family Planning Agencies; WIC Agencies.

B. Pregnancy-related services are those services that are necessary for the health of the pregnant woman or fetus, or that have become necessary as a result of the woman having been pregnant.

1.06-4 **Non-Covered Services**

A. MaineCare will not reimburse for non-covered services. Providers may bill members for non-covered services only if, prior to the provision of the service, the provider has clearly explained to the member that MaineCare does not cover the service and that the member will be responsible for the payment. Providers must document in the member's record that the member was told, prior to provision, that the service was not a MaineCare covered service and that the member is responsible for the payment.

1.06 COVERED AND NON-COVERED SERVICES (cont.)

B. The following services are considered non-covered services. Costs for these non-covered services are not reimbursable by MaineCare, or by the member unless the notification requirements described in Section 1.06-4(A) have been met.

MaineCare does not reimburse for:

1. Services not described in the MBM, or related Principles of Reimbursement;

2 Experimental procedures or drugs not approved by the Food and Drug Administration (FDA);

3. Services that are primarily custodial care, respite care, socialization, academic, religious, vocational, or educational, unless specifically permitted elsewhere in this Manual including:

a. **Custodial Services**

Custodial Services are any services, or components of services, of which the basic nature is to provide custodial care.

b. **Socialization or Recreational Services**

Socialization or recreational services are any services, or components of services, of which the basic nature is to provide opportunities for socialization, or those activities that are solely recreational in nature. These non-covered services include, but are not limited to picnics, dances, ball games, parties, field trips, and social clubs.

c. **Academic/Educational Services**

Any services or components of service provided to members that are academic or educational in nature. Academic services include, but are not limited to, those traditional subjects such as science, history, literature, foreign languages, and mathematics.

d. **Vocational Services**

Vocational services include organized programs such as vocational skills training, or sheltered employment, that prepare individuals for paid or unpaid employment.

4. Services that have prerequisites that have not been met as defined in the appropriate section of the MBM, including prior authorization and medical eligibility requirements;

1.06 COVERED AND NON-COVERED SERVICES (cont.)

5. Any items or services that have been purchased elsewhere that are required to be purchased through a volume purchase agreement between the state and a provider;

6. Services provided without a pre-admission screening and/or concurrent review as required by the Department;

7. Services provided by a psychiatric facility, institution for mental diseases, or institutional service provided for members age twenty-one (21) to sixty-five (65). No federal financial participation is available for these services or this population;

8. Administrative tasks, including verification of MaineCare eligibility, updating member contact information, scheduling of appointments, tasks performed for the provider's own administrative purposes, and similar activities. Certain administrative tasks may be covered when described in the appropriate Section of the MBM; and

9. Any other services not provided in conformance with the requirements of this Manual.

C. **Coverage Limitations Associated with Managed Care**

MaineCare will not cover the cost of services denied by a managed care plan when the service was denied because the member did not comply with the plan's requirements. When a member receives services not in compliance with the managed care plan, the member is responsible for paying for those services. Examples of member non-compliance include but are not limited to, failure to obtain the necessary referral from the managed care plan or receiving services from a provider that does not participate in the managed care plan. This applies both to MaineCare managed care benefits and private managed care plans. There is an exception for members with emergency medical conditions that are screened, stabilized, and transferred as required by federal law.

Providers of MaineCare Managed Care services, as noted in Chapter VI Primary Care Case Management, must have a referral from the member's primary care provider site prior to the member visit. Certain services are exempt from needing a referral from the primary care provider and are outlined under Chapter VI, Section 1, Primary Care Case Management, Section 1.05.

D. **Request for Rule Change or New Rules for MaineCare Coverage of Non-Covered Services**

1. When a member or provider requests authorization for MaineCare coverage of a service not currently covered by MaineCare, that request will be denied

1.06 COVERED AND NON-COVERED SERVICES (cont.)

(see exception in Section E, for members with EPSDT). The individual or group making the request may contact MaineCare Services, Director, Division of Policy, to request a formal review of a proposed new service. Appropriate staff will then review the request.

2. MaineCare Services will consider, but is not obligated to cover, health interventions within the specified service sections if they meet all of the following outcome criteria:

   a. The intervention is for a medical condition;

   b. There is sufficient evidence to draw conclusions about the effects of the intervention on health outcomes;

   c. The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes;

   d. The intervention's expected beneficial effects on health outcomes outweigh its expected harmful effects; and

   e. The intervention is the most cost-effective method available to address the medical condition.

3. Key definitions to support the above statements are:

   a. Medical Condition: A disease, an illness, or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness, or injury.

   b. Health Outcomes: Outcomes of medical conditions that directly affect the length or quality of a person's life.

   c. Sufficient Evidence: Evidence is considered to be sufficient to draw conclusions if it is peer reviewed, is well controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

   d. Health Intervention An activity undertaken for the primary purpose of preventing, improving, or stabilizing a medical condition. Activities that are not considered health interventions include those that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner.

1.06 COVERED AND NON-COVERED SERVICES (cont.)

e. Cost: An intervention is considered cost effective if there is no other available intervention that offers a clinically appropriate benefit at a lower cost.

E. As described in Section 1.14, the Department shall take all reasonable and necessary steps to ensure that all requests for prior authorization of services for MaineCare members receiving EPSDT that are determined to be non-covered under this Manual, be considered for coverage under EPSDT, prior to being denied as non-covered.

1.06-5 **Broken Appointments**

Providers may not bill members for broken appointments, even if providers advised members prior to the service. However, providers may refuse to continue to see members who have repeatedly broken appointments without prior notice. In such situations, providers must provide prior notice of office policies concerning no-shows to members before refusing to continue to see those members.

1.06-6 **Rental Equipment**

Members for whom the Department is renting medical equipment (for example, certain wheelchairs or C-PAPs) are required to return the equipment following the end of the authorization period.

1.07 THIRD PARTY LIABILITY

1.07-1 **Definitions Relative to this Section**

A. Insurer is:

1. Any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-rated insurance contracts and indemnity contracts;

2. Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of any injury, disease, or disability; or

3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

B. Third Party is any individual, entity, benefit or program, excluding MaineCare, that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member as described in Section 1.07-3.

1.07 THIRD PARTY LIABILITY (cont.)

C. EPSDT are services provided to MaineCare members under the age of 21 and described in Chapter II, Section 94, Early and Periodic Screening, Diagnosis and Treatment Services, of the MBM.

1.07-2 Premiums for Enrollment under Group Health Plans

As a result of the *Omnibus Budget Reconciliation Act of 1990* (OBRA 90, Section 4402), covered services include MaineCare payment of group health plan premiums when a member's enrollment under a group health plan is cost-effective. MaineCare considers a premium payment cost-effective when the costs of a member's MaineCare services are likely to be greater than the cost of paying the premium for a member to receive care under the group health plan. The Division of Third Party Liability of MaineCare Services determines cost-effectiveness and follows guidelines approved by the Centers for Medicare and Medicaid Services.

1.07-3 Provider/Department/Member Responsibility Regarding Third Party Liability

A. State and federal rules and regulations determine the Department's liability for payment of claims submitted to MaineCare for services provided to individuals enrolled in a health maintenance organization or managed care plan or those who have other available third party resources.

B. MaineCare is the payer of last resort. The only exception is for services involving Indian Health Services (IHS) claims. IHS is the payer of last resort for Native Americans enrolled in MaineCare.

C. If a claim has been denied by a member's third party payer for services deemed as not medically necessary, the provider must appeal the decision of the third party payer before billing MaineCare EXCEPT AS PROVIDED BELOW. If the appeal results are unfavorable, the provider must submit the original denial, the appeal results and a completed claim form to MaineCare for evaluation.

Providers do not have to appeal the decision of a Medicare denial of reimbursement if: (1) the denial is based on Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs); or (2) the service was provided by a Licensed Marriage and Family Therapist (LMFTs), Licensed Professional Counselor (LCPCs) or Licensed Master Social Workers Clinical Conditional (LMSW-CC) and the Member has an established relationship with the provider and another provider is not available.

D. The Department recognizes extenuating circumstances where services covered by third party payers:

1. May not be geographically accessible;

1.07 THIRD PARTY LIABILITY (cont.)

2. Members are not given the opportunity to directly choose a provider that participates in the member's primary insurance. This may occur, for example, when the provider is involved in the member's care to interpret test or radiological results or to administer anesthesia; or

3. Good cause has been established pursuant to 42 C.F.R. §433.147.

The Department will reimburse for services for which the member would otherwise be eligible in instances where these extenuating circumstances exist. The Department shall have total discretion to adopt standards for the above circumstances for members covered by third party insurers.

A member may request an extenuating circumstance exception in writing to the Director of MaineCare Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011. If the member's request for extenuating circumstances is denied, the Department shall provide written notice to the member of the member's right to an administrative hearing

E. The provider must establish whether the member has third party resources available for payment of the rendered service. Third party resources may include, but not be limited to, private or group insurance benefits, participation in a health maintenance organization (HMO), Workers' Compensation, Medicare or other potentially liable insurers and responsible parties. For all questions involving the determination of coverage by a third party insurer, providers may contact MaineCare Services, the Division of Third Party Liability, directly to verify health insurance information.

F. The provider must take all necessary and reasonable measures within the provider's ability to receive payment from such resources prior to billing MaineCare. Payment by the primary HMO to non-participating providers does not obligate MaineCare to pay as a secondary payer. This applies even if the primary HMO authorizes the service. If the provider will not be eligible to receive MaineCare reimbursement as a result of failing to participate in the member's plan, the member must be notified in writing that he or she will be billed. This must be done prior to providing the service and documented in the member's record. The following exceptions apply:

1. When a claim is for EPSDT; and

2. When the third party liability has not yet been established (litigation).

G. In cases where third party payment responsibility is questionable or unavailable, providers are responsible for billing the Department for covered services within the one (1) year time frame described in Section 1.10 of this Chapter.

1.07 THIRD PARTY LIABILITY (cont.)

H. The Department will take reasonable measures to ascertain any legal liability of third parties for medical care and services rendered to members, the need for which arises out of injury, disease or disability. With the exception of those services described in this sub-section, MaineCare is not liable for payment of services when denied or paid at a rate reduced by a liable third party payer, including Medicare, because the services were not authorized, or a non-participating provider provided services that were coverable under the plan.

I. The Department is not responsible for payment of services inappropriately obtained (including self-referrals which result in reduced payments) by a member enrolled with any liable third party payer including Medicare or for making additional payments to providers that offer discounts to (or that agree to accept reduced payments from) third party payers.

J. The Department is not liable for payment of services provided to MaineCare members enrolled with a liable third party payer, including Medicare, when services have not been authorized prior to provision and/or approved by the member's primary care physician when required.

K. The Department is responsible for payment of a copayment, deductible or coinsurance required by a third party payer when services have been appropriately obtained under MaineCare. Such payments shall be limited to the maximum amount designated by the Department for covered services, in accordance with Section 1.07-7(B) and (C).

L. The Department shall also be responsible for payment of covered services provided outside an eligible individual's liable third party payer including Medicare, in situations where providers available to the individual under the plan were geographically unavailable (i.e., out-of-state policyholder).

M. The member must do whatever his or her primary health plan requires to assure that the plan provides maximum coverage for services. This includes, but is not limited to, seeing a geographically accessible participating provider, seeking referrals from his or her primary care provider where indicated, utilizing network providers, obtaining prior authorization when required, or other actions as appropriate. If the member fails to do what is necessary to maximize benefits from these primary payers, MaineCare will not reimburse the provider for the service and the member will be responsible for payment.

1.07-4 **Implementing Maine State Income Tax Refund Offset**

The Department will seek reimbursement from a third party when the party's liability is established after assistance is granted and in any other case in which the liability of a third party existed but was not treated as a resource.

1.07 THIRD PARTY LIABILITY (cont.)

Submission to the Maine State Tax Assessor for state income tax refund offset may be utilized to recover money from an individual or entity that is due the Department.

A. **Established Debt**

1. When implementing a Maine State Income Tax Refund Offset, the Department will notify the individual or entity of the alleged debt and his or her right to an administrative hearing.

2. If the individual or entity fails to request a hearing within sixty (60) calendar days of the date of the receipt of the notice alleging the debt, the individual or entity is deemed to have forfeited the right to an administrative hearing and waived any objection he or she may have to this debt, and the Department will implement a Maine State Income Tax Refund Offset. The debt shall be deemed paid only to the extent of the amount received by the Department.

B. **Administrative Hearing**

If an administrative hearing is requested within sixty (60) calendar days of the date of the receipt of the notice alleging the debt, a hearing shall be held pursuant to the Maine Administrative Hearings Regulations. In determining if a debt is established, the hearing shall be limited to the issue of whether the money is due the Department. If a hearing was held and the alleged debt owed to the Department was affirmed by the hearing decision, the Department will implement a Maine State Income Tax Refund Offset. The offset shall be applied, and the debt shall be deemed paid, only to the extent of the amount received by the Department.

C. **Notification of State Tax Assessor**

The Department shall notify the State Tax Assessor annually of all individuals or entities who owe a debt to the Department that is greater than twenty-five dollars ($25.00).

D. **Changes to the Notification**

The Department shall notify the State Tax Assessor of any decrease in or elimination of past due debt which has been submitted for effective collection by State Income Tax Refund Offset.

1.07 THIRD PARTY LIABILITY (cont.)

E. **Administrative Hearing-Tax Offset**

Pursuant to 36 M.R.S. §5276-A (2), before a tax offset may be made, the State Tax Assessor will provide notice to the debtor of the intended tax offset and of the debtor's right to request that hearing.

Upon such timely request, an administrative hearing shall be held pursuant to 5 M.R.S. §8001, *et. seq*. and the Maine Administrative Hearings Regulations. These hearings shall be limited to the issues of whether the debt is collectable and whether any post collection events have affected the debt.

F. **Finalization of Offset**

If the debtor fails to make a timely request for a hearing or a hearing is held before the Department and a collectable debt is determined to be due the Department, the offset is final except as determined by further appeal. The Department must release to the taxpayer any offset refund amount determined after a hearing not to be a debt due to the agency within ninety (90) calendar days of such determination or as otherwise provided by the creditor agency in a promulgated rule.

1.07-5 **Medicare**

Medicare, authorized by Title XVIII of the *Social Security Act*, provides health insurance for most individuals age sixty-five (65) and over, and for others who meet specified disability requirements. Medicare benefits include hospital insurance and related care (Part A) and supplemental medical insurance (Part B). MaineCare complements and supplements the Medicare Program, subject to Section 1.07-5 (C). Each person eligible for Medicare (Part A and/or Part B) is issued a red, white and blue Social Security Health Insurance Card showing the beneficiary claim number, Medicare coverage and effective date.

In order to receive MaineCare reimbursement, providers must accept assignment (unless specifically noted in other Chapters of this Manual) of Medicare for services to MaineCare members for whom coinsurance/insurance and deductible may be payable. All providers delivering services reimbursable by Medicare must participate in Medicare in order to receive MaineCare reimbursement.

Providers must indicate acceptance of this assignment by checking the appropriate box on the Medicare invoice. Coinsurance and deductible charges for Medicare covered services are to be made to the Department only after adjudication of the claim by the Medicare Intermediary or carrier.

In determining the Department's liability for the Medicare deductible and coinsurance the following shall hold:

1.07 THIRD PARTY LIABILITY (cont.)

A. **Hospitals**, Nursing Facilities, (except as provided below for hospitals and nursing facilities for QMB only), Federally qualified health centers, rural health centers, physicians, psychologists, Advanced Practice Registered Nurses, ambulance providers, mental health clinics, ambulatory care clinics, QMB providers, podiatrists, and optometrists may bill MaineCare for Medicare coinsurance and deductible. The total payment from both Medicare and MaineCare cannot exceed the lowest rate that Medicare determines to be the allowed amount.

B. **Indian Health Centers**

Indian Health Centers providing services under ambulatory care clinics are eligible for the all-inclusive rate published in the most recent federal register.

C. For all other providers, for claims received on or after March 1, 2000, (except for psychologists, for whom the effective date is April 1, 2001, and podiatrists for whom the effective date is September 21, 2001, and optometrists for whom the effective date is July 1, 2002) the total payment to the provider from both Medicare and MaineCare cannot exceed the lower of the Medicare approved amount or the maximum allowance established by the Department for services provided, in cases where assignment is required. In cases where assignment is not required (as described in Chapter II, Section 60, "Medical Supplies and Durable Medical Equipment", of the *MaineCare Benefits Manual*), payment will not exceed the maximum allowance established by the Department for the services provided.

D. If CMS approves, effective January 1, 2014, for hospitals and nursing facility providers, for Qualified Medicare Beneficiary without other Medicaid (QMB Only), MaineCare will limit cost sharing payments to the amount necessary to provide a total payment equal to the amount MaineCare would pay for these services under the State plan.

E. **Impermissible Balance Billing of QMBs**: Providers are strictly prohibited, under 42 USC §1396a(n)(3), from seeking to collect any amount from a QMB for Medicare deductibles or coinsurance, even if the MaineCare payment is less than the total amount of the Medicare deductible and coinsurance. Providers are, however, allowed to collect from the QMB Member any MaineCare copayment for the service.

1.07-6 **Assignment: Medicare Part B and Companion Plan I Payments**

MaineCare is not liable for payment of any charges for services provided to dually eligible (MaineCare/Medicare) members that exceed the approved amount by Medicare Part A, Part B unless specifically noted in other Chapters and for Companion Plan I collectively. MaineCare's liability is limited to the lowest amounts listed in Section 1.07-7(C).

1.07 THIRD PARTY LIABILITY (cont.)

1.07-7 Procedures

A. All providers must:

1. Take all necessary and reasonable measures within the provider's ability to receive payment from any third party resource (accept assignment, enrollment, participation), also available to their eligible patients, before billing MaineCare with the exception of those services described in Section 1.07-3;

2. Identify third party resources and total third party payments on the MaineCare claim;

3. Wait ninety (90) calendar days from the date of service for a MaineCare member or policyholder to cooperate with respect to third party resources. If after ninety (90) calendar days the member or policyholder has failed to cooperate, MaineCare may then be billed, according to appropriate billing instructions available from the Department.

   MaineCare does not reimburse providers that inappropriately provide services to MaineCare members enrolled in a health maintenance organization or managed care plan who do not participate in the HMO or managed care plan, or where services must be authorized prior to provision by the member's primary care provider.

   Cooperative policyholder(s) and/or members include:

   a. Those who provide necessary third party insurance information to providers when requested to do so;

   b. Those for whom providers are able to obtain necessary signatures required to process third party claims; and

   c. Those who have been reimbursed by a third party, and have then reimbursed the provider for the services for which they received the reimbursement. The Department will not reimburse in any situation where the member or policyholder received third party payment because the provider did not accept assignment and/or was not enrolled.

4. Show evidence of third party resource responses (explanation of benefits, including explanation of the basis for denials, and related information) prior to billing MaineCare for covered services. Claims that include such evidence may only be billed to the Department as instructed, according to the appropriate billing instructions.

1.07 THIRD PARTY LIABILITY (cont.)

5. Bill MaineCare without having received payment or denial notice from the third party in cases where insurance is provided by an absent parent of a member. Providers must first bill the third party. If no answer is received within one hundred (100) calendar days of the date of service, providers may then bill MaineCare.

   Providers must certify they have billed the insurer and have not received a response. Certification must be submitted on the provider's office letterhead. For proper certification wording and the Department's follow-up plans, please see the following:

   Proper Certification Wording:

   I certify that I have submitted the attached claim to _____ (health insurance company name).

   I have waited one hundred (100) calendar days. I have received no response.

   I understand the Department will audit provider compliance with these certification requirements.

   _____
   (Signature)

   _____
   (Date)

6. Ensure that any time a MaineCare bill (copy) or an itemized hospital bill is given to a MaineCare member, attorney or insurance company, the following must be stated on the copy: "MaineCare Member Benefits Assigned to the State of Maine by Law."

B. **Payments to Hospitals**

MaineCare payment for hospital services is based upon rules established by the Department of Health and Human Services that are in effect for dates of service, less payment obligated or made by any third party. When a third party payment is available, MaineCare will pay only the difference between the amount of the third party payment and the MaineCare allowed amount.

1.07 THIRD PARTY LIABILITY (cont.)

C. Individual Providers Balance Billing After Third Party Payment

When billing MaineCare after receiving a third party payment, individual providers must follow these procedures:

1. Fee-for-Service Claims

a. Charges must equal the allowed amount as agreed to with the particular insurance carrier as determined from the Explanation of Benefits (EOB).

b. The third party amount must equal the actual third party payment plus any withheld amount as indicated on the insurance company's EOB.

2. Capitated Services

Charges must equal the copay amount when balance billing for capitated services. Capitated services should be billed with the charges equal to the copay amount. Capitated services are services covered under the monthly capitation payment agreement between a managed care plan and the member's provider.

1.08 REIMBURSEMENT

1.08-1 Maximum Amount

Unless specified in other Chapters of this Manual, the maximum amount of payment for services rendered shall be the lowest of the following:

A. The MaineCare rate of reimbursement as found in the applicable Chapter of the MBM or as published by the Department;

B. The lowest amount allowed by Medicare Part B;

C. The usual and customary charges;

D. The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set forth in Section 1.07-7. A claim is considered paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

It is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

1.08 REIMBURSEMENT (cont.)

1.08-2 General Information

A. MaineCare members, family members or guardians do not have the authority to prohibit a provider from billing for a MaineCare covered service.

B. MaineCare will only reimburse enrolled providers for MaineCare covered services. Under no circumstance can MaineCare reimburse MaineCare members.

1.09 COPAYMENT

A copayment will be charged to each MaineCare member each time certain MaineCare services are provided if stipulated in the Chapter and Section of this Manual covering those services. If a section does not specify that copays be charged, no MaineCare copayment is collected from MaineCare members for services provided under that section. If a copayment is required, the exact amount of the copayment shall be as specified in the MBM that covers the specific service provided.

1.09-1 Copayment Amount

This section supplements the copayment information included in all sections of Chapter II of the MBM, except in those sections where additional provisions are specifically noted.

A. The member shall be responsible for copayments up to the limit per month specified in the section of Chapter II covering the particular service, whether the copayment has been paid or not. The limit may vary, depending upon the service type. After the monthly cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

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

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

1.09-2 Copayment Exemptions

No copayment may be imposed with respect to the following services:

A. Family planning services and supplies;

B. Services furnished to members under twenty-one (21) years of age;

1.09 COPAYMENT (cont.)

C. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF/IID, or other medical institution, or a resident of a private non-medical institution, if that individual is determined by the Department to be responsible, as a condition of receiving services in that institution, to have an "assessment" or a "cost of care." Cost of care is defined in the *MaineCare Eligibility Manual* and is not waived or affected by any of these exemptions;

D. Services and drugs furnished to pregnant women, including services and drugs provided during the three (3) months following the end of a pregnancy;

E. Services received under the Limited Family Planning Benefit;

F. Members in State custody;

G. Services provided in Indian Health Service Centers and services for Native American members who are eligible to receive services funded by Contract Health Services.

H. Members under State guardianship;

I. Members receiving Hospice Services;

J. Emergency services as defined in Chapter I, Section 1.02.4 (B) of this Manual;

K. Tobacco cessation services and products;

L. Members whose monthly copayment sum has totaled five percent (5%) of their monthly income;

M. Any additional exceptions listed in specific sections of Chapter II of this Manual.

Providers are responsible for verifying copayment responsibility by calling Provider Services or other means made available by the Department.

For billing instructions for copayment exemptions, see the specific section in Chapter II of the MBM under which services are provided.

1.09-3 **Copayment Disputes**

Providers must notify members of their right to dispute copayments. If a member believes that he or she is exempt from a copayment, disputes the amount of the copayment, or has been denied a service for failure to make a copayment, he or she may contact the Department for assistance in resolving that dispute. Complaints should be directed to the Director, MaineCare Services, 11 State House Station, Augusta, Maine 04333-0011.

1.10 SUBMISSION OF CLAIMS

1.10-1 Claims

A. Charges to the Department for services provided under MaineCare are to be submitted only on original claims approved by MaineCare Services, or in the electronic format approved by MaineCare Services. The MaineCare Services web site contains information pertaining to billing instructions. MaineCare providers must include their NPI on all MaineCare claims.

B. Claims based on orders or referral from Non-Billing, Ordering, Prescribing and Referring Providers (NOPR) will be denied if the NOPR is not enrolled with MaineCare, and if the claim does not submit the NPI of the MaineCare NOPR.

1.10-2 Time Limits for Submission of Claims

The following time limits apply unless waived under special circumstances by the Department. Providers have one (1) year from the date services are provided to file a claim correctly with the Department, regardless of when eligibility is verified, except claims for services provided before September 1, 2010 must be filed correctly within one (1) year from the date services are provided or by January 31, 2011, whichever is sooner. Since it is the responsibility of providers to verify eligibility, members may not be billed for covered services that have been denied by the Department for exceeding this time limit for claims submission because the provider did not verify eligibility. The time limit in this paragraph may be exceeded only as follows:

A. If eligibility for MaineCare is determined after a service is provided, providers have one (1) year from the date that MaineCare eligibility was granted to bill the Department.

B. In cases involving other insurance carriers or Workers' Compensation, claims must be filed correctly within one (1) year from the date on the carrier's explanation of benefits.

1.10-3 Methods of Claims Submission

A. Original Paper Claims

It is extremely important and necessary that all paper claims be accurate, complete and legible. Only typed original claims or computer generated original claims with information clearly entered within the required information fields are acceptable for processing. All attachments must be on eight and one-half (8.5) by eleven (11) inch (8½x11) paper. Providers must follow billing instructions issued by the Department. All claims are computer processed, and any mistakes may substantially delay processing. All claims must be signed and dated by the provider, or by an employee so authorized by the provider. Computer generated authorization or a stamped signature is also acceptable.

1.10 SUBMISSION OF CLAIMS (cont.)

The provider must assume full responsibility for the accuracy of the invoice even when submitted by the provider's office. Any claim lacking clear authorization will be rejected (refer to Section 1.11-3) without payment.

B. **Direct Data Entry (DDE)**

Providers may submit claims directly into the claims processing system via a HIPAA-compliant web portal using Direct Data Entry (DDE). When DDE is used, providers will have the ability to identify and correct certain errors at the time the claim is entered, notwithstanding other provisions of this Chapter. Providers can obtain access to this portal at https://mainecare.maine.gov/Default.aspx .

C. **Electronic Data Interchange (EDI)**

Providers may submit claims using an 837 HIPAA format for submission of electronic claims. Refer to both the Implementation Guide and Companion Guide for MaineCare-specific submittal instructions at https://mainecare.maine.gov/ProviderHomePage.aspx .

1.11 PAYMENT PROCESS

1.11-1 Payments

The Office of the State Treasurer issues all payments. A Remittance Advice (RA) is generated with each payment showing the payment or denial of specific claims. Payment will be made by Electronic Fund Transfer (EFT), unless the provider is unable to accept payment in this manner. In those cases the Office of the State Treasurer shall provide an alternative method of payment.

1.11-2 National Correct Coding Initiative Edits

A. MaineCare will perform National Correct Coding Initiative (NCCI) Edits on all outpatient UB-04 and 1500 claims forms. There are two (2) types of NCCI edits:

1. Procedure-to-Procedure (PTP) Edits define pairs of HCPCS and CPT codes that should not be reported together.

2. Medically Unlikely Edits (MUEs) define the maximum units of service for each HCPCS and CPT code that a provider would generally report for a single patient on a single date of service.

B. MaineCare will reject claims not in conformity with NCCI requirements.

1.11 PAYMENT PROCESS (cont.)

1.11-3 Rejected Invoices

If the claim is rejected due to invalid or incomplete information, no reimbursement is made. Rejected claims will be identified either during the claim submission process or on the RA and will include a reason for the rejection. A correct claim must be resubmitted within the time limits previously stated in Section 1.10-2 before payment will be considered.

If a covered service was denied payment, or an incorrect amount was paid due to a billing or processing error, providers must follow appropriate billing instructions issued by the Department (see Section 1.12).

1.11-4 Payments and Denials for all Third Party Payers, Including Medicare

Providers shall bill the appropriate third party payer, including Medicare, for those MaineCare members also covered by the third party payer. Providers are to comply with the most current billing instructions as made available by the Department.

1.12 CLAIM ADJUSTMENTS

Under certain circumstances, an adjustment may be made on the billing claim form or on electronically filed claims to reverse or to reverse and replace a claim. Providers must comply with the most current billing instructions issued by the Department.

1.12-1 Underpayments

When, as the result of an audit, the Department determines that an underpayment has been made to a provider, the Department will notify the provider and send written authorization allowing the provider to bill MaineCare.

If a provider believes an underpayment has been made for covered services rendered, based upon policy and procedures as described in this Manual, the provider should accept and cash the check issued for the services provided. The provider must request a review of payments, using the MaineCare Adjustment Request form, within one hundred and twenty (120) days of the remittance statement date or waive any right to a review of that payment. MaineCare Adjustment Request forms are available at https://mainecare.maine.gov/Provider%20Forms/Forms/Publication1.aspx?RootFolder=%2fProvider%20Forms%2fClaims&FolderCTID=&View=%7b55EF7D29%2d59ED%2d4CC1%2dA015%2d69037A886B14%7d .

1.12 CLAIM ADJUSTMENTS (cont.)

1.12-2 Overpayments

An overpayment from MaineCare may indicate that a provider has submitted bills and/or received payment to which he or she is not properly entitled.

A. When, as a result of an audit, review or other information, the Department determines that it has overpaid a provider, the Department will notify the provider, in writing, as to the nature of the discrepancy, the method of computing the reasonable dollar amount to be refunded and of any further action.

B. Provider Determination of Overpayment. When a provider determines that an overpayment has been made, the provider shall comply with the most recent reimbursement instructions issued by the Department. Overpayments must be reported to the Department within thirty (30) days of identification and repaid in accordance with Title XI, §1128J(d) of the *Social Security Act* within sixty (60) days or by the date any corresponding cost report, if applicable, is due, whichever is later.

Failure to reimburse the Department for an overpayment may result in provider sanctions, as detailed in the *Social Security Act*, Title XI, §1128J(d). These sanctions are described in Section 1.20.

C. The Department or its Authorized Entity may recover overpayments made to a provider through direct reimbursement, offset, civil action or other actions authorized by law, pursuant to Title 22, M.R.S. §1714-A, including interest on overpayments.

1. **Direct Reimbursement**

Unless other regulations apply, the provider must reimburse the Department within thirty (30) calendar days of the date of the notice of the overpayment.

2. **Offset/Recoupment**

The Department may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when overpayments are not repaid as required in Section 1.12-2(C)(1) in accordance with state and federal rules and regulations. The Department may offset and/or recoup against MaineCare providers related by ownership and control to the provider that owes a collectible debt as defined in Title 22, section 1714-A(2). Providers are related by ownership and control only if the relationship allows the person whose relationship is the subject of the offset to control at least the number of votes of the Provider's governing body or management that is needed to govern the operation of the Provider.

1.12 CLAIM ADJUSTMENTS (cont.)

3. **Civil Action**

The Department may file a civil action in the appropriate Court and exercise all other civil remedies available to the Department in order to recover the amount of an overpayment.

4. **Liens and Foreclosure**

Pursuant to 22 M.R.S. §1714-A the Department may recover the amount of an established debt through lien and foreclosure thirty-one (31) calendar days after exhaustion of all administrative appeals and any judicial reviews under 5 M.R.S. §8001 *et seq*.

1.12-3 **MaineCare Adjustment Requests**

Providers shall submit adjustment requests, which require review by MaineCare Services, on a MaineCare Adjustment Request form with appropriate documentation and a new claim form.

Some examples for use of this form are: the provider is requesting additional funds on a previously paid claim, an original claim was denied as a duplicate, medical necessity/medical review is required, and Prior Authorization is required. Providers have one hundred twenty (120) days from the date of the remittance statement to submit the MaineCare Adjustment Request form.

1.13 INQUIRY PROCESS

There are two (2) options available to providers to check member eligibility, co-pay information, claim status, third party payment insurance, and eligibility for MaineCare managed care benefits. These options are a web based system and an Interactive Voice Response System. These options are available twenty-four (24) hours a day, seven (7) days a week and allow unlimited inquiries. Providers will be required to furnish the MaineCare provider ID number, the member's name, date of birth, and the member's ID number or Social Security Number before any information can be given. Providers should attempt to resolve questions via the web based system or the Interactive Voice Response System, or other means made available by the Department, prior to calling the Provider Services Unit.

When a provider is in need of an immediate resolution to a policy and/or procedural question, the Provider Relations Unit may be contacted by telephone, or by submitting an e-mail inquiry.

Written inquiries regarding the payment or nonpayment of claims should be mailed or faxed to:

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

1.13 INQUIRY PROCESS (cont.)

Priority will be given to written inquiries that contain copies of claims, Remittance Advices and any other pertinent documents, because these documents expedite issue resolution.

1.13-1 Unpaid Claims

When a provider does not receive information regarding the payment of a specific claim from the Department, he or she may use the web-based system or call the Interactive Voice Response System, or use other means made available by the Department, regarding the status of the claim before rebilling. The web based system and Voice Response System will let the provider know if the claim has been paid or denied and on what date. If there is no information on file, it means the claim was not received and should be resubmitted.

1.13-2 Re-evaluation of Charges

If a provider questions the payment he or she has received for a service, a written inquiry must be made within one hundred and twenty (120) calendar days from the date of the Remittance Advice. The provider must comply with the most current procedures made available by the Department.

1.14 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain services. The PA requirement is spelled out in each section of other Chapters of this Manual whenever it applies to a covered service. In addition, management of high cost member services and/or supplies may require PA by the Department or its Authorized Entity.

1.14-1 In-State Services

A. The dated and signed request for PA must be made by the member's provider in writing and sent to the MaineCare Prior Authorization Unit, or as appropriate, to the Department's Authorized Entity or any other office as required by the Department and provided in other sections of this Manual.

For PA, contact information and where to send completed PA forms, visit the MaineCare Services website at: https://mainecare.maine.gov.

A request for prior authorization must be signed by the provider and must include:

1. Member's name and MaineCare identification number;

2. Diagnosis for which the request is being made;

1.14 PRIOR AUTHORIZATION (cont.)

3. The procedure(s) requested and its/their corresponding code(s);

4 Date(s) of the scheduled procedure, if known;

5. The billing provider ID number of the physician and/or physicians practice or other authorized provider that will render the requested service(s), if known;

6. All clinical records to support the requested service (describing diagnostic studies and treatment completed to date along with results, and clinical records upon which the request has been made); and

7. Additional information as determined by the Department or its Authorized Entity.

B. PA may be effective for up to twelve (12) months as determined by medical criteria and documentation of ongoing necessity. In some cases, for covered health care expenditures that require PA, financial eligibility for medical services may be determined retroactively. MaineCare will provide reimbursement for these services if it can be shown that all Departmental requirements were met at the time the services were performed.

C. For enrolled MaineCare members, the provider must verify the need for PA with the Department and subsequently, ensure that authorization has been obtained when applicable. This must be done prior to provision of services, except in cases of medical emergency, or as described in Section 1.14-2 (B).

D. Notwithstanding any other provision herein, MaineCare Services or its Authorized Entity shall act on requests for PA with reasonable promptness and shall adjust the time periods specified herein as circumstances require. In circumstances that do not require an immediate decision, MaineCare Services or its Authorized Entity will make a decision to authorize or deny the request for PA within thirty (30) days of the receipt of the completed request, or thirty (30) days after the date the application is determined to be complete following a decision in an administrative hearing as provided herein, or services will be considered authorized. MaineCare Services will notify the provider and member of the decision.

E. The thirty (30) day provision regarding the treatment of complete requests shall not apply in the case of an emergency. In the case of an emergency, the PA decision will be made expeditiously to address the emergency, including notifying the provider of an incomplete request.

1.14 PRIOR AUTHORIZATION (cont.)

F. Providers that submit an incomplete request for authorization of services will be notified within thirty (30) days of receipt of the incomplete request. MaineCare Services or its Authorized Entity will defer the request until the specific additional information necessary to complete the request is received. Such notice shall be sent to the provider and member, within thirty (30) days of receipt of the incomplete request and shall clearly identify the following:

1. The information necessary to complete the request;

2. Specific citation of the regulations requiring the information; and

3. The name and telephone number of the person in MaineCare Services or its Authorized Entity, who should be contacted should the provider and/or member have questions regarding the deferral.

G. The member's provider shall make a reasonable effort to submit to MaineCare or its Authorized Entity the information requested within thirty (30) days from the date that notice is received that it is incomplete, failing which the application may be considered abandoned and may be denied for that reason.

Any notice that an application is incomplete, sent out by MaineCare or its Authorized Entity, more than thirty (30) days from the date the original application was filed with MaineCare, shall be considered an adverse action by MaineCare. Such notice shall be accompanied with a statement advising the applicant of an opportunity for an administrative hearing to challenge the determination that the application is incomplete.

In the case of a notice of incompleteness given more than sixty (60) days from the date the original application was filed, the statement shall advise the applicant of an opportunity for an administrative hearing to determine not only whether the application is complete, but, in the event that it is deemed so, whether MaineCare Services should be ordered to take final action on the application within ten (10) days. Any such order by the administrative hearing officer shall provide that the request shall be considered authorized if a decision is not made within such ten (10) day period.

H. Once approval has been given, if the provider originally requesting PA is unable or unwilling to provide the service requested within a reasonable time, the member may choose another provider. The second provider is responsible for notifying MaineCare Services of his/her intention to provide the service subject to the initial approval. MaineCare Services, upon request, will assist the member in attempting to locate a provider when the member is unable to do so.

1.14 PRIOR AUTHORIZATION (cont.)

I. If the request for prior authorization is denied, MaineCare or its Authorized Entity will clearly explain the denial reasons in the denial notice. This explanation shall include any facts, circumstances, calculations, and other data that were used as a basis for making the denial and shall specify any additional information that could be supplied, by the provider or member, to permit the request to be approved. This explanation shall be set forth clearly and conspicuously and shall be phrased, to the extent possible, in simple terms easily understandable by a layperson.

J. MaineCare will not deny a request for services without examining the nature of the request to determine whether any portion of the services requested or reasonable alternative services thereto might be covered by MaineCare. A notice of denial shall be given when the services requested are denied in whole or in part.

If a portion of the request is covered under MaineCare and a portion is not, MaineCare or its Authorized Entity shall give notice of a denial of only those services not covered and shall give approval of those services that are covered.

K. MaineCare Services or its Authorized Entity shall promptly refer requests for PA for mental health services not covered (or for the portion of services not covered for partially denied services) by MaineCare to DHHS, Adult Mental Health Services or Children's Behavioral Health Services.

Such referrals will be made within three (3) business days of the determination that mental health services requested are not covered by MaineCare and shall be made to the appropriate regional office of DHHS by telephone or electronic mail or other method to ensure that the referral is received as soon as practicable. Any denial of requested services, in whole or in part, shall be accompanied by a statement advising the applicant of a right to an administrative hearing. If an applicant chooses to request a hearing, the request shall be made no later than thirty (30) days from the date of receipt of the notice and, if requested, MaineCare Services or its Authorized Entity, shall forward the request to the DHHS Division of Administrative Hearings (DAH) within twenty-four (24) regular business hours (that is, by the next day if not a holiday or weekend) and a hearing shall be held within seven (7) working days thereafter. (See Sections 1.23 & 1.24).

L. When a participating provider furnishes a service or equipment and has either failed to request PA or has been notified that PA has been refused, that provider is liable for the costs of those services and that provider may not bill either the Department or the member for such care or services, except in the following situation: Prior to the provision of the services the member shall acknowledge in writing that he or she is aware that PA has not been granted and, therefore, MaineCare will not pay for the services and that he or she accepts financial liability to pay for the services.

1.14 PRIOR AUTHORIZATION (cont.)

In addition, if and when a member chooses not to utilize the PA process, the service is considered non-covered by MaineCare if the member acknowledged in writing that he or she understood that he or she would assume financial responsibility for the service.

1.14-2 Out-Of-State Services

Unless otherwise allowed in Chapter II of this Manual, medical care that is covered under MaineCare that is only available outside the State of Maine requires prior authorization. MaineCare will not guarantee payment for services received out-of-state unless PA has been granted pursuant to the procedure outlined in Section 1.14-2(A).

The provider is responsible for verifying the need for PA and subsequently, that authorization has been obtained from the Department or its Authorized Entity when applicable. This needs to be done prior to provision of services, except in cases of medical emergency, or as described in Section 1.14-2 (B).

PA for services will be granted to out-of-state providers for covered services described in this Manual, only when a member's continuity of care must be preserved for medical reasons and only after it is determined that the needs of the member cannot be met in the State of Maine.

Notwithstanding any other provision herein, MaineCare Services or its Authorized Entity shall act on applications for PA for out-of-state services with reasonable promptness and shall adjust the time periods specified herein as circumstances require.

If the request for PA is denied, MaineCare or its Authorized Entity will clearly explain the reasons for denial in the denial notice. This explanation shall include any facts, circumstances, calculations, and other data that were used as a basis for making the denial and shall specify any additional information that could be supplied, by the provider or member, to permit the request to be approved. This explanation shall be set forth clearly and conspicuously and shall be phrased, to the extent possible, in simple terms easily understandable by a layperson.

A. Procedure and Requirements for Out-Of-State Services

The procedure to request prior authorization is as follows:

1. Each member must be currently under the care of a licensed professional providing physician services, or a recognized primary care provider acting within the scope of his/her license, and practicing in the State of Maine, or within fifteen (15) miles of the Maine/New Hampshire border.

1.14 PRIOR AUTHORIZATION (cont.)

2. The request for PA must be made by the Maine physician for services provided out-of-state. Criteria for PA of out-of-state services shall be as set forth in this Chapter and in the specific section of this Manual covering those services. PA contact information and prior authorization forms can be found at http://www.maine.gov/dhhs/oms/provider_index.html.

3. The request must be made at least thirty (30) calendar days prior to the date medical care/services are to be provided in another state. The only exception would be for medical or behavioral health emergency cases.

   In cases involving such an emergency, the PA decision will be made as soon as necessary to relieve the emergency. Emergency cases will be given special consideration and should be so identified by the physician or provider requesting approval.

   Telephone requests, which must be followed by written materials, will be accepted only in emergency situations. Faxed requests are allowed.

4. The provider's request for PA must include:

   a. Member's name;

   b. Member's MaineCare identification number;

   c. Diagnosis (describe diagnostic studies and treatment completed to date along with results, and clinical records upon which the request for out-of-state referral has been made). Send clinical records to support diagnosis and referral;

   d. Names of physicians and/or facilities that the member has previously been referred in Maine for diagnosis and/or treatment. Include second opinion documentation;

   e. Physicians consulted by attending physician relative to availability of diagnosis and/or recommended treatment in Maine. Send second opinion documentation supporting out-of-state referral;

   f. Recommended treatment or further diagnostic work;

   g. Reasons why medical care cannot be provided in Maine or the next closest location outside the State;

1.14 PRIOR AUTHORIZATION (cont.)

h. Names of physicians and facility outside of Maine to provide services and date of appointment(s) if known, and

i. Additional information if specified in applicable Chapters of this Manual.

5. If additional information is needed or it appears that the service may be available within the State, the Department or its Authorized Entity reserves the right to require that the patient seek consultation and/or treatment from providers of the service within the State.

6. The reviewing Department or its Authorized Entity will notify the provider and member of approval or disapproval. If approved, a letter will be sent to the member and the out-of-state provider(s) authorizing medical care. The out-of-state provider must enroll as a MaineCare provider for the State of Maine and must accept MaineCare reimbursement as payment in full for the covered services authorized. The Department reserves the right to set rates for services. If disapproved, an explanation will be given, and notice of the member's right to request an administrative hearing will be given.

7. The procedures for granting, denying and processing requests for in state services, as set forth in Section 1.14-1, shall apply to requests for out-of-state services.

8. Once approval has been given, if the provider originally requesting prior authorization is unable or unwilling to provide the service requested within a reasonable time, the member may choose another provider. The second provider is responsible for notifying the applicable Department of his or her intention to provide the service subject to the initial approval and conditions set forth above. The applicable Department, upon request, will assist the member in attempting to locate a provider when he or she is unable to do so.

9. The attending physician in the State of Maine is expected to perform follow up for medical procedures provided out-of-state, unless medical necessity requires return to the out-of-state provider. Therefore, it is expected that the referring physician will receive medical reports of services provided by the out-of-state provider and follow the above procedures for any required out-of-state follow up.

B. **Exceptions**

MaineCare will evaluate claims for MaineCare services rendered to eligible members out-of-state without prior authorization only under the following circumstances.

1.14 PRIOR AUTHORIZATION (cont.)

1. Emergency medical services rendered to members who are temporarily absent from the State, and for which they cannot reasonably be expected to return to Maine or because the member's health would be endangered if required to travel back to the State of Maine. Out of state emergency medical services will be reviewed for medical appropriateness. Providers must notify the Department, or its Authorized Entity, within one (1) business day of an emergency admission for a MaineCare member. For inpatient emergency services, the provider must seek and receive approval for an appropriate length of stay, determined by the Department or its Authorized Entity, based on the evidence of medical necessity provided in the member's medical documentation. In order to be reimbursed by MaineCare for emergency inpatient services, the provider must submit an authorization number on the claim form submitted to the Department. In cases where the provider is unable to confirm proof of MaineCare coverage (e.g. member is unconscious, or the member does not have MaineCare card readily available), the provider may exceed the one-day requirement by providing a sufficient explanation of the case.

2. MaineCare covered services rendered to eligible members who intend to remain out-of-state. The Office of for Family Independence will determine when MaineCare coverage will terminate.

3. MaineCare covered services rendered to eligible members by qualified providers within fifteen (15) miles of the Maine/New Hampshire border.

4. MaineCare covered services rendered to persons prior to their date of application, when eligibility is determined retroactively to cover the time period in which the services were provided.

5. MaineCare covered services received by qualified Medicare beneficiaries out-of-state when the providers have accepted Medicare assignment and only the deductible and coinsurance are to be billed.

6. MaineCare covered services provided through out-of-state, culturally appropriate, alcohol treatment and substance abuse services, that are fully reimbursed (100%) by Indian Health Service funds, and provided by enrolled MaineCare providers. These services are subject to post payment review by the Division of Program Integrity.

C. Specific Requirements for Behavioral Health Emergencies and Mental Health Services for Children

Requests involving behavioral health emergencies are in a unique group that does not require PA.

1.14 PRIOR AUTHORIZATION (cont.)

1. The definition of a behavioral health emergency is as follows:

   The member displays significant, prolonged, escalation of volatile or suicidal behaviors to the point that the parent, guardian, or service provider is unable to reasonably assure the safety of the member and/or others. There must be clinical documentation of professional inability to secure safety, as well as inability to obtain the necessary behavioral health emergency services in the State of Maine.

1.14-3 Early and Periodic Screening, Diagnosis and Treatment Services

MaineCare Services shall take reasonable and necessary steps to ensure that all requests for PA of services for MaineCare members under age twenty-one (21) are not denied without first taking reasonable steps to determine if the services can under the MBM, Section 94, Early and Periodic Screening, Diagnosis and Treatment Services. Reasonable steps may include, but are not limited to, contacting the provider to inform the provider of the EPSDT for these treatment services. Such services include those medically necessary treatment/diagnostic services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the EPSDT benefit and are described in a member's comprehensive plan of care.

These MaineCare covered services are furnished in accordance with the *Omnibus Budget Reconciliation Act (OBRA) of 1989* and are covered under federal regulations.

1.14-4 Medical Necessity

Some services under this section require prior authorization by the Department or its Authorized Entity. Prior authorization contact information and prior authorization forms can be found at: http://www.maine.gov/dhhs/oms/provider_index.html.The Department may use evidence-based criteria and/or may use criteria based on national standards for evaluating what is considered medically necessary.

1.15 PROVISION OF NECESSARY TRANSPORTATION TO MEDICAL SERVICES

MaineCare meets the federal requirement to provide necessary transportation (42 C.F.R. §431.53) to MaineCare members who have no other means of transportation to MaineCare covered services. See MBM, Ch. II, Sec. 113 (Non-Emergency Transportation (NET) Service), and Sec. 5 (Ambulance Services).

1.16 AUDITS

The Division of Audit, Program Integrity Unit, or duly Authorized Entities appointed by the Department have the authority to monitor payments to any MaineCare provider by an audit or post-payment review.

1.17 UTILIZATION REVIEW

The Department or its Authorized Entity is responsible for carrying out a series of safeguarding measures. These measures safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assess the quality of services available under MaineCare. The Department may use consultants and peer reviewers with expertise appropriate to the medical care or services to be reviewed.

Delegation of any utilization review activities pertaining to length of stay in acute care hospitals will be carried out in accordance with the hospital's utilization review program/plan.

The Department has the authority to request medical records and other records as necessary to support utilization review, utilization management, concurrent review, or other service review activities. Providers must respond to the requests in a timely manner and at no charge to the Department.

1.17-1 Behavioral Health Managed Care

The Department uses a behavioral health managed care system for all members receiving selected behavioral health services that are covered by MaineCare to ensure access to appropriate care and improve member outcomes.

The Department’s Administrative Services Organization (Authorized Entity) is used for eligibility verification, utilization management, and for examination of clinical appropriateness for selected services as identified in the behavioral health services sections of the MBM. The Authorized Entity performs the following duties: facilitates referrals to appropriate service providers; prior authorizes selected services; expedites delivery of services to members in need of treatment; tracks the service status of members enrolled in the system; and gathers data that will inform the Department of resource development needs. The Department’s goal is to promote early intervention of services provided to avoid unnecessary reliance on emergency and inpatient services. All providers must submit notification of their intent to initiate behavioral health services identified in the MBM prior to the start of services for all members. The Department’s Authorized Entity must have prior notification of services for utilization review purposes to assess the medical necessity, efficiency, appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis.

Please refer to the appropriate Sections of the MBM for additional requirements and information on behavioral health managed care.

1.18 PROGRAM INTEGRITY

The Program Integrity Unit, Division of Audit, or the Department’s Authorized Entity, or any combination of the three (3) entities, is responsible for surveillance and referral activities that may include, but are not limited to:

1.18 PROGRAM INTEGRITY (cont.)

A. A continuous sampling review of the utilization of care and services for which payment is claimed;

B. An on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to members;

C. An extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;

D. A post-payment review that may consist of member utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;

E. The implementation of the Restriction Plans (described in Chapter IV of this Manual);

F. Referral to appropriate licensing boards or registries as necessary;

G. Referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases where fraudulent activity is suspected; and

H. A determination whether to suspend payments to a provider based upon a credible allegation of fraud.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records, including but not limited to: treatment/service plans, progress notes, product and/or service order forms, invoices, and documentation of delivery of services and/or products provided are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

1.19 TERMINATION FROM PARTICIPATION IN MAINECARE

1.19-1 Termination of Participation by Provider or Department

A. Non-Emergency Termination

The Department may terminate a provider's participation, or the provider may terminate participation in MaineCare, without cause. The terminating party must send written notification of the termination at least thirty (30) days prior to the effective date of termination. Providers must send this notification to the Director of Compliance, MaineCare Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011.

1.19 TERMINATION FROM PARTICIPATION IN MAINECARE (cont.)

Primary care providers must also abide by the termination regulations set forth in the Primary Care Case Management Policy.

B. **Emergency Termination**

The Department may terminate MaineCare participation of a provider immediately by giving written notice to the provider if the Department reasonably believes that conditions exist that place the health and safety of members in immediate jeopardy. The provider will be given the opportunity for an informal review after the effective date of the emergency termination. A request for an informal review must be made within seven (7) days of the date of the receipt of the termination notice, or an informal review shall be deemed waived. Any administrative hearing or informal review will be scheduled after the effective termination date and the transfer of members.

C. **Procedures Following Notice of Termination**

1. Except as otherwise directed by the Department, after notice of termination by either the provider or the Department or after notice of emergency termination, the provider shall furnish the Department with access to all information pertaining to each individual member presently being cared for by the provider in such detail as deemed necessary by the Department.

2. The Department shall reimburse providers for covered services rendered during the period following a notice of termination up to the effective date of termination. The Department may decide to extend the effective date of a termination for providers of residential services, if necessary, to achieve the safe relocation of members. A provider remains obligated to follow the provisions of its MaineCare Provider Agreement and all applicable sections of the MBM in order to continue to receive reimbursement for services.

1.20 SANCTIONS/RECOUPMENTS

1.20-1 Grounds for Sanctioning and/or Recouping MaineCare payments from Providers, Individuals or Entities

The Department may impose sanctions and/or recoup identified overpayments against a provider, individual, or entity for any one or more of the following reasons:

A. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise;

B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

1.20 SANCTIONS/RECOUPMENTS (cont.)

C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements;

D. Failing to retain or disclose or make available to the Department or its Authorized Entity contemporaneous records of services provided to MaineCare members and related records of payments;

E. Failing to provide and maintain quality services to MaineCare members within accepted principles and values of medical professionalism and national standards of care;

F. Engaging in a course of conduct or performing an act deemed improper, abuse of the MaineCare Program, or continuing such conduct following notification that said conduct should cease;

Examples of such abusive acts include, but are not limited to, the following:

1. Furnishing services or supplies which are determined by the Department to be substantially in excess of the needs of, or harmful to, individuals, or to be of inferior quality, or not of usual or customary quality;

2. Soliciting or accepting from a member, his or her family, friend or other representative an amount over and above the reasonable charge amount or fee schedule for covered services (supplementation);

3. Maintaining a separate schedule of charges for MaineCare and non-MaineCare patients that results in higher charges for MaineCare than for non-MaineCare patients;

4. Billing based on "gang" visits, (for example, a dental provider in a school setting, or a physician visits a nursing home, walks through the facility, and bills for individual nursing home visits, without rendering any specific service to individual patients).

G. Breaching the terms of the MaineCare Provider Agreement, and/or the Requirements of Section 1.03-8 for provider participation;

H. Over utilizing MaineCare by inducing, furnishing, or otherwise causing a member to receive service(s) or merchandise not otherwise required or requested by the member;

1.20 SANCTIONS/RECOUPMENTS (cont.)

I. Rebating or accepting a fee or portion of a fee or charge for a MaineCare member referral (kickback);

J. Physician self-referrals determined to be in violation of Title XVIII, §1877 of the *Social Security Act* (42 U.S.C. §1395nn), which prohibits certain physician self-referrals for designated health services, and 42 C.F.R. §§ 1001.951/952 and 42 C.F.R. §411.353.

Designated health services include any of the following items or services:

1. Clinical laboratory services;
2. Physical therapy services;
3. Occupational therapy services;
4. Radiology services, including MRIs, CAT scans, and ultrasound services;
5. Radiation therapy services and supplies;
6. Durable medical equipment and supplies;
7. Parenteral and enteral nutrients, equipment, and supplies;
8. Prosthetics, orthotics, and prosthetic devices and supplies;
9. Home health services;
10. Outpatient prescription drugs;
11. Inpatient and outpatient hospital services; and
12. Speech-language pathology services

K. Violating the applicable provision of any law governing benefits governed by this Manual, or any rule or regulation promulgated pursuant thereto;

L. Submission of a false or fraudulent application for provider status;

M Violation of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;

1.20 SANCTIONS/RECOUPMENTS (cont.)

N. Conviction of a criminal offense relating to performance of a Provider Agreement with the State, negligent practice resulting in death or injury to patients, or misuse or misapplication of program funds;

O. Failure to meet standards required by state or federal law for participation (e.g. licensure or certification requirements);

P. Documented practice of charging members for services over and above the amount paid by the Department and/or charging members for services prior to receipt of MaineCare payments;

Q. Failure to correct deficiencies in provider operations in accordance with an accepted plan of correction after receiving written notice of these deficiencies from the Department;

R. Formal reprimand or censure by an association of the provider's peers for unethical practices;

S. Suspension, exclusion or termination from participation in another governmental medical program, such as Medicare, Workers' Compensation, Children With Special Health Needs Program, and Rehabilitation Services, for fraudulent or abusive practices;

T. Conviction for fraudulent billing practices, negligent practice, or patient abuse;

U. Failure to repay or make arrangements to repay overpayments or payments made in error;

V. Failure to return money paid by members to a provider for covered services rendered during any period of MaineCare eligibility, including failing to pay back members for services for which they were charged when they have eligibility determined retroactively and there is evidence of notification of retroactive eligibility for the member;

W. Unauthorized use of a primary care provider's MaineCare Identification number as described in Section 1.03-8;

X. Breach of the terms of legal and binding contract(s) with contractor(s) or subcontractor(s) who provide their contractual services to MaineCare members; or

1.20 SANCTIONS/RECOUPMENTS (cont.)

Y. Failure to abide by the provisions of 42 C.F.R. §1000 *et seq*., pertaining to the exclusion of individuals and entities;

Z. For an organization or entity that is an HMO or any entity furnishing services under a waiver approved under 42 U.S.C. §1396n(b)(1), having a substantial contractual relationship with an individual or entity that could be excluded. A substantial contractual relationship is one in which the sanctioned individual or entity has direct or indirect business transactions to more than $25,000 or five percent (5%) of the organization or entity's total operating expenses, whichever is less. Business transactions include but are not limited to contracts, agreements, purchase orders or leases to obtain services, supplies, equipment, space or salaried employment; and

AA. Conviction of a crime that occurred while performing services as a health care worker or provider.

BB. Failure to provide information to the Department or to otherwise respond to Departmental requests for information within a reasonable timeframe established by the Department.

1.20-2 **Sanction Actions**

The Department may impose the following sanctions against providers, individuals or entities based on the grounds specified in Section 1.20-1, in accordance with applicable state and federal rules and regulations.

A. Termination/Exclusion from participation in MaineCare;

B. Suspension of participation in MaineCare;

C. Limitation of services for which the Provider is authorized to perform and receive payment;

D. Withholding or offset of future payments toward recoupment of prior MaineCare reimbursements;

E. Transfer to a closed-end Provider Agreement not to exceed twelve (12) months or the shortening of an already existing closed-end Provider Agreement;

1.20 SANCTIONS/RECOUPMENTS (cont.)

F. If the provider is a nursing facility or an ICF-IID Intermediate Care Facility for Individuals with Intellectual Disability (as defined in Chapter II, Section 67 or Section 50 of this Manual), and if the grounds for this sanction are based on the provider's failure to comply with 42 U.S.C. §1396r, Subsections (b) Requirements Relating to Provision of Services, (c) Requirements Relating to Residents' Rights, and/or (d) Requirements Relating to Administration and Other Matters (refer to Section 1.20-1(N) of this Manual), then the Department may sanction the provider by denying payment for all MaineCare admissions which take place after the date on which the Department gives notice to both the provider, and to the public, that the provider is out of compliance with 42 U.S.C. §1396 (b), (c) and/or (d);

Notwithstanding the delineation of provider appeal rights in Section 1.23-1 (A) of this Manual, this sanction may be enforced immediately if the noncompliance jeopardizes the health and safety of residents or three (3) months after the facility is notified of the noncompliance if the facility has not been brought into compliance within that three-month period. Hence, under these particular circumstances, this sanction may be enforced prior to and during the appeal process.

G. Forfeiture of any payment for services, supplies or goods, associated with grounds for sanctioned providers;

H. Imposition of a penalty due to lack of adequate documentation. When the Department proves by a preponderance of the evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services, the Department in its discretion may impose the following penalties:

1. A penalty equal to one hundred percent (100%) recoupment of MaineCare payments for services or goods if the provider has failed to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members.

2. A penalty equal to twenty-five percent (25%) where the provider’s records lack a required signature from a member or the member’s guardian.

3. A penalty equal to twenty-percent (20%) recoupment if the provider is able to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members. The penalty will be applied against each MaineCare payment associated with the records at issue.

1.20 SANCTIONS/RECOUPMENTS (cont.)

Following a request from a provider to impose a recoupment of a lower percentage than twenty percent (20%), the Department may consider the following factors as the basis for its decision:

a. The nature and extent of the identified violations;
b. The impact or potential impact of the violation(s) on members;
c. The impact or potential impact of the violation on administration of the MaineCare program;
d. The financial impact of the violation on MaineCare;
e. The provider's acceptance of responsibility;
f. Any history of prior violations;
g. Any quality assurance, licensing, or other notices of deficiency;
h. Any other factor the Department finds relevant to its consideration.

I. **Plan of Corrective Action (POCA)**

Require the provider to submit a plan of correction to the Department for review and approval. Failure to provide a plan of correction satisfactory to the Department within the time specified may result in the Department choosing to impose different and/or additional sanction(s) on the provider. The plan of correction must be a specific plan which describes how the provider will correct or address the identified deficiency (event, incident, or risk), including the actions the provider will undertake to bring about correction. The plan of correction must:

1. Address correction of the specific deficiencies cited;

2. Address all identified areas where the correction of all related deficient circumstances will be implemented;

3. Identify specific actions/steps the provider will complete to prevent the identified deficiency from recurring. The specific events cited may not represent all instances within the site/services where the practice is deficient;

4. Specify the date or frequency when each element of the plan will occur. Terms such as "frequently," "periodically," "as needed," and "ongoing" lack the necessary specificity;

5. Identify, by title and name, the individual(s) responsible for implementing and monitoring the plan;

6. Provide dates by which all components of the plan will be implemented and when the corrections will be completed. The length of time to correct the deficiency must be as soon as possible; and

1.20 SANCTIONS/RECOUPMENTS (cont.)

7. Not duplicate or closely parallel a previously submitted and failed plan of correction

Providers may satisfy the plan of correction requirement by sharing a copy of a plan of correction approved by another Office or Division within the Department for the identical violation(s) for which OMS sought the plan of correction.

J. Impose a suspension of referrals to a provider;

K. Deny or pend any enrollment applications submitted by a provider;

L. Limit the number of service locations a provider may enroll; and

M. Limit the number of MaineCare members the provider may serve.

1.20-3 **Rules Governing the Imposition and Extent of Sanction**

A. **Imposition of Sanction**

The decision to impose a sanction shall be the responsibility of the Commissioner of DHHS, who may delegate sanction responsibilities to a designee.

1. The following factors may be considered in determining the sanction(s) to be imposed:

a. Nature and seriousness of the offense(s);

b. Extent of violation(s);

c. History of prior violation(s);

d. Prior imposition of sanction(s);

e. Prior provision of provider education;

f. Whether a lesser sanction will be sufficient to remedy the problem; and

g. Actions taken or recommended by peer review groups, other payers, or licensing boards, if applicable.

1.20 SANCTIONS/RECOUPMENTS (cont.)

2. Where a provider, individual or entity, has been convicted of defrauding the MaineCare Program, or has been previously suspended due to MaineCare Program abuse, or has been terminated from the Medicare Program for abuse, the Department shall institute proceedings to terminate participation of the provider, individual or entity, from the MaineCare Program.

3. Nursing facilities that fail to comply with state licensing regulations may be subject to the imposition of sanctions and/or federal penalties as described in Chapter 22, (Enforcement), of the Department's policy titled: Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.

B. **Scope of Sanction**

1. A sanction may be applied to a provider, individual, or entity, or to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances.

2. Suspension or termination from participation of any provider, individual or entity shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Department or its Authorized Entity for any services or supplies provided under MaineCare except for those services or supplies provided prior to the suspension or termination.

3. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Department or its Authorized Entities for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in MaineCare except for those services or supplies provided prior to the suspension or termination.

4. When a provider of services that is a clinic, group, corporation or other association are in violation of the provisions of Section 1.20-3(B)(3), the Department may suspend or terminate such organization and/or any individual within said organization that is responsible for such violation, and administer other sanctions.

1.20 SANCTIONS/RECOUPMENTS (cont.)

C. **Notice of Sanction**

1. When a provider, individual or entity, has been sanctioned and/or a recoupment has been imposed, the Department shall notify, if appropriate, the applicable professional society, Board of Registration or Licensure, his or her employer, and federal or state agencies of the findings made and the sanctions imposed.

2. Once a provider, individual or entity's participation in MaineCare has been suspended or terminated, the provider must notify all affected MaineCare members within thirty (30) days that the provider, individual or entity, has been suspended or terminated and must arrange orderly transfer of records to other providers as applicable.

1.20-4 **Mandatory and Permissive Exclusions from MaineCare**

The Department may exclude individuals, entities, and providers from participation in MaineCare for any reason identified in 42 C.F.R. Part 1001 or 1003.

1.20-5 **Notice of Violation/Recoupment**

If the Department has information that indicates that a provider may have submitted bills and/or has been practicing in a manner inconsistent with the program requirements, and/or may have received payment for which he or she may not be properly entitled, the Department shall notify the provider of the discrepancies noted. The written notification shall be sent to the provider allowing at least sixty (60) calendar days from the date of the notice before the effective date of any further action or imposition of sanction pursuant to state and federal laws, unless the life and/or safety of the member is felt to be endangered which would be cause for immediate sanction, and shall set forth:

A. The nature of the discrepancies or violations;

B. The dollar value of such discrepancies or violations;

C. The method of computing such dollar value may be from:

1. Extrapolation from a systematic random sampling of records,

2. A calculation from a selective sample of records, or

3. A total review of all records.

1.20 SANCTIONS/RECOUPMENTS (cont.)

D. Any further actions to be taken or sanctions to be imposed by the Department; and

E. Any actions required of the provider, and the right to request an informal review and administrative hearing, as set forth in Section 1.23. An adverse decision may be appealed pursuant to the procedures outlined in Section 1.23 of this Chapter. A request for review or proceedings there under, does not stay the sanction imposed by the Department.

1.20-6 **Suspension or Withholding of Payments Pending a Final Determination**

The Department may impose a sanction or withhold payment when the Department has obtained an order from Superior Court allowing interim sanctions upon showing a substantial likelihood that overpayment or fraud has occurred and that substantial harm to the Department will result from further delay or when the Department has taken final agency action and the provider has waived or exhausted its right to judicial review.

No court order is required when the Department suspends payments in accord with subsection 1.22-3.

The Department may terminate or suspend the participation of a provider in MaineCare pursuant to federal and state rules and regulations.

1.20-7 **Procedures Following a Suspension**

Except as otherwise directed by the Department, the Provider under suspension shall:

1. Not accept new members for services unless otherwise specifically requested in writing on an individual case basis by the Department.

2. Furnish the Department with access to all information pertaining to each individual member presently being cared for by the Provider in such detail as deemed necessary by the Department.

1.21 REINSTATEMENT FROM TERMINATION OR EXCLUSION

A. **Reinstatement Procedures from Termination or Exclusion**

1. For reinstatement to occur, a request for reinstatement must be addressed to the Manager of Program Integrity in writing. Considerations for reinstatement include:

1.21 REINSTATEMENT FROM TERMINATION OR EXCLUSION (cont.)

a. Any sanctions, including outstanding monetary sanctions;
b. Whether all fines and debts (including overpayments) due and owed to any federal, state or local government that relate to MaineCare, Medicare or any state health care program have been paid or whether satisfactory arrangements have been made to fulfill these obligations;
c. The conduct of the individual or entity prior to the date of the notice of the exclusion, including conduct not known to the agency at the time of the exclusion; and
d. The conduct of the individual or entity after the date of the notice of exclusion.

Any request for reinstatement will be reviewed in relation to any decisions or actions made by the United States Department of Health and Human Services, to past actions in MaineCare, and to other relevant factors such as professional sanctions.

2. Reinstatement after termination or exclusion may not be considered before one (1) year or the minimum period of time when stated below, whichever is greater, as calculated from the effective date of the termination or exclusion, unless a different time period is required consistent with federal law or rule. The following minimum periods of time apply:

a. Conviction of program-related crimes, five (5) years;
b. Conviction relating to patient abuse or neglect, five (5) years;
c. Felony conviction relating to health care fraud, five (5) years;
d. Conviction of two (2) of the above offenses, ten (10) years;
e. Conviction of three (3) of the above offenses, permanent exclusion;
f. Misdemeanor conviction relating to health care fraud, three (3) years;
g. License revocation or suspension, no less than period imposed by state licensing authority;
h. Exclusion or suspension under federal health care program, no less than the period imposed by federal health care program;
i. Individuals controlling a sanctioned entity, same period as entity; and
j. Violation of the terms of an exclusion or termination:
    i. Any month in which an excluded individual violates the terms of their exclusion or termination shall not be counted against the minimum period of time before reinstatement may be requested.
    ii. The Department shall impose an additional period of exclusion or termination equal to one-half of the original minimum period after becoming aware of any violation. The additional period of exclusion or termination will commence upon written notification to the individual of the violation.

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS

1.22-1 **Fraud**

A. Fraud includes intentional deception or misrepresentation, oral or written, which an individual knows to be false, or does not believe to be true, made with knowledge that deception or misrepresentation could result in some unauthorized benefits. The requisite intent is present if the misrepresentation was made knowingly or with a reckless disregard for the truth.

B. Examples of conduct that could constitute fraud include, but are not limited to, the following:

1. Billings for services, supplies, or equipment that were not rendered to, or used for, MaineCare members;

2. Billings for supplies or equipment that are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;

3. Flagrant and persistent over utilization of medical or paramedical services with little or no regard for results, the member's ailments, condition, medical needs, or the provider's orders;

4. Claiming of costs for non-covered or non-chargeable services, supplies or equipment disguised as covered items;

5. Misuse of the "rounding rule," Section 1.03-8(J), in billing for services;

6. Material misrepresentations of dates and descriptions of services rendered, or of the identity of the member or the individual who rendered the services;

7. Duplicate billing which appears to be deliberate. This includes, but is not limited to: billing MaineCare twice for the same service or billing both MaineCare, a third party insurer, and/or the member, family, or representative for the same services, billing for the same service under different codes or different policies, billing separately for a service that is included in a per diem or other bundled rate, or billing for the same service under different provider numbers;

8. Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge MaineCare with various devices (commissions, fee splitting) used to siphon off or conceal profits;

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

9. Charging to MaineCare, by subterfuge, costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses of principals;

10. Deliberately providing, or receiving medical services on the MaineCare account of another individual;

11. Deliberately billing members rather than MaineCare for covered services;

12. Concealing business activities that would prevent compliance with the provisions of the Provider Agreement;

13. Falsifying provider records in order to meet or continue to meet the conditions of participation; and

14. Soliciting, offering, or receiving a kickback, bribe, or rebate.

1.22-2 Statutory Provisions

A. The State of Maine participates financially in MaineCare. Therefore, provider claims for payment from MaineCare are subject to Maine Statutes pertaining to criminal fraud including the following:

a. 17-A M.R.S. §354, Theft by Deception, makes it a crime to obtain or exercise control over property of another as a result of deception, and with an intention to deprive a person thereof.

2. 17-A M.R.S. §453, Unsworn Falsification, makes it a crime if a person makes a written false statement which he or she does not believe to be true, on or pursuant to, a form conspicuously bearing notification authorized by statute or regulation to the effect that false statements made therein are punishable; or with the intent to deceive a public servant in the performance of his or her official duties, he or she makes any written false statement which he or she does not believe to be true; or knowingly creates, or attempts to create a false impression in a written application for any pecuniary or other benefit by omitting information necessary to prevent statements therein from being misleading and is punishable as a Class D crime.

3. Title 17-A M.R.S. §151, the Conspiracy Statute, makes it a crime if, with the intent that conduct be performed which, if fact, would constitute a crime or crimes, a person agrees with one (1) or more others to engage in or cause the performance of such conduct.

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

B. The Federal Government also participates financially in MaineCare. Therefore, provider claims for payment from MaineCare are subject to federal statutes pertaining to criminal fraud including the following:

1. 18 U.S.C. §286, which makes it a crime to enter into an agreement, combination, or conspiracy to defraud the United States by obtaining or aiding to obtain payment of a false claim;

2. 18 U.S.C. §287, which makes it a crime to present a claim against the United States knowing it to be false;

3. 18 U.S.C. §371, which makes it a crime for two (2) or more persons to conspire to commit an offense against the United States or to defraud in any manner or for any purpose;

4. 18 U.S.C. §669, which makes it a crime to embezzle, steal, or intentionally misapply money, funds, property, or other assets of a health care benefit program;

5. 18 U.S.C. §1001, which makes it a crime for any person in any manner within the jurisdiction of any Department of the United States to knowingly conceal a material fact, or make false statement or representations, or make or use any false writing or document knowing it to be false;

6. 18 U.S.C. §1035, which makes it a crime for any person involved in any manner with a health care benefit program to knowingly and willfully makes false, fictitious, or fraudulent oral or written statement or representation of a material fact;

7 18 U.S.C. §1341, which makes it a crime for any person to use the postal service for purposes of executing or intending to execute any fraudulent scheme or artifice;

8. 18 U.S.C. §1347, which makes it a crime for any person to knowingly and willfully defraud, or obtain by false pretense, through the delivery of or payment for health care benefits any money or property owned by any health care benefit program;

9. 18 U/S.C. §1516, which makes it a crime for any person to influence, obstruct, or impede a federal auditor in the performance of official duties;

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

10. 18 U.S.C. §1518, which makes it a crime for any person to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a federal health care offense to a criminal investigator; and

11. 31 U.S.C. §3729(c) *False Claims Act* – See Chapter I, Appendix #3, of this Manual.

Because MaineCare is subject to federal statutes in order to receive federal funding, compliance with federal regulations and/or law is necessary, and federal law will supersede any state regulation that may be contradictory.

C. Section 42 U.S.C. §1320a-7 (b) of the *Social Security Act* provides that:

1. **Whoever**

a. Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in application for any benefit or payment under the State Plan approved under this Title;

b. At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment;

c. Having knowledge of the occurrence of any event affecting:

(i) His or her initial or continued right to any such benefit or payment; or

(ii) The initial or continued right to any such benefit or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulent to secure such benefits or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized; or

d. Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person;

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

e. Presents or causes to be presented a claim for a physician's service for which payment may be made under a program under the State Plan approved under this Title and knows that the individual who furnished the service is not licensed as required, shall in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, shall be guilty of a felony and upon conviction thereof, fined no more than twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) years or both or in the case of such a statement, representation, concealment, failure, or conversion by another person, be guilty of a misdemeanor and upon conviction thereof fined not more than ten thousand dollars ($10,000) or imprisoned for not more than one (1) year, or both.

In addition, in any case where an individual who is otherwise eligible for assistance under a State Plan approved under this Title is convicted of an offense under the preceding provisions of this Sub-Section, the state may at its option (not withstanding any other provision of this Title or of such Plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one (1) year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

2. Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind:

a. In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this Title, or

b. In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, be fined not more than twenty-five thousand dollars $25,000 or imprisonment for not more than five (5) years, or both.

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

3. Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly overtly or covertly, in cash or kind to any person to induce such person:

   a. To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

   b. To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility service, or item for which payment may be made in whole or in part under this Title, shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) years, or both.

4. Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification) as a hospital, nursing facility, ICF/IID Intermediate Care Facility for Individuals with Intellectual Disability, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty- five thousand dollars ($25,000) or imprisoned for not more than five (5) years, or both.

5. Whoever knowingly and willfully:

   a. Charges a member, for any service provided to that member under a State Plan approved under this Title, money or other consideration at a rate in excess of the rates established by the State, or

   b. Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State Plan approved under this Title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):

      i. As a precondition of admitting a patient to a hospital,

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

ii. As a requirement for the patient's continued stay in such a facility when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State Plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) years or both.

1.22-3 **Suspension of Payment Upon Credible Allegation of Fraud**

A. The Department shall suspend payments to a provider upon a Credible Allegation of Fraud for which an investigation is pending under the MaineCare program or any Medicaid Program. A suspension of payments under this subsection is not a sanction under subsection 1.20. A Credible Allegation of Fraud is an allegation that the department has verified, from any source, which has one (1) or more indicia of reliability and which allegation, facts and evidence have been carefully reviewed by the Department, on a case-by-case basis. The source of an allegation may be, but is not limited to, fraud hotline complaints, claims data mining or patterns identified through provider audits, civil false claims cases and law enforcement investigations.

B. The Department shall send notice to a provider of a suspension of payments within five (5) days after suspending payments unless the Department is requested in writing by a law enforcement agency to delay such notice. Such request shall temporarily withhold the sending of notice up to thirty (30) days after suspending payments. A request for delay may be renewed in writing up to twice, but in no event may the time for sending of notice exceed a total of ninety (90) days after payment suspension.

C. The notice must include or address the following:

1. State that payments are being suspended in accordance with the relevant federal and state provision.

2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation.

3. State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated.

4. Specify, when applicable, the type of MaineCare claims or business units as to which the suspension is effective.

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

5. Inform the provider of the right to timely submit written evidence for consideration by the Department in an informal review.

6. Set forth the administrative appeals process and corresponding citations to this Chapter.

D. The suspension of payments is for a temporary period. Payment suspension will not continue after either of the following:

1. The determination is made by the investigating or prosecuting authorities that there is insufficient evidence of fraud by the provider; or

2. Civil and criminal legal proceedings related to the provider's alleged fraud are completed.

E. The appeal process provided by subsection 1.23 below is available to a provider whose payments have been suspended in whole or in part. The suspension of payments shall not be stayed during the informal review or appeal. A request for informal review may include or consist of a request to the Department to find good cause not to continue a payment suspension or to convert a suspension to one only in part, in accordance with any of the criteria set forth in sub-sections G or H.

F. A provider whose payments have been suspended in whole or in part may request expedited informal review, which the Department in its discretion may accommodate. The request must be in writing and included within the request for informal review.

G. The Department may find that good cause exists not to suspend payments, or not to continue a payment suspension, when:

1. Law enforcement officials specifically have requested that a payment suspension not be imposed because it may compromise or jeopardize an investigation;

2. Other available remedies implemented by the state more effectively or quickly protect Medicaid funds;

3. The Department determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

4. Member access to items or services would be jeopardized by a payment suspension because either the provider is the sole community physician or the sole source of essential specialized services in the community, or the provider services a large number of members within a HRSA-designated medically underserved area;

5. The relevant law enforcement entity declines to certify that a matter continues to be under investigation as required by 42 C.F.R. §455.23(d)(3) (2011), or

6. The Department determines that payment suspension is not in the best interests of the MaineCare program.

H. The Department may find that good cause exists to suspend payments only in part, or to convert a payment suspension previously imposed in whole to one only in part, when:

1. Member access to items or services would be jeopardized by a payment suspension in whole or in part because either the provider is the sole community physician or the sole source of essential specialized services in the community, or the provider services a large number of members within a HRSA-designated medically underserved area;

2. The Department determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be imposed only in part;

3. The Credible Allegation of Fraud focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Department determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;

4. The relevant law enforcement entity declines to certify that a matter continues to be under investigation as required by 42 C.F.R. §455.23(d)(3) (2011); or

5. The Department determines that payment suspension only in part is in the best interests of the MaineCare program.

1.22 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY, AND SUSPENSION OF PAYMENTS (cont.)

I. Upon a Final Informal Review Decision by the Department, a provider whose payments have been suspended in whole or in part may request expedited appeal to an administrative hearing, which the Department in its discretion may accommodate. The request for expedited hearing must be in writing and included within the appeal for administrative hearing and shall specify any scheduling restraints, location restraints, and the amount of time the provider estimates is required for its case at hearing. A request for expedited hearing waives the twenty-day (20) notice requirement provided by Section 1.23-1(A) below.

J. In an administrative appeal, the Department must show that, at the time of its determination of the existence of a Credible Allegation of Fraud for which an investigation is pending, a sufficient basis existed for that determination. If the Department has made a finding as to lack of good cause regarding a payment suspension, the provider must demonstrate by a preponderance of evidence that the Department erred upon informal review in its finding.

K. Upon any final determination that monies are owed by the provider to the Department, and thirty-one (31) days after exhaustion of all administrative appeals and any judicial review available under Title 5, Chapter 375, the Department may retain and apply as an offset any payments that have been suspended by the Department pursuant to this subsection. The amount retained pursuant to this Subsection may not exceed the amount determined to be finally owed.

1.23 PROVIDER AND PROVIDER APPLICANT APPEALS

1.23-1 General Principles

Any provider or provider applicant that is aggrieved by a Departmental action made pursuant to this Manual (excluding emergency terminations as referenced in Section 1.19-1-B) may request an informal review within sixty (60) calendar days from the date of receipt of that decision. If the deadline falls on a weekend or holiday, the deadline will be extended to the next business day. A provider or provider applicant is not aggrieved by, and may not request an informal review of, Departmental action issued to, directed at, or concerning another provider or provider applicant.

The request for an informal review must be in writing (handwritten, typed, or emailed) and addressed to the Director of Compliance, Office of MaineCare Services. This review will be conducted by a designated Department representative who was not involved in the decision under review. The informal review will consist solely of a review of documents in the Department's possession including submitted materials/documentation and, if deemed necessary by the Department, it may include a personal meeting with the provider or provider applicant to obtain clarification of the materials. Issues that are not raised by the provider, provider applicant, individual, or entity through the written request for an informal review or the submission of additional materials for consideration prior to the informal review are waived in subsequent appeal proceedings.

1.23 PROVIDER AND PROVIDER APPLICANT APPEALS (cont.)

The request for informal review may not be amended to add further issues.

Requests for informal reviews shall be submitted to MaineCare Services or other designated Department representative unless otherwise directed by the governing sections of Chapter II or Chapter III of this Manual. A written report of the decision resulting from that review will be issued to the provider.

A. Administrative Hearing

A provider or provider applicant must properly request an informal review and obtain a decision before requesting an administrative hearing. If the provider or provider applicant is dissatisfied with the informal review decision, he or she may write the Director of Compliance, Office of MaineCare Services, to request a hearing provided he/she does so within sixty (60) calendar days from the date of the informal review report on the Department's action. If the deadline falls on a weekend or holiday, the deadline will be extended to the next business day. Subsequent appeal proceedings will be limited only to those issues raised during the informal review process.

The DAH shall notify the provider or provider applicant in writing of the date, time and place of the hearing, and shall designate a presiding officer. Providers and provider applicants will be given advance notice of at least twenty (20) calendar days from the mailing date of the hearing date. The hearing shall be held in conformity with the *Maine Administrative Procedure Act*, 5 M.R.S. §8001 *et seq*. and the Administrative Hearings Regulations.

The presiding officer shall issue a written decision and findings of fact to the provider or, pursuant to provisions of the Administrative Hearings Regulations, issue a written recommendation to the Commissioner of Health and Human Services. The Commissioner will then make the final decision. Legal counsel may represent providers and provider applicants at a hearing and may request or subpoena persons to appear at the hearing where they can be expected to present testimony or documents relating to issues at the hearing.

If the provider is dissatisfied with the final decision, an appeal may be taken to the Superior Court pursuant to the *Administrative Procedure Act*.

B. Arbitration Alternative

In lieu of the administrative hearing procedure, the parties may choose binding arbitration by a qualified arbitrator or panel of arbitrators as an alternative means of resolving a dispute. Both parties must agree to this optional method of dispute resolution. The *Maine Uniform Arbitration Act* shall regulate the arbitration. A provider's request for arbitration must be made within sixty (60) days from the date of receipt of the informal review decision prompting the

1.23 PROVIDER AND PROVIDER APPLICANT APPEALS (cont.)

request. Issues for arbitration shall be limited to those issues raised during the informal review. The arbitrator or panel of arbitrators must be selected and compensated as agreed by both parties.

If the parties cannot agree to the terms of arbitration, the arbitration alternative will not apply and the normal procedures of administrative hearing with the option of appeal to the Superior Court will apply. If agreement for arbitration cannot be reached, a timely request for arbitration shall be construed as a request for an administrative hearing and all other terms of an administrative hearing shall apply. Arbitration is only available as an option when the amount in controversy is ten thousand dollars ($10,000) or less and the subject matter in controversy is assessments, recovery or recoupment orders, sanctions, or administrative fines. A provider choosing arbitration may waive any right of appeal.

1.23-2 **Appeal Options by Type of Facility**

A. Special additional procedures apply to appeals for nursing facilities, residential care facilities, adult family care homes, and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) for which the certification or provider enrollment/agreement is denied, terminated or not renewed for MaineCare.

Any nursing facility, residential care facility, adult family care home, or ICF/IID for which the MaineCare certification or Provider Agreement is denied, terminated or not renewed must be given an opportunity for a full evidentiary hearing on the denial, termination or nonrenewal. A facility representative must request a hearing within thirty (30) calendar days of the notice of the Department's informal review decision.

1. If the facility requests an administrative hearing, it must be completed either before the effective date of the denial, termination or nonrenewal or within one hundred and twenty (120) calendar days after that date.

2. The hearing must, at a minimum, include:

   a. Timely written notice to the facility of the basis for the decision and disclosure of the evidence on which the decision is taken;

   b. An opportunity for the facility to appear before an impartial decision maker to refute the basis for the decision;

   c. An opportunity for the facility to be represented by counsel or another representative;

   d. An opportunity for the facility or its representatives to be heard in person, to call witnesses, and to present documentary evidence;

1.23 PROVIDER AND PROVIDER APPLICANT APPEALS (cont.)

e. An opportunity for the facility to cross-examine witnesses; and

f. A written decision by the impartial decision maker, setting forth the reasons for the decision and the evidence upon which the decision is based.

B. **Medicare/MaineCare Participating Nursing Facilities: Federal Appeal Option**

In accordance with 42 C.F.R. §431.153, if a nursing facility is participating, or seeking to participate, in both Medicare and MaineCare, and if the basis for the State's denial, termination or nonrenewal of participation in MaineCare is also a basis for denial, termination or nonrenewal of participation in Medicare, the state must advise the facility that:

1. The facility is entitled to the review procedures specified for Medicare facilities in Part 405, Subpart R, Title 42 of the *Code of Federal Regulations* in lieu of the procedures specified above; and

2. A final decision entered under the Medicare review procedures will be binding for purposes of MaineCare participation.

C. **Certified Nursing Facility Informal Reconsideration**

If the state decides to provide the opportunity for an administrative hearing as outlined in this section only after the effective date of a denial, termination or nonrenewal, the state must offer the facility an informal reconsideration, to be completed before the effective date. The informal reconsideration must, at a minimum, include:

1. Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based;

2. A reasonable opportunity for the facility to refute those findings in writing;

3. A written affirmation or reversal of the denial, termination, or nonrenewal; and

4. If the provider is still dissatisfied with the decision, he or she may write the Commissioner of the Department of Health and Human Services to request an administrative hearing provided he or she does so within thirty (30) calendar days of the date of the Director's informal reconsideration decision.

1.24 MEMBER APPEALS

1.24-1 Right to Administrative Hearing

In accordance with 42 C.F.R. §431.220 the Department must grant an opportunity for a hearing to:

A. Any member who requests it because his or her claim for services is denied or not acted upon with reasonable promptness; and

B. Any member who requests it because he or she believes the agency has erroneously terminated, reduced, or suspended MaineCare medical eligibility or covered services.

1.24-2 Notice of Intent to Deny, Terminate, Reduce or Suspend MaineCare Eligibility or Covered Services

A. Notice must be mailed or delivered in person to the member when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services or when there has been a determination by a skilled nursing facility or nursing facility to transfer or discharge residents, as set forth below.

Specific information that must be in this notice includes:

1. A statement of the intended action;

2. An explanation of the reasons for the action, as well as a specific citation to the underlying state or federal regulations that support the action;

3. A statement that the member has a right to a hearing;

4. An explanation of exactly how to obtain a hearing;

5. A statement that a member may be represented by legal counsel, relatives, friends or a spokesperson and a list of selected legal service providers available to assist the member in arranging for legal counsel;

6. The name and telephone number of the person who should be contacted, should the member have questions regarding the notice; and

7. An explanation of the circumstances under which medical eligibility for MaineCare or covered services are continued if a hearing is requested.

B. Advance notice must be mailed or delivered in person to a member at least ten (10) calendar days before an action to deny, terminate, suspend, or reduce services becomes effective, except as required by licensing of other state mandates. A member is presumed to have been provided a notice if there is evidence of when the notice was placed in the mail system or delivered in person.

1.24 MEMBER APPEALS (cont.)

The advance notice requirement applies unless:

1. The Department has facts indicating that the action should be taken because of probable fraud, and the facts have been verified if possible, in which case advance notice of five (5) calendar days is required;

2. The Department has factual information confirming the death of a member;

3. The agency receives a clear written statement, signed by the member, that the member no longer wishes services; or gives information that requires termination or reduction of services and indicates that the member understands that this termination or reduction is the result of giving that information;

4. The member has been admitted to an institution where he or she is ineligible for further services;

5. The member's whereabouts are unknown, and the post office returns agency mail directed to him or her indicating no forwarding address;

6. The member has been accepted for services by another local jurisdiction, state or territory; or

7. A change in the level of medical care is prescribed by the member's physician or primary care provider where authorized.

C. Continuation of MaineCare eligibility or services during the appeal process applies as follows:

1. In accordance with 42 C.F.R. §431.230 and when this section requires advance notice, MaineCare Services currently being provided will not be terminated, reduced, or suspended until an administrative hearing decision is rendered provided that the member requests an administrative hearing before the date of action. This applies unless it is determined at the hearing that the sole issue is one of federal or state law or policy, and the Department promptly informs the member in writing that services are to be terminated, reduced or suspended while awaiting the hearing decision.

2. The date of action means the intended date on which a termination, reduction or suspension becomes effective.

3. For Order of Reference decisions, as defined in the Administrative Hearings Regulations, the Department will take action to terminate, reduce or suspend services five (5) business days from the date of the final agency decision.

1.24 MEMBER APPEALS (cont.)

1.24-3 Procedure to Request an Administrative Hearing

A member may request an administrative hearing if he or she is aggrieved by any Departmental action that may deny, terminate, reduce, or suspend services provided by MaineCare. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. Members must follow the procedures described in this section when requesting an administrative hearing.

A. A member or his/her authorized representative may request an administrative hearing.

B. Unless otherwise specified in this Chapter, a request for an administrative hearing must be received within sixty (60) calendar days of the date of written notification to the member of the action the member wishes to appeal.

C. Unless otherwise specified in this Manual, the request must be made by the member or his or her representative, in writing or verbally, to: MaineCare Member Services, P. O. Box 709, Augusta, ME 04332, or an address otherwise specified by the Department in a written notice, for a hearing with the DAH, Department of Health and Human Services. For the purposes of determining when a hearing was requested, the date of the hearing request shall be the date on which the request for a hearing is received by MaineCare Member Services. The date a verbal request for an administrative hearing is made is considered the date of request for the hearing. MaineCare Member Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received. MaineCare Member Services shall send a fax or copy of all hearing requests to a Hearings Representative and to the DAH no later than five (5) business days after receiving the request. MaineCare Member Services shall send all expedited hearing requests within twenty-four (24) hours of identifying the request.

D. The hearing will be held in conformity with the *Maine Administrative Procedure Act*, 5 M.R.S. §8001 *et seq.* and the Department's Administrative Hearings Regulations.

E. The hearing will be conducted at a time, date and place convenient to the parties and at the discretion of the DAH, and a preliminary notice will be given at least ten (10) calendar days, from the mailing date. Shorter notice may be given in order to comply with provisions of Section 1.14-1 governing denials of mental health services. In scheduling a hearing, there may be instances where the hearing officer shall schedule the hearing at a location near the member or by telephone or interactive television system.

1.24 MEMBER APPEALS (cont.)

F. The Department and the member may be represented by others, including legal counsel and may have witnesses appear on his or her behalf.

G. An impartial official will conduct the hearing.

H. The hearing officer on his or her own motion or at the request of either Department representatives or the member may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing. The cost of the subpoena shall be borne by the Department.

I. When a medical assessment as defined in 42 C.F.R. §431.240(3)(b) by a medical authority other than the one involved in the decision under question is requested by the hearing officer or the member, and considered necessary by the hearing officer, it will be obtained at the Department's expense, and forwarded to the member or the member's representative and hearing officer allowing both parties to comment.

J. When the member, the Department, or an Authorized Entity of the Department requests a delay, the hearing officer may reschedule the hearing, after notice to both parties.

K. The decisions, rendered by the hearing authority, in the name of the Maine Department of Health and Human Services will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision-making authorization to him or herself.

L. Any person who is dissatisfied with the hearing authority's decision has the right to judicial review under Maine Rules of Civil Procedure, Rule 80C.

1.24-4 **Procedure to Request an Expedited Appeal**

Members may request an expedited appeal. Requests for an expedited appeal must be submitted in writing to the MaineCare Hearings Representative and contain all documents supporting the request. The Hearings Representative shall forward the request and all supporting documents to the DAH upon receipt.

A. The DAH may grant a member's request for an expedited appeal if it determines that the member has proven that the time otherwise permitted for a hearing could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. In making this determination, the DAH may consider the following factors:

1. Any submitted medical evidence of record;

1.24 MEMBER APPEALS (cont.)

2. Medical opinions from the member's health care providers or Department;

3. The timing of the member's request;

4. The current level of services authorized for the member;

5. Refusal or failure of the member or their representative to appear for a status conference; and

6. Any other factors the DAH determines relevant.

The DAH may require the parties or their representatives to participate in a status conference prior to ruling on a request for an expedited appeal.

B. The DAH will notify the member and Department representative whether the request is granted or denied as expeditiously as possible.

If a member is granted an expedited hearing, the Department must take final agency action on the appeal:

1. For a claim related to eligibility, nursing facilities, or preadmission and annual resident review, as expeditiously as possible and no later than seven (7) working days after the agency receives the expedited appeal request; or

2. For a claim related to services or benefits, as expeditiously as possible and no later than three (3) working days after the Department receives the expedited appeal request.

C. The Department is not required to take final agency action within the timelines above if:

1. The Department cannot reach a decision because the member requests a delay or fails to take a required action; or

2. There is an administrative or other emergency beyond the Department's control.

The Department must document the reasons for any delay in the member's record.

D. The DAH may make any adjustments to the hearing process as it deems necessary to accommodate the expedited time frame for the hearing. These adjustments may include, but are not limited to:

1. Limiting the time for the hearing;

2. Limiting the number of witnesses each party may call;

1.24 MEMBER APPEALS (cont.)

3. Limiting the timeframe to submit evidence;

4. Limiting the ability of parties to submit written closing statements or other post-hearing briefs;

5. Requiring parties to participate telephonically or by other remote means; and

6. Any other modification the DAH deems necessary.

If a member objects to any adjustment made by the DAH, the member may withdraw their request for an expedited appeal and have their appeal proceed under normal procedures. If the member does not withdraw their request, the member waives any objections to the adjustments.

1.24-5 **Dismissal of Administrative Hearing Requests**

A. If any of the following circumstances exist, the DAH may dismiss the request for an administrative hearing. This dismissal is the final agency action on the matter.

1. The member withdraws the request for a hearing.

2. The member, without good cause, abandons the hearing by failing to appear.

3. The sole issue being appealed is one of federal or state law requiring an automatic change adversely affecting some or all members. The procedure to follow when requesting a change in state policy is described in Section 1.06-4(D) of this Manual.

B. Where an applicant's or member’s request for an administrative hearing is dismissed pursuant to this section, the DAH shall notify the member of his/her right to appeal that decision in Superior Court.

1.24-6 **Corrective Action**

The Department must promptly make corrective payments when appropriate, retroactive to the date an incorrect action was taken by the Department if:

A. The hearing decision is favorable to the applicant or member; or

B. The agency decides in the applicant or member’s favor before the hearing.

1.25 MAINECARE ADVISORY COMMITTEE

1.25-1 Definitions

The MaineCare Advisory Committee (MAC) is a committee required by Federal Statute (Section 1902(a) (22) of the *Social Security Act*) to advise the MaineCare agency about health and medical care services. Policy for the Committee is set forth in Section 431.12, Title 42, (Chapter IV) of the *Code of Federal Regulations*.

1.25-2 Purposes

The MAC shall advise MaineCare Services and the Office for Family Independence of the Department of Health and Human Services on MaineCare services. The MaineCare Advisory Committee shall be given adequate opportunity for meaningful participation in policy development and program administration, including furthering the participation of beneficiary members in the MaineCare program. The advice of the Committee is not binding upon the Department.

1.25-3 Members of the Committee

The Director of MaineCare Services shall appoint members of the Committee. There shall be no fewer than fifteen (15) and no more than thirty (30) members on the Committee. The Committee shall include as members:

A. Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care.

B. Members of consumers' and consumer advocacy groups, including at least two (2) Medicaid beneficiaries, and consumer organizations, such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others.

C. The Director of the Office for Family Independence and/or the State's public health department.

Each member shall be appointed to a three (3) year term and may be re-appointed for additional three (3) year terms after serving a full term. Appointments shall be made on a continuous and rotating basis.

1.25-4 Chairperson and Subcommittees

A. Officers

The Committee shall have the following officers:

1. Chairperson

1.25 MAINECARE ADVISORY COMMITTEE (cont.)

The Chairperson shall be a member or member representative.

2. Vice Chairperson

Officers shall have the same power to make motion and to vote as other members of the Committee.

B. **Election of Chairperson**

The members of the Committee shall elect the Chairperson.

C. **Duties of Officers**

1. The Chairperson shall:

a. Preside at meetings of the Committee;

b. Plan the agenda for Committee meetings in consultation with the staff;

c. Have the power to call special meetings of the Committee;

d. Act as official representative interpreting and disseminating decisions of the Committee; and

e. Appoint the chairperson of each subcommittee.

2. Vice Chairperson

The Vice Chairperson shall:

a. Assist in planning the agenda for Committee meetings in consultation with the staff; and

b. Conduct Committee meetings in the absence of the chairperson.

D. **Subcommittees of the Committee**

The Committee may establish subcommittees as necessary, the members to be appointed by the chairperson. No fewer than three (3) members shall constitute a subcommittee.

1.25 MAINECARE ADVISORY COMMITTEE (cont.)

Non-members of the Committee may serve on subcommittees with the approval of the Committee chairperson of the specified subcommittee.

1.25-5 Meetings of the Committee

The Committee shall meet no fewer than six (6) times during a year. Regular meetings shall be held at a date, time, and place determined by the Committee.

Special meetings may be called by the chairperson, or at the request of MaineCare Services or upon the written request of at least two (2) Committee members to the chairperson, stating the reason for the special meeting. Special meetings would be convened in the event of an emergency that in the judgment of the chairperson cannot wait until the next regular meeting. The Chairperson shall notify the Committee members and the Director of MaineCare Services of the date, time, place, and agenda in advance of any scheduled or special meetings.

1.25-6 Attendance at Committee Meetings

Members of the Committee must attend at least a majority of Committee meetings, annually. If a member holding a Committee seat fails to meet this requirement, the Director of the Office of MaineCare Services may replace the member. MAC meetings shall be arranged to permit remote participation and attendance by remote video or other means when practical.

1.25-7 Staff Support

A staff person shall be assigned to the Committee. The staff shall:

A. Provide staff support for all Committee meetings, including minutes of committee meetings, dissemination of materials, and coordination of programmatic initiatives;

B. Record and distribute minutes of meetings;

C. Provide independent technical assistance to the Committee, as necessary.

D. Provide staff assistance from the agency and independent technical assistance as needed to enable the Committee to make effective recommendations; and

E. Provide the Committee with financial arrangements, if necessary, to make possible the participation of beneficiary members.

1.25 MAINECARE ADVISORY COMMITTEE (cont.)

1.25-8 Powers

A. Committee Action

The Committee acts through duly recorded votes of members of the Committee during meetings of the Committee. Binding Committee action can be taken only when a quorum of the Committee is present.

A quorum is defined as at least two-thirds of Committee members including the chairperson.

B. Public Statements by Committee Members

Committee members may make personal statements on public matters and may report on actions taken by the Committee but may not make an official statement or appear before the Legislature on behalf of the Committee unless expressly authorized to do so by the chairperson of the Committee, who may not give such approval unless the issue has been discussed at a meeting of the MaineCare Advisory Committee and supported by a majority of the Committee members present at that meeting. Any testimony must clarify the Committee's role as advisory to the Department.

C. Regular Review of Policy Developments

At each regularly scheduled meeting, the Committee shall be provided with a list of all policy issues related to MaineCare that are currently under consideration by the Office for Family Independence or MaineCare Services. In addition, it shall list the subject matter of all currently proposed rules and issues scheduled for rulemaking within the next month, and the stage of those proposals. At each scheduled meeting, members of the Committee shall be given the opportunity to discuss any issue on the list or set any such issue aside for further discussion at a subsequent meeting.

APPENDIX #1

CODE OF ETHICS FOR INTERPRETERS*

The following principles of ethical behavior are affirmed to protect and guide interpreters and transliterators, both for non-English speaking, and for hearing and deaf members. Underlying these principles is the desire to ensure for all the right to communicate.

This Code of Ethics applies to all interpreters and transliterators providing services to MaineCare members and reimbursed by MaineCare.

- Interpreters/transliterators shall keep all assignment-related information strictly confidential.
- Interpreters/transliterators shall render the message faithfully, always conveying the content and spirit of the speaker using language most readily understood by the person(s) whom they serve.
- Interpreters/transliterators shall not counsel, advise or interject personal opinions.
- Interpreters/transliterators shall accept assignments using discretion with regard to skill, setting, and the members involved.
- Interpreters/transliterators shall request compensation for services in a professional and judicious manner.
- Interpreters/transliterators shall function in a manner appropriate to the situation.
- Interpreters/transliterators shall strive to further knowledge and skills through participation in workshops, professional meetings, interaction with professional colleagues, and reading of current literature in the field.
- Interpreters/transliterators shall strive to maintain high professional standards in compliance with the Code of Ethics.

I have read, understand and agree to abide by the Code of Ethics as stated above.

_____

Printed name Written Signature

_____

Date

* Adapted from the Code of Ethics of the Registry of Interpreters for the Deaf (RID).

APPENDIX #2

PERTINENT SECTIONS FOR REQUIRED COMPLIANCE UNDER THE FALSE CLAIMS ACT

The *False Claims Act* (FCA) referenced in 31 U.S.C. §3729 provides in pertinent part:

"Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 plus three (3) times the amount of damages which the Government sustains because of the act of that person…."

Compliance with Section 6032 (Employee Education about False Claims Recovery) of the *Deficit Reduction Act of 2005*, is mandatory for providers or provider entities making or receiving payments of at least $5,000,000 under the MaineCare Program in any federal fiscal year. The $5,000,000 threshold, for MaineCare purposes, is based upon paid claims or amount of contract, net of any adjustments to those claims or contracts. Those affected providers or provider entities meeting this threshold include the following:

An individual governmental agency, organization, unit, corporation, partnership, individuals, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for profit or not for profit, that receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 during any federal fiscal year (FFY).

1. The Maine Department of Health and Human Services (hereinafter "the Department") will monitor compliance with these federal requirements by notifying all entities who met this threshold in the previous federal fiscal year. This notification will be completed in June of each calendar year thereafter. The Department will incorporate into the provider enrollment agreement and any contracts, the responsibilities of the entities in implementing Section 6032 (Employee Education about False Claims Recovery) of the *Deficit Reduction Act of 2005*.

2. The Department will request copies of the affected provider's written policies, including any employee handbooks or instructions, if they exist, and the plan to disseminate those policies to staff.

3. The Department will conduct a desk review of the entity's written policies and procedures and provide a written response of approval and/or suggestions to said policies and dissemination plan. Said policies and procedures will include an explanation of the false claims act; the entity's policies and procedures for detecting and preventing waste, fraud and abuse; the rights of the employee to be protected as whistle blowers and telephone numbers and/or addresses for reporting fraud and abuse.

APPENDIX #2 (cont.)

4. Thereafter, the Department will contact entities in June on an annual basis for any update or change to its written policies in order to assure on-going compliance. The Department will accomplish this verification by provider survey.

5. Newly identified entities will be required to submit their policies, dissemination plan and any additional information needed by the Department to determine compliance with the requirements referenced in #2, 3 and 4 above.

6. The Department has a range of sanctions contained in its administrative regulation for non-compliance with MaineCare policies. These sanctions range from requiring a plan of correction to termination from the MaineCare Program. These sanctions will be applied to non-compliance with the "Employee Education about False Claims Recovery."