STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

PT 13-04

MARYLAND MEDICAL ASSISTANCE PROGRAM
Rare and Expensive Case Management Program No. 3
EPSDT: Private Duty Nursing Services Transmittal No. 6
Home Health Transmittal No. 38
Managed Care Organization Transmittal No. 45

October 9, 2003

TO: EPSDT Private Duty Nursing Providers
Home Health Agencies
Managed Care Organizations
REM Case Management Providers

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that the appropriate staff members in your organization are informed of the contents of this transmittal

RE: Proposed repeal of Regulations .01-.17 and adoption of new Regulations .01 -.17 under COMAR 10.09.69 Managed Care Program: Rare and Expensive Case Management (REM)

ACTION:
Proposed Regulation

PROPOSED EFFECTIVE DATE:
January 1, 2004

WRITTEN COMMENTS TO:
Michele Phinney
201 West Preston Street, Room 538
Baltimore, Maryland 21201
410-767-6499 or
1-877-4MD-DHMH extension 6499
FAX: 410-767-6843

PROGRAM CONTACT PERSON:
Nancy Cutair, Division Chief
Division of Nursing Services
410-767-1448 or
1-877-4MD-DHMH extension 1448

COMMENT PERIOD EXPIRES: November 3, 2003

The Maryland Medical Assistance Program proposes to repeal Regulations .01-.17 and adopt new Regulations .01-.17 under COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management (REM) to be effective January 1, 2004.

The proposed regulations clarify the REM Program's design, participant eligibility and enrollment criteria, detail provider participation criteria including licensure or certification requirements, detail provider responsibilities, add limitations to the coverage of services and detail preauthorization requirements. Please note that the purpose, participant eligibility and participant enrollment/disenrollment criteria for the REM program remain the same.

In addition, the regulations formally delete certain services that were never implemented as part of the REM program. The optional services proposed for deletion are acupuncture, behavioral management, chore, convalescent care, emergency call system and electronic device, environmental modifications, CARF-accredited community rehabilitation, nursing facility, specialized equipment and supplies, social work and transportation. Many of these services are offered through Medicaid's fee-for-service system or other State programs. They are, therefore, deemed duplicative since REM participants may access these services through fee-for-service providers, other Medicaid 1915(c) waiver programs and/or other State Programs.

The proposed new regulations as they have been submitted to the Maryland Register are attached.

Attachment

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management

Authority: Health-General Article, §§15-102.1(b)(1) and 15-103(b)(4)(i), Annotated Code of Maryland

Notice of Proposed Action

[03-281-P]

The Secretary of Health and Mental Hygiene proposes to repeal Regulations **.01 — .17** and adopt new Regulations **.01 — .17** under **COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management**.

Statement of Purpose

The proposed regulations are intended to clarify the REM program's design, eligibility and enrollment criteria, detail provider participation criteria including licensure or certification requirements, detail provider responsibilities, add limitations to the coverage of services, and detail preauthorization requirements.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, Room 521, 201 West Preston Street, Baltimore, Maryland 21201, or fax to (410) 333-7687, or email to regs@dhmh.state.md.us, or call (410) 767-6499 or 1-877-4MD-DHMH extension 6499. These comments must be received by November 3, 2003.

.01 Purpose.

A. The purpose of the Rare and Expensive Case Management (REM) program is to provide case management services and subspecialty care for Maryland Medicaid Managed Care Program eligible individuals with rare and expensive conditions.

B. The program is designed to provide Maryland Medicaid Managed Care Program eligible individuals diagnosed with qualifying rare and expensive conditions the following benefits when the individual elects to participate in the program:

(1) Case management services; and

(2) REM optional services.

.02 Definitions.

A. Definitions of terms for this chapter are specified in COMAR 10.09.62.

B. Additional Terms Defined. "Cause" means a significant change in medical condition such that it is no longer medically appropriate for the individual to remain in the MCO as determined by the Department.

.03 Eligibility.

A. An individual is eligible to participate in the REM program if the individual:

(1) Is eligible for Maryland Medicaid Managed Care;

(2) Has one or more of the diagnoses specified in Regulation .17 of this chapter; and

(3) Elects to participate in the REM program.

B. The Department shall render a determination of an individual's eligibility within 5 business days on receipt of:

(1) A completed REM application;

(2) Any requested documentation verifying an individual meets the criteria set forth in §A of this regulation; and

(3) Verbal or written confirmation an individual elects to participate.

.04 Enrollment and Disenrollment.

A. Anyone may refer an individual into the REM program including, but not limited to a:

(1) Family member;

(2) Physician;

(3) Discharge planner;

(4) Hospital;

(5) Clinic;

(6) Social worker; and

(7) Managed care organization (MCO).

B. The Department shall enroll an individual determined eligible in the REM program when:

(1) All pertinent documentation regarding needed medical services is received and reviewed;

(2) Confirmation of the individual's election to participate in the program is received; and

(3) Service coordination is complete when the individual is being discharged from an institution or transitioning from an MCO.

C. When an MCO participant is referred to the REM program for enrollment, the MCO shall:

(1) Provide confirmation of the qualifying diagnosis to the Department; and

(2) Continue to provide the MCO participant's care until the Department confirms the diagnosis and enrolls the MCO participant into REM.

D. An individual shall be enrolled in or auto-assigned into an MCO as specified in COMAR 10.09.63 not later than 100 days from the date an individual becomes ineligible for REM as a result of changes in the diagnosis or age group criteria specified in Regulation .17 of this chapter.

E. A REM participant may elect to disenroll from REM and enroll in an MCO by notifying the Department of that decision.

F. Election to Remain in MCO.

(1) An individual who becomes eligible for REM while enrolled in an MCO may elect to remain in an MCO by notifying the Department of that decision.

(2) When a REM-eligible individual elects to remain in an MCO, the Department, in consultation with the MCO and the REM-eligible individual, may determine whether the MCO can appropriately meet the individual's medical needs within the parameters of the program benefit package as described in COMAR 10.09.67.

(3) If the MCO determines it cannot appropriately meet the individual's medical needs, the MCO shall submit to the Department written justification for its decision.

(4) If the Department determines the MCO can meet the individual's medical needs, the Department shall notify the MCO of its decision in writing.

(5) If the Department determines that the MCO cannot appropriately meet the individual's needs, the Department shall issue a written determination to the individual and the MCO which includes:

(a) The reason for the determination; and

(b) An explanation of the individual's right to appeal the determination according to the procedures set forth in COMAR 10.09.72.

(6) If the Department determines that the MCO can appropriately meet the individual's medical needs, the individual's election becomes effective and cannot be revoked without cause for a period of 1 year from the effective date.

G. The Department shall allow an individual who, immediately before enrollment in REM, was receiving medical services from a specialty clinic or other setting to continue to receive services in that setting on enrollment in the REM program when the provider is willing to participate as a Medicaid fee-for-service provider.

H. An individual eligible for REM who has elected to enroll in an MCO or to remain enrolled in an MCO may not receive REM services under the REM program.

I. The Department shall disenroll from the REM program a participant who no longer meets the conditions specified in Regulation .03 of this chapter.

J. An individual disenrolled from REM by the Department who maintains HealthChoice eligibility is subject to the MCO enrollment provisions specified in COMAR 10.09.63.

.05 Benefits.

A REM participant is eligible for the following:

A. Fee-for-service Medicaid benefits available to a Program recipient not enrolled in an MCO;

B. Services described in Regulations .10 and .11 of this chapter when determined medically necessary and, for adults, appropriate by the Department; and

C. Case management services performed by a REM case manager who shall:

(1) Gather all relevant information needed to determine the participant's condition and needs including the participant's medical records;

(2) Consult with the participant's current service providers;

(3) Evaluate the relevant information and complete a needs analysis including medical, psychosocial, environmental, and functional assessments;

(4) When necessary, assist the REM participant, offering the participant a choice, if possible, in selecting and obtaining an appropriate primary care provider, who may be a specialist as appropriate to the condition, giving preference to any pre-established relationships between the participant and the primary care provider;

(5) Develop a plan of care in consultation with the participant, the participant's family members, the primary care provider, and other providers rendering care;

(6) Implement the plan of care and assist the participant in gaining access to medically necessary and appropriate services by linking the participant to those services;

(7) Monitor service delivery, perform record reviews, and maintain contacts with the participant, services providers, and family members to evaluate the participant's condition and progress and to determine whether revision is needed in the plan of care or in services' delivery;

(8) As necessary, initiate and implement modifications to the plan of care and communicate these changes to the participant, parents or guardians, and pertinent health care providers;

(9) Monitor a participant's receipt of Early and Periodic Screening, Diagnosis and Treatment services as specified in COMAR 10.09.67; and

(10) Assist the participant with the coordination of school health-related services such as the local education plan, the Individualized Education Program (IEP), or the individual family service plan as described in COMAR 10.09.50.

.06 Requirements for Provider Licensing or Certification.

A. A case manager providing case management service under this chapter shall be a:

(1) Licensed registered nurse who is qualified to practice in the State; or

(2) Licensed social worker who is qualified to practice in the State.

B. The following professionals providing fee-for-service or optional services under this chapter to REM participants shall be licensed or certified to practice in the jurisdiction in which the services are rendered:

(1) Physicians;
(2) Registered nurses and licensed practical nurses;
(3) Chiropractors;
(4) Dentists;
(5) Nutritionists;
(6) Occupational therapists;
(7) Social workers;
(8) Speech therapists; and
(9) Certified nursing assistants and home health aides.

C. An agency providing services pursuant to this chapter shall meet all applicable licensure and certification requirements of the jurisdiction in which the agency is providing services.

.07 Conditions for Participation — General Requirements.

An individual, agency, or provider rendering services or medical care pursuant to this chapter shall:

A. Meet the applicable conditions for participation set forth in COMAR 10.09.36;

B. Meet the licensure and certification requirements specified in Regulation .06 of this chapter for its provider type;

C. Meet the specific conditions for provider participation set forth in this chapter;

D. Provide services in accordance with the applicable requirements of this chapter and all other relevant State and local laws and regulations;

E. Verify the qualifications of all subcontracted or employed professionals and individuals engaged by the provider agency to render services covered under this chapter and provide a copy of their current licensure and credentials on request to the Department;

F. Provide services to REM program beneficiaries in a manner consistent with the REM beneficiary's plan of care;

G. Notify the Department in writing within 10 business days when a service requested by a participant is deemed not medically necessary and, for adults, not medically appropriate;

H. Agree not to suspend, terminate, increase, or reduce services for participants without seeking authorization from the Department;

I. Comply with the requirements in the Department's quality plan for this Program;

J. When the Department determines it is necessary, participate in interdisciplinary team meetings for the purpose of:

(1) Developing and implementing a participant's treatment plan or plan of care with the Department; or

(2) Accessing a specific service;

K. Provide and bill the Program for only those services covered under this chapter included in the case manager's plan of care, or treatment plan developed by the physician, or both; and

L. Verify the eligibility of participants by calling the Program's Eligibility Verification System (EVS).

.08 Specific Conditions for Provider Participation.

A. Chiropractic Service Providers. To participate in the Program, the chiropractic service provider shall:

(1) Meet the conditions set forth in Regulation .07 of this chapter;

(2) Develop a goal-directed treatment plan that is based on an evaluation conducted during the initial assessment, unless the Department determines a more frequent review period is appropriate, which includes but is not limited to:

(a) A review or evaluation of the treatment plan 30 days after the initial assessment; and

(b) A review and update of the treatment plan every 90 days;

(3) Develop a written justification for chiropractic treatment on request by the Department which shall include but is not limited to the treatment's objective;

(4) Participate in interdisciplinary team meetings when requested by the Department; and

(5) Render services in accordance with a physician's order.

B. Dental Service Providers. To participate in the Program, the dental service provider shall meet the:

(1) Conditions set forth in Regulation .07 of this chapter; and

(2) Requirements for dental providers specified in COMAR 10.09.05.

C. Nutritional Supplement Providers. To participate as a provider of nutritional supplements, a provider shall meet the:

(1) Conditions of participation as set forth in Regulation .07 of this chapter; and

(2) Criteria of the conditions for participation for pharmacy providers set forth in COMAR 10.09.03.

D. Shift Private Duty Nursing/Certified Nursing Assistant/Home Health Aide Providers. To participate as a provider agency for shift private duty nursing, certified nursing assistant services, or home health aide, a provider shall:

(1) Meet the conditions set forth in Regulation .07 of this chapter;

(2) Meet all requirements of condition for participation set forth in:

(a) COMAR 10.09.53.03;

(b) COMAR 10.09.27.03; or

(c) COMAR 10.09.04;

(3) Participate in interdisciplinary team meetings, when requested by the Department;

(4) In conjunction with the REM case manager, develop a goal-directed written nursing care plan that is based on an evaluation conducted during the initial assessment, unless the Department determines a more frequent medical review to determine or re-examine treatment goals is appropriate, in the following manner:

(a) A review or evaluation of the nursing care plan 30 days after the initial assessment; and

(b) A review and update of the nursing care plan every 90 days;

(5) Ensure timesheets are signed by the individual rendering services;

(6) Ensure a nurse's, a certified nursing assistant's, or a home health aide's shift to be not more than 16 consecutive hours and that the individual is off 8 or more hours before starting another shift unless otherwise authorized by the Department;

(7) Obtain the participant's signature or the signature of the participant's witness on the provider's official forms to verify receipt of service; and

(8) Either be a:

(a) Residential service agency licensed in accordance with COMAR 10.07.05; or

(b) Home health agency licensed in accordance with COMAR 10.07.10 which meets the conditions of participation specified by the Medicare program in 42 CFR §484.36.

E. Occupational Therapy Providers. To participate in the Program as a provider of occupational therapy services, a provider shall:

(1) Meet the conditions set forth in Regulation .07 of this chapter;

(2) Be a self-employed occupational therapist licensed according to COMAR 10.46.01;

(3) Be an agency or clinic which employs licensed occupational therapists or be a Program provider of home health services under COMAR 10.09.04; and

(4) Develop a goal-directed written treatment plan in conjunction with the REM case manager that is based on an evaluation conducted during the initial assessment, unless the Department determines a more frequent review is appropriate, in the following manner:

(a) A review or evaluation of the treatment plan 30 days after the initial assessment; and

(b) A review and update of the treatment plan every 90 days.

F. Speech and Language Providers. To participate in the Program, a speech and language provider shall:

(1) Meet the conditions set forth in Regulation .07 of this chapter;

(2) Be a self-employed speech therapist licensed according to COMAR 10.41.03 or be a Program provider of home health services under COMAR 10.09.04; and

(3) Develop a goal-directed written treatment plan in conjunction with the REM case manager that is based on an initial assessment, unless the Department determines a more frequent review period is appropriate, in the following manner:

(a) A review or evaluation of the treatment plan 30 days after the initial assessment; and

(b) A review and update of the treatment plan every 90 days.

.09 Covered Services — General Requirements.

For participants in the REM program, the Program covers and shall reimburse for services specified in Regulations .10 and .11 of this chapter when these services are:

A. Medically necessary;

B. For adults, medically appropriate;

C. Physician prescribed;

D. Preauthorized, when required, by the Department;

E. Rendered in accordance with accepted health professional standards;

F. Rendered in accordance with the treatment plan or physician's order, or both; and

G. Delivered by an enrolled Medicaid provider.

.10 Covered Optional Services.

A. Chiropractic services are covered for REM participants when:

(1) Services are provided to a REM participant who is 21 years old or older;

(2) Services are provided by a licensed physician or licensed chiropractor;

(3) The qualifying REM diagnosis or related illness shows a deterioration or unrelieved worsening symptoms and other traditional treatments have been ineffective;

(4) The treatment enhances or restores the participant's level of functioning; or

(5) Symptoms resulting from the REM diagnosis or related illness impairs a participant's activities of daily living.

B. Dental services are covered when services are:

(1) Provided to a REM participant who is 21 years old or older; and

(2) Rendered as specified in COMAR 10.09.05.

C. Nutritional counseling services are covered when services are provided:

(1) By a licensed nutritionist or dietitian; and

(2) To a REM participant who is 21 years old or older.

D. Nutritional supplements are covered when the services:

(1) Include nutritional supplements or enteral feeding when medically necessary other than those administered by tube; and

(2) Are as described in COMAR 10.09.03.

E. The Department shall cover a physician's participation at interdisciplinary team meetings when the case manager, in conjunction with the team or specific team members, convenes the team meeting for the purpose of developing or reviewing the REM participant's plan of care to ensure continuity of care or access to a specific service.

F. Occupational therapy services are covered when the services:

(1) Require the judgment, knowledge, and skills of a licensed occupational therapist;

(2) Are specified in the plan of care developed by the REM case manager;

(3) Are provided to a REM participant who is 21 years old or older; and

(4) Are provided in accordance with COMAR 10.46.01 and 10.46.02.

G. Speech, Hearing, and Language Services. Speech, hearing, and language services include only those services that:

(1) Require the judgment, knowledge, and skills of a licensed speech, hearing, or language pathologist;

(2) Are provided to a REM participant who is 21 years old or older;

(3) Are specified in the treatment plan; and

(4) Are provided in accordance with COMAR 10.41.02 and 10.41.03.

.11 Covered Optional Services — Private Duty Nursing, Certified Nursing Assistant, and Home Health Aide.

A. The Program shall cover shift nursing services provided by a licensed registered nurse or a licensed practical nurse when:

(1) The complexity of the service or the condition of a participant requires the judgment, knowledge, and skills of a licensed nurse for a shift of 4 or more continuous hours;

(2) The services are delivered to the participant in the participant's home, in school, or in other normal life activity setting or settings which occur outside the participant's home;

(3) Services are provided to a REM participant who is 21 years old or older;

(4) Services are rendered in accordance with COMAR 10.09.53;

(5) Services are rendered in accordance with Health Occupations Article, Title 8, Annotated Code of Maryland;

(6) Sufficient documentation concerning the services provided is maintained by the registered nurse or licensed practical nurse, including:

(a) Verification of the participant's receipt of services as documented by the participant's signature or the signature of the participant's witness on the provider's official forms; and

(b) Signed and dated progress notes which are reviewed monthly by the nurse supervisor;

(7) The nurse's shift is limited to not more than 16 consecutive hours and the nurse is off 8 or more hours before starting another shift;

(8) Services are rendered by a licensed registered or practical nurse who is certified in cardiopulmonary resuscitation and the certification is renewed every 2 years;

(9) Services are preauthorized in accordance with the criteria set forth in COMAR 10.09.53; and

(10) Monthly supervisory visits of a licensed practical nurse are conducted and documented by a registered nurse.

B. The Program shall cover services provided by a certified nursing assistant when:

(1) The certified nursing assistant is certified by the Maryland Board of Nursing and meets all the requirements to render services pursuant to Health Occupations Article, Title 8, Annotated Code of Maryland;

(2) The complexity of the service or the condition of a participant requires the judgment, knowledge, and skills of a certified nursing assistant for a shift of 4 or more continuous hours as specified in COMAR 10.09.27;

(3) The services provided include but are not limited to:

(a) Assistance with activities of daily living when performed in conjunction with other delegated nursing services; or

(b) Other health care services properly delegated by a licensed nurse pursuant to Health Occupations Article, Title 8, Annotated Code of Maryland;

(4) Services are rendered by a certified nursing assistant who is certified in cardiopulmonary resuscitation and the certification is renewed every 2 years;

(5) The certified nursing assistant's shift is limited to not more than 16 consecutive hours and the certified nursing assistant has 8 hours or more off before starting another shift;

(6) Sufficient documentation concerning the services provided is maintained by the certified nursing assistant including:

(a) Verification of the participant's receipt of services as documented by the participant's signature or the signature of the participant's witness on the provider's official forms; and

(b) Signed and dated progress notes which are reviewed every 2 weeks by the nurse supervisor;

(7) Supervisory visits are conducted every 2 weeks and documented by a registered nurse;

(8) The services are included in the REM participant's plan of care developed by the case manager; and

(9) Services are preauthorized by the Department.

C. The Program shall cover services provided by a home health aide when:

(1) The complexity of the service or the condition of a participant requires the judgment, knowledge, and skills of a home health aide for a shift of 4 or more continuous hours as specified in COMAR 10.09.27;

(2) Services are provided by an unlicensed person who meets all the conditions of participation specified by the Medicare program in 42 CFR §484.36 and Health Occupations Article, Title 8, Annotated Code of Maryland;

(3) The services provided include but are not limited to:

(a) Assistance with activities of daily living when performed in conjunction with other delegated nursing services; or

(b) Other health care services properly delegated by a licensed nurse pursuant to Health Occupations Article, Title 8, Annotated Code of Maryland;

(4) Services are rendered by a home health aide who is certified in cardiopulmonary resuscitation and the certification is renewed every 2 years;

(5) The home health aide's shift is limited to not more than 16 consecutive hours and the home health aide has 8 hours or more off before starting another shift;

(6) Sufficient documentation is maintained by the home health aide including:

(a) Verification of the participant's receipt of services as documented by the participant's signature or the signature of the participant's witness on the provider's official forms; and

(b) Signed and dated progress notes which are reviewed every 2 weeks by the nurse supervisor;

(7) Supervisory visits are conducted every 2 weeks and documented by a registered nurse;

(8) The services are included in the REM participant's plan of care developed by the case manager; and

(9) Services are preauthorized by the Department.

.12 Limitations.

A. The Department shall pay for services specified in this chapter delivered to a REM participant only if the service has been recommended by the participant's case manager, ordered by the participant's physician, and preauthorized, when necessary, by the Department.

B. For REM participants, the Department may not pay for the following comparable case management services:

(1) HIV targeted case management as described in COMAR 10.09.32, except for HIV Diagnostic Evaluation Services as described in COMAR 10.09.32.03C and .04A;

(2) HealthyStart case management as described in COMAR 10.09.38; and

(3) Model Waiver case management as described in COMAR 10.09.27.

C. The REM program does not cover the following:

(1) Services covered under Medicaid;

(2) Shift private duty nursing, certified nursing assistant, or home health aide services rendered by a nurse, certified nursing assistant, or home health aide who is a member of the participant's immediate family or who ordinarily resides with the participant;

(3) Services which are not medically necessary;

(4) For adults, services which are not medically appropriate;

(5) Services not supervised by a registered nurse when delivered by the following:

(a) A licensed practical nurse;

(b) A certified nursing assistant; or

(c) A home health aide;

(6) REM optional services not preauthorized as required by the Department;

(7) REM optional services not prescribed by the participant's physician;

(8) Services specified in this chapter which duplicate or supplant services rendered by the participant's family caregivers or primary caregivers as well as other insurance, privilege, entitlement, or Program services that the participant receives or is eligible to receive;

(9) Services not included in the REM case manager's plan of care;

(10) Services provided for the convenience or preference of the participant or the primary caregiver rather than required by the participant's medical condition;

(11) Speech, hearing, language, or occupational therapy services rendered on a group basis or in a classroom setting; and

(12) Direct payment for nursing, home health aide, or certified nursing assistant supervisory visits by the licensed nurse supervisor as payment is included in the rate set for the direct care supervised.

.13 Preauthorization Requirements.

A. The Department or its designee shall preauthorize all services covered in Regulations .10 and .11 of this chapter with the exception of initial assessments unless otherwise specified.

B. The Department shall issue preauthorization when the Department:

(1) Determines that services are medically necessary and, for adults, medically appropriate; and

(2) Authorizes the services before the initiation or continuance of the requested service.

C. Authorization of services shall be rescinded by the Department when:

(1) The participant is admitted to a hospital, residential treatment facility, institution, nursing facility, or intermediate care facility for mental retardation or addiction;

(2) The participant is no longer REM eligible;

(3) The Department determines the care is no longer medically necessary;

(4) For adults, the Department determines the care is no longer medically appropriate; or

(5) The participant dies.

.14 Payment Procedures.

A. Request for Payment.

(1) A provider shall submit a request for payment for the services covered under this chapter according to the procedures set forth in COMAR 10.09.36.

(2) Billing time limitations for the services covered under this chapter are the same as those set forth in COMAR 10.09.36.

(3) The Department shall pay for covered services at the lower of:

(a) The lowest price, including negotiated contract prices, that is offered to any other purchaser for the same or similar service during the same time period, after extending to the Program all rebates, coupons, and negotiated discounts;

(b) The actual charge billed by the provider; or

(c) Any fee schedule developed for reimbursement of the same service provided under Medicaid.

(4) Payment for all services covered under this chapter are reimbursed on an all inclusive basis.

.15 Recovery and Reimbursement.

Recovery and reimbursement under this chapter are set forth in COMAR 10.09.36.

.16 Cause for Suspension or Removal and Imposition of Sanctions.

Cause for suspension or removal and imposition of sanctions is set forth in COMAR 10.09.36.

.17 Table of Rare and Expensive Disease List.

ICD-9	Disease	Age Group
042	Symptomatic HIV disease/AIDS (pediatric)	0-20
V08	Asymptomatic HIV status (pediatric)	0-20
795.71	Infant with inconclusive HIV result	0-12 months
270.0	Disturbances of amino-acid transport: Cystinosis Cystinuria Hartnup disease	0-20
270.1	Phenylketonuria — PKU	0-20
270.2	Other disturbances of aromatic-acid metabolism	0-20
270.3	Disturbances of branched-chain amino-acid metabolism	0-20
270.4	Disturbances of sulphur-bearing amino-acid metabolism	0-20
270.5	Disturbances of histidine metabolism: Carnosinemia Histidinemia Hyperhistidinemia Imidazole aminoaciduria	0-20
270.6	Disorders of urea cycle metabolism	0-20
270.7	Other disturbances of straight-chain amino-acid: Glucoglycinuria Glycinemia (with methylmalonic acidemia) Hyperglycinemia, Hyperlysinemia Pipecolic acidemia Saccharopinuria Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine	0-20
270.8	Other specified disorders of amino-acid metabolism: Alaninemia Ethanolaminuria Glycoprolinuria Hydroxyprolinemia Hyperprolinemia Iminoacidopathy Prolinemia Prolinuria Sarcosinemia	0-20
271.0	Glycogenosis	0-20
271.1	Galactosemia	0-20
271.2	Hereditary fructose intolerance	0-20
272.7	Lipidoses	0-20
277.00	Cystic fibrosis without ileus	0-64
277.01	Cystic fibrosis with ileus	0-64
277.02	Cystic fibrosis with pulmonary manifestations	0-64
277.03	Cystic fibrosis with gastrointestinal manifestations	0-64
277.09	Cystic fibrosis with other manifestations	0-64
277.2	Other disorders of purine and pyrimidine metabolism	0-64
277.5	Mucopolysaccharidosis	0-64
277.81	Primary Carnitine deficiency	0-64
277.82	Carnitine deficiency due to inborn errors of metaboism	0-64
277.89	Other specified disorders of metabolism	0-64
284.0	Constitutional aplastic anemia	0-20
286.0	Congenital factor VIII disorder	0-64
286.1	Congenital factor IX disorder	0-64
286.2	Congenital factor XI deficiency	0-64
286.3	Congenital deficiency of other clotting factors	0-64
286.4	von Willebrand's disease	0-64
330.0	Leukodystrophy	0-20
330.1	Cerebral lipidoses	0-20
330.2	Cerebral degenerations in generalized lipidoses	0-20
330.3	Cerebral degeneration of childhood in other diseases classified	0-20
330.8	Other specified cerebral degeneration in childhood	0-20
330.9	Unspecified cerebral degeneration in childhood	0-20
331.3	Communicating hydrocephalus	0-20
331.4	Obstructive hydrocephalus	0-20
333.2	Myoclonus	0-5
333.6	Idiopathic torsion dystonia	0-64
333.7	Symptomatic torsion dystonia	0-64
333.90	Unspecified extrapyramidal disease and abnormal movement disorder	0-20
334.0	Friedreich's ataxia	0-20
334.1	Hereditary spastic paraplegia	0-20
334.2	Primary cerebellar degeneration	0-20
334.3	Cerebellar ataxia NOS	0-20
334.4	Cerebellar ataxia in other diseases	0-20
334.8	Other spinocerebellar diseases NEC	0-20
334.9	Spinocerebellar disease NOS	0-20
335.0	Werdnig-Hoffmann disease	0-20
335.10	Spinal muscular atrophy unspecified	0-20
335.11	Kugelberg-Welander disease	0-20
335.19	Spinal muscular atrophy NEC	0-20
335.20	Amyotrophic lateral sclerosis	0-20
335.21	Progressive muscular atrophy	0-20
335.22	Progressive bulbar palsy	0-20
335.23	Pseudobulbar palsy	0-20
335.24	Primary lateral sclerosis	0-20
335.29	Motor neuron disease NEC	0-20
335.8	Anterior horn disease NEC	0-20
335.9	Anterior horn disease NOS	0-20
341.1	Schilder's disease	0-64
343.0	Diplegic infantile cerebral palsy	0-20
343.2	Quadriplegic infantile cerebral palsy	0-64
344.00	Quadriplegia, unspecified	0-64
344.01	Quadriplegia, C1-C4, complete	0-64
344.02	Quadriplegia, C1-C4, incomplete	0-64
344.03	Quadriplegia, C5-C7, complete	0-64
344.04	Quadriplegia, C5-C7, incomplete	0-64
344.09	Quadriplegia, Other	0-64
359.0	Congenital hereditary muscular dystrophy	0-64
359.1	Hereditary progressive muscular dystrophy	0-64

ICD-9	Disease	Age Group
359.2	Congenital myotonic dystrophy (Steinert's only)	0-64
437.5	Moyamoya disease	0-64
579.3	Short gut syndrome	0-20
582.0	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	0-20
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	0-20
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	0-20
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	0-20
582.81	Chronic glomerulonephritis in diseases classified elsewhere	0-20
582.89	Other: Chronic glomerulonephritis with lesion of exudative nephritis interstitial (diffuse) (focal) nephritis	0-20
582.9	Chronic glomerulonephritis with unspecified pathological lesion in kidney: Nephritis specified as chronic, Nephropathy specified as chronic NOS glomerulonephritis specified as chronic Hemorrhagic glomerulonephritis specified as chronic	0-20
585	Chronic renal failure diagnosed by a pediatric nephrologists	0-20
585, V45.1	Chronic renal failure with dialysis	21-64
741.00	Spina bifida with hydrocephalus NOS	0-64
741.01	Spina bifida with hydrocephalus cervical region	0-64
741.02	Spina bifida with hydrocephalus dorsal region	0-64
741.03	Spina bifida with hydrocephalus lumbar region	0-64
741.90	Spina bifida unspecified region	0-64
741.91	Spina bifida cervical region	0-64
741.92	Spina bifida dorsal region	0-64
741.93	Spina bifida lumbar region	0-64
742.0	Encephalocele: Encephalocystocele Encephalomyelocele Hydroencephalocele Hydromeningocele, cranial Meningocele, cerebral Menigoencephalocele	0-20
742.1	Microcephalus: Hydromicrocephaly Micrencephaly	0-20
742.3	Congenital hydrocephalus	0-20
742.4	Other specified anomalies of brain	0-20
742.51	Other specified anomalies of the spinal cord: Diastematomyelia	0-64
742.53	Other specified anomalies of the spinal cord: Hydromyelia	0-64
742.59	Other specified anomalies of spinal cord: Amyelia Congenital anomaly of spinal meninges Myelodysplasia Hypoplasia of spinal cord	0-64
748.1	Nose anomaly — cleft or absent nose ONLY	0-5
748.2	Web of larynx	0-20
748.3	Laryngotracheal anomaly NEC-Atresia or agenesis of larynx, bronchus, trachea, only	0-20
748.4	Congenital cystic lung	0-20
748.5	Agenesis, hypoplasia and dysplasia of lung	0-20
749.00	Cleft palate NOS	0-20
749.01	Unilateral cleft palate complete	0-20
749.02	Unilateral cleft palate incomplete	0-20
749.03	Bilateral cleft palate complete	0-20
749.04	Bilateral cleft palate incomplete	0-20
749.20	Cleft palate and cleft lip NOS	0-20
749.21	Unilateral cleft palate with cleft lip complete	0-20
749.22	Unilateral cleft palate with cleft lip incomplete	0-20
749.23	Bilateral cleft palate with cleft lip complete	0-20
749.24	Bilateral cleft palate with cleft lip incomplete	0-20
749.25	Cleft palate with cleft lip NEC	0-20
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis	0-3
751.2	Atresia large intestine	0-5
751.3	Hirschsprung's disease	0-15
751.61	Biliary atresia	0-20
751.62	Congenital cystic liver disease	0-20
751.7	Pancreas anomalies	0-5
751.8	Other specified anomalies of digestive system NOS	0-10
753.0	Renal agenesis and dysgenesis, bilateral only: Atrophy of kidney congenital and infantile Congenital absence of kidney(s) Hypoplasia of kidney(s)	0-20
753.10	Cystic kidney disease, bilateral only	0-20
753.12	Polycystic kidney, unspecified type, bilateral only	0-20
753.13	Polycystic kidney, autosomal dominant, bilateral only	0-20
753.14	Polycystic kidney, autosomal recessive, bilateral only	0-20
753.15	Renal dysplasia, bilateral only	0-20
753.16	Medullary cystic kidney, bilateral only	0-20
753.17	Medullary sponge kidney, bilateral only	0-20
753.5	Exstrophy of urinary bladder	0-20
756.0	Musculoskeletal—skull and face bones: Absence of skull bones Acrocephaly Congenital deformity of forehead Craniosynostosis Crouzon's disease	0-20

ICD-9	Disease	Age Group
	Hypertelorism	
	Imperfect fusion of skull	
	Oxycephaly	
	Platybasia	
	Premature closure of cranial sutures	
	Tower skull	
	Trigonocephaly	
756.4	*Chondrodystrophy*	*0-1*
756.50	*Osteodystrophy NOS*	*0-1*
756.51	*Osteogenesis imperfecta*	*0-20*
756.52	*Osteopetrosis*	*0-1*
756.53	*Osteopoikilosis*	*0-1*
756.54	*Polyostotic fibrous dysplasia of bone*	*0-1*
756.55	*Chondroectodermal dysplasia*	*0-1*
756.56	*Multiple epiphyseal dysplasia*	*0-1*
756.59	*Osteodystrophy NEC*	*0-1*
756.6	*Anomalies of diaphragm*	*0-1*
756.70	*Anomaly of abdominal wall*	*0-1*
756.71	*Prune belly syndrome*	*0-1*
756.79	*Other congenital anomalies of abdominal wall*	*0-1*
759.7	*Multiple congenital anomalies NOS*	*0-10*
V46.1	*Dependence on respirator*	*1-64*
V46.9	*Machine dependence NOS*	*1-64*

NELSON J. SABATINI
Secretary of Health and Mental Hygiene

Subtitle 11 MATERNAL AND CHILD HEALTH

10.11.04 Lead Poisoning Screening Program

Authority: Education Article, §7-403; Environment Article, §4-303; Health-General Article, §18-106; Annotated Code of Maryland

Notice of Proposed Action

[03-275-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations .02 — .06 under COMAR 10.11.04 **Lead Poisoning Screening Program.**

Statement of Purpose

The purpose of this action is to clarify the timing of the blood lead testing and minimize the scope of the reporting requirements.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. This action clarifies and amends existing regulations on the timing of blood lead testing and reporting upon entry into school. The existing regulations are intended to increase blood lead testing for children in Maryland living in areas considered to be "at-risk". Many of the children in these areas already should be receiving blood lead testing based on other requirements such as those of the EPSDT program in Medicaid. Therefore, the number of additional children to be tested and to receive treatment or case management services is unknown but would not be expected to be large. In an effort to increase testing, these regulations require a child's parent or guardian to provide, upon the child's entry into public school, documentation by a health care provider certifying that the child received blood lead testing. The school personnel will be required to report to the local health departments the names, addresses, and phone numbers of each at-risk child who does not have certified documentation of a lead test or a statement of exemption. These reporting requirements will place an administrative burden on school personnel as well as on local health departments. However, this administrative burden will be less than that which would have resulted if current regulations are not amended under this proposal. The current regulations would have required, beginning not later than September 2003, the reporting of all blood lead testing results of at-risk children to the schools and then the schools would have been required to report all results to local health departments.

The local health departments will then have the opportunity to follow-up with children who have not been tested. Proper screening of young children for elevated blood levels accompanied by appropriate intervention offers an economic advantage to the children and the State by minimizing the neurodevelopment effects of lead toxicity.

II. Types of Economic Impact.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency: Department of Health and Mental Hygiene	(E+)	Undeterminable
B. On other State agencies:	(E+)	Minimal
C. On local governments:	(E+)	Undeterminable
	Benefit (+) Cost (−)	Magnitude
D. On regulated industries or trade groups:	(−)	Minimal
E. On other industries or trade groups:		NONE
F. Direct and indirect effects on public:	(+)	Significant

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. Some additional children will be tested based on the provisions of enrolled House Bill 1221 (2000) which requires the Department to adopt regulations requiring blood tests for lead poisoning required of children entering schools, but many of these children should already have been receiving testing based on Medicaid requirements. Certain provisions of enrolled House Bill 1221 (2000) subsequently were amended by House Bill 819 (2003) which, in part, minimized the scope of the reporting requirements to ease the administrative burden on school personnel and the local health departments. The DHMH laboratory participates both in testing and training in blood collection on an ongoing basis and might encounter some additional outlay. DHMH is expected to provide modified forms for health care providers to use in documenting when a child has been tested. This may require some additional expenditure for the development of the required forms. DHMH is expected to support provider education regarding the implementation of these regulations. DHMH is funded under the Childhood Lead Initiative. With this continued funding, these activities could be covered without additional funding.

Requiring certified documentation of testing at school entry will enable schools to identify children who have not been tested for the purpose of notifying the appropriate local health departments. Follow-up may be indicated. The number of cases requiring follow-up is not yet determined.

B. The impact on other State agencies is minimal. The Department of Education would work with local school systems and DHMH to implement the reporting at school entry.

C. The impact on local governments depends primarily on the burden imposed by reporting at school entry. Local school systems will have some additional work in collecting the certified documentation and forwarding the names, addresses, and telephone numbers of children who have not been tested to the local health departments. Since the scope of the reporting has been minimized by this proposal, the administrative burden will be less than that which