

§3174-FF. MaineCare Basic

1. Established. The MaineCare Basic program is established to deliver medically necessary health care services to adult members of the MaineCare program.

[PL 2003, c. 673, Pt. MMM, §1 (NEW).]

2. Rules. The department shall adopt rules to implement MaineCare Basic in accordance with this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2003, c. 673, Pt. MMM, §1 (NEW).]

3. Services. The rules adopted pursuant to subsection 2 must provide for access to medically necessary services as provided in the federally approved Medicaid state plan. Benefits for certain services are limited as follows.

A. A member is eligible for speech therapy benefits if the member has been assessed to have rehabilitation potential or a demonstrated medical necessity for speech therapy to avoid a significant deterioration in the member's ability to communicate orally, safely swallow or masticate. In order for the member to be eligible for speech therapy benefits, a physician must document that the member has experienced a significant decline in ability to communicate orally, safely swallow or masticate or may reasonably suffer a significant deterioration in these functions if therapy is not provided. Speech therapy benefits must cover one initial evaluation of the member per provider per year and one reevaluation every 6 months per provider. Speech therapy benefits must cover outpatient therapy provided in the home, independent practitioners' offices and speech and hearing clinic sites. [PL 2007, c. 71, §1 (RPR).]

B. A member is eligible for rehabilitation services benefits for brain injury subject to levels of care determined by rule. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

C. A member is eligible for psychological services benefits for individual and group counseling. Benefits for one or both types of counseling combined are limited to a total of 16 one-hour visits per year, except that the department may increase the maximum number of visits for psychological services to 24 visits in a 12-month period as long as any cost associated with this increase is offset by savings from managing the use of these services by methods that may include prior authorization. [PL 2005, c. 680, §1 (AMD).]

D. A member is eligible for benefits for durable medical equipment, prosthetics and orthotics for one pair of shoes and one pair of inserts per year, medical supplies required to meet standard daily needs and power wheelchairs for a member who is nonambulatory and has a significant neuromuscular disease or disorder. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

E. A member is eligible for occupational and physical therapy benefits provided by occupational and physical therapists licensed under Title 32 and who are acting within their scope of practice. Services of occupational and physical therapists may be provided in all outpatient settings, including the home. For services subject to this paragraph, the department may require a member to have that member's rehabilitation potential documented by a physician and may limit treatment to:

- (1) Treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities;
- (2) Treatment after a surgical procedure performed for the purpose of improving physical function; or
- (3) Treatment in those situations in which a physician has documented that the patient has in the preceding 30 days required extensive assistance in the performance of one or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.

The department may limit occupational and physical therapy services benefits under this paragraph for palliative care and maintenance of function to one visit per year to design a plan of care and train the member or caretaker of the member to implement the plan or to reassess the plan of care. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

F. A member is eligible for benefits for chiropractic services provided by a chiropractor licensed under Title 32. Benefits under this paragraph may be limited by the department by requiring a member to have that member's rehabilitation potential documented by a physician. Benefits may be limited to treatment as follows:

- (1) Treatment for acute neuromuscular skeletal conditions affecting range of motion, muscle strength and physical functional abilities; or
- (2) Treatment after a surgical procedure performed for the purpose of improving physical function. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

G. A member is eligible for benefits under the private duty nursing and personal care program and waiver programs for the physically disabled or elderly as long as those benefits may be limited by reductions in units of service or by rate reductions. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

H. A member who is eligible for benefits under section 3174-G, subsection 1, paragraph F is eligible for benefits under this section subject to the provisions of paragraphs A to G and to additional rules limiting benefits as specified in this paragraph.

- (1) Benefits for inpatient hospital admissions are limited to 2 per year, except that more admissions may be approved through prior authorization by the department. This subparagraph does not limit inpatient hospital benefits for laboratory services, x-ray services, prenatal care and mental health diagnoses.
- (2) Benefits for outpatient visits to a hospital are limited to 5 per year, except that more visits may be approved through prior authorization by the department. This subparagraph does not limit benefits for visits for laboratory services, x-ray services, prenatal care and mental health diagnoses.
- (3) Benefits for brand-name prescription medications are limited to 5 medications dispensed during the same time period, except that benefits for additional brand-name medications may be approved through prior authorization by the department. In addition to the brand-name limitation, as compared to members who are eligible under other paragraphs of section 3174-G, subsection 1, prescription medication benefits for members who are eligible under paragraph F are limited by stricter prior authorization requirements, increased review of pharmacy use and a request for federal permission to waive freedom of choice.
- (4) A member who is eligible for benefits under section 3174-G, subsection 1, paragraph F begins coverage on the date that the department determines that the member is eligible. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

[PL 2007, c. 71, §1 (AMD).]

SECTION HISTORY

PL 2003, c. 673, §MMM1 (NEW). PL 2005, c. 680, §1 (AMD). PL 2007, c. 71, §1 (AMD).

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