Dear Senators VANORDEN, Zuiderveld, Wintrow, and
Representatives VANDER WOUDE, Erickson, Chew:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Health and Welfare:

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0309-2301).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 08/21/2023. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 09/18/2023.

The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-4854, or send a written request to the address on the memorandum attached below.

Terri Kondeff
Director

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Principal Legislative Drafting Attorney - Elizabeth Bowen

DATE: August 02, 2023

SUBJECT: Department of Health and Welfare

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0309-2301)

Summary and Stated Reasons for the Rule

This temporary and proposed rule revises terminology and makes other technical corrections to existing rules regarding Medicaid basic plan benefits. The rule also includes updates to conform to HB 153, regarding bridge year physicians; HB 223, regarding the Medical Consent and Natural Death Act; HB 374, regarding criminal abortions; and SB 1094, regarding international medical graduates. The Department states that the reasons for the rule include decreasing regulatory burden and updating rules to comply with governing law.

Negotiated Rulemaking / Fiscal Impact

Negotiated rulemaking was not conducted because of the nature of the rule, which is to comply with governing law. There is no anticipated negative fiscal impact on the state general fund.

The Governor finds that the temporary rule is appropriate because it confers a benefit and aligns the rules with governing law.

Statutory Authority

This rule appears to be authorized pursuant to Sections 56-202, 56-264, and 56-1610, Idaho Code.

cc: Department of Health and Welfare
Frank Powell and Trinette Middlebrook

***** PLEASE NOTE *****

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2301

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2023.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Thursday, July 13, 2023 **4:00 p.m. - 5:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m52baf11a0fdb1fe4179f5791a82980b4** **Join by meeting number** **Meeting number (access code): 2760 060 4198** **Meeting password: PytTUgg5y53 (79888445 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Monday, July 17, 2023 **10:00 a.m. -11:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=me93b96b1ea479828068a79d89916478c** **Join by meeting number** **Meeting number (access code): 2764 933 3016** **Meeting password: Aty6k6iMQf4 (28965646 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign into the meeting.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with the latest changes to Idaho statutes (H0153, H0223, H0374, and S1094 from the 2023 legislative session), IDAPA 16.05.06, "Criminal History and Background Checks," and make changes to the Idaho State Plan for behavioral health services appropriated by the legislature.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule of the rule is appropriate for the following reasons:

This rulemaking aligns these rules with laws passed by the 2023 legislature (H0153, H0223, H0374, and S1094), and confers benefits to participants and reduces administrative burdens on providers.

These changes are to comply with deadlines in amendments to governing law or federal programs, and to confer a benefit.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees in this chapter of rule.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no impact to the state general fund, grant funds, or any other funds as funding has already been appropriated for the changes to services.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2)(b), Idaho Code, negotiated rulemaking was not conducted because this rulemaking was deemed to be not feasible as it aligns with statutes passed by the 2023 Legislative session.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The rulemaking changes in the Incorporation By Reference Section include:

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR, 2022); and
- Updated title for Travel Policies and Procedures by the Idaho Office of the State Controller.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: The rulemaking changes in the Incorporation By Reference Section includes updated title for Travel Policies and Procedures by the Idaho Office of the State Controller.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact William Deseron, 208-859-0046.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2023.

DATED this 26th day of May, 2023.

Trinette Middlebrook and Frank Powell
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov email

THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT OF DOCKET NO. 16-0309-2301
(Only Those Sections With Amendments Are Shown.)

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (3-17-22)

01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: https://www.asha.org/. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-17-22)

02. DSM-5-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) Arlington, VA, American Psychiatric Association, 20~~13~~22. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ~~(3-17-22)~~(7-1-23)T

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-17-22)

04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual). Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at https://med.noridianmedicare.com/web/jddme/education/supplier-manual. (3-17-22)

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-17-22)

06. Travel Polic~~ies~~y and Procedures ~~of the Idaho State Board of Examiners~~. The text of "~~Idaho~~ State Travel Polic~~ies~~y and Procedures ~~of the Idaho State Board of Examiners~~," Appendices A and B, ~~June 13, 2000~~January 17, 2023, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or ~~on the Internet~~ at ~~http://www.sco.idaho.gov~~https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx. ~~(3-17-22)~~(7-1-23)T

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION, AND ENFORCEMENT.
~~In addition to any actions specified in these rules, t~~The Department may audit, investigate, and take enforcement action under ~~the provisions of~~ IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and

Misconduct." ~~(3-17-22)~~(7-1-23)T

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance With ~~Department Criminal History~~Background Checks. ~~Criminal history~~Background checks are required for certain types of providers under these rules. Providers who are required to have a ~~criminal history~~background check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." ~~Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.~~ ~~(3-17-22)~~(7-1-23)T

02. Department-Issued Variances to Requirements for a ~~Criminal History Check~~ Clearance. ~~(3-17-22)~~(7-1-23)T

a. Notwithstanding those provider types required to obtain a ~~criminal history check~~ clearance or ~~Department~~ enhanced clearance under these rules or under IDAPA 16.05.06, "Criminal History and Background Checks," the Department ~~at its discretion~~ may allow variances to clearance requirements under certain circumstances. Providers who are subject to a ~~criminal history and~~ background check must still complete and notarize an application for a ~~criminal history and~~ background check. ~~(3-17-22)~~(71-23)T

b. In cases where the application process results in a denial rather than a clearance, and the denial is due to the applicant's prior convictions for disqualifying drug and alcohol-related offenses, the applicant may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. (3-17-22)

c. A variance may be granted on a case-by-case basis upon review by the Department ~~or its designee~~ of any underlying facts and circumstances in each individual case. The Department will establish the process for the administrative review which will be conducted separate from the ~~criminal history~~ background check unit. During the Department's review, the following factors may be considered: ~~(3-17-22)~~(7-1-23)T

i. The severity or nature of the crimes or other findings; (3-17-22)

ii. The period of time since the incidents occurred; (3-17-22)

iii. The number and pattern of incidents being reviewed; (3-17-22)

iv. Circumstances surrounding the incidents that would help determine the risk of repetition; (3-17-22)

v. The relationship between the incidents and the position sought; (3-17-22)

vi. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation; (3-17-22)

vii. A pardon ~~that was~~ granted by a state governor or the President of the United States; ~~(3-17-22)~~(7-1-23)T

viii. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and (3-17-22)

ix. Any other factor deemed relevant to the review. (3-17-22)

d. A variance granted under these rules is not a criminal history and background check clearance and

does not set a precedent for subsequent application for variance. The Department may revoke a variance when it identifies a risk to participants' health and safety. Providers who have been granted a variance must still meet all other Department requirements for Medicaid coverage and reimbursement of Peer Support and Recovery Coaching services, and are prohibited from delivering any other covered Medicaid service without the required clearance or Department enhanced clearance. (3-17-22)

03. Availability to Work or Provide Service. (3-17-22)

a. The employer~~, at its discretion,~~ may allow an individual to provide care or services on a provisional basis once the application for a ~~criminal history and~~ background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. ~~(3-17-22)~~(7-1-23)T

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the ~~criminal history and~~ background check is completed and a clearance issued by the Department. ~~(3-17-22)~~(7-1-23)T

04. Additional Criminal Convictions. Once an individual has received a ~~criminal history~~ clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. ~~(3-17-22)~~(7-1-23)T

05. Providers Subject to ~~Criminal History~~ Background Check Requirements. The following providers must receive a ~~criminal history~~ clearance: ~~(3-17-22)~~(7-1-23)T

a. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants ~~must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of~~ except for individuals contracted as transportation providers defined in Subsection 870.02 of these rules. ~~(3-17-22)~~(7-1-23)T

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules ~~must consent to comply with criminal background checks, including fingerprinting, in accordance with~~ and 42 CFR 455.434. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

011. DEFINITIONS: I THROUGH O.

~~For the purposes of these rules, the following terms are used as defined below:~~ ~~(3-17-22)~~

01. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An ~~ICF/IID is an~~ entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. ~~(3-17-22)~~(7-1-23)T

02. Idaho Behavioral Health Plan (IBHP). ~~The Idaho Behavioral Health Plan is a~~A prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment ~~as well as~~and case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. ~~(3-17-22)~~(7-1-23)T

03. Idaho Infant Toddler Program (ITP). ~~The Idaho Infant Toddler Program s~~Serves children from birth through the end of their 36th month of age~~,~~ who meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C. ~~(3-17-22)~~(7-1-23)T

04. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-17-22)

05. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-17-22)

06. Intermediate Care Facility Services. ~~Those s~~Services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. ~~(3-17-22)~~(7-1-23)T

07. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-17-22)

08. Legend Drug. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-17-22)

09. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-17-22)

10. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-17-22)

11. Licensed Practitioner of the Healing Arts. The term ~~licensed practitioner of the healing arts comprises~~ includes the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA), as defined in these rules. ~~(3-17-22)~~(7-1-23)T

12. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-17-22)

13. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-17-22)

14. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act~~, as amended~~. ~~(3-17-22)~~(7-1-23)T

15. Medicaid. Idaho's Medical Assistance Program. (3-17-22)

16. Medicaid-Related Ancillary Costs. ~~For the purpose of these rules, those s~~Services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. ~~(3-17-22)~~(7-1-23)T

17. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-17-22)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-17-22)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly. (3-17-22)

c. Medical services must be: (3-17-22)

i. Of a quality that meets professionally-recognized standards of health care; and (3-17-22)

ii. Substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-17-22)

18. Medical Supplies. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (3-17-22)

19. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual). A publication ~~that is~~ incorporated ~~by reference~~ in Section 004 of these rules ~~and~~ that contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. ~~(3-17-22)~~(7-1-23)T

20. Nurse Midwife (NM). An advanced practice registered nurse who meets all the applicable requirements to practice as a nurse midwife according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

21. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-17-22)

22. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-17-22)

23. Non-Physician Practitioner (NPP). A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), pharmacist (RPh), and physician assistants (PA), as defined in these rules. (3-17-22)

24. Nurse Practitioner (NP). A ~~registered nurse or licensed professional nurse (RN)~~ person who meets all the applicable requirements to practice as a nurse practitioner according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

25. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-17-22)

26. Ordering, Rendering, Prescribing Providers. Providers who order services, refer for services or prescribe services, products, or prescription drugs for Medicaid participants. (3-17-22)

27. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-17-22)

28. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-17-22)

29. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-17-22)

012. DEFINITIONS: P THROUGH Z.
~~For the purposes of these rules, the following terms are used as defined below:~~ ~~(3-17-22)~~

01. **Participant**. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-17-22)

02. **Patient**. The person undergoing treatment or receiving services from a provider. (3-17-22)

03. **Pharmacist**. A person who meets all the applicable requirements to practice as a licensed pharmacist according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

04. **Physician**. A person possessing a Doctor of Medicine (MD) degree or a Doctor of Osteopathy (DO) degree, and within the State or United States territory services are provided is either licensed to practice medicine, ~~or~~ is a resident enrolled in a postgraduate medical training program, is a licensed international medical graduate, or is a licensed bridge year physician. ~~(3-17-22)~~(7-1-23)T

05. **Physician Assistant (PA)**. A person who meets all the applicable requirements to practice as a licensed ~~physician assistant~~ PA according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

06. **Plan of Care**. A written description of medical, remedial, habilitative, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services, and treatments are identified specifically as to amount, type, and duration of service. ~~(3-17-22)~~(7-1-23)T

07. **Prepaid Ambulatory Health Plan (PAHP)**. ~~As defined in~~ Under 42 CFR 438.2, ~~a PAHP is~~ an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. ~~(3-17-22)~~(7-1-23)T

08. **Private Rate**. Rate most frequently charged to private patients for a service or item. (3-17-22)

09. **Prosthetic Device**. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of their practice as defined by state law to: (3-17-22)

a. Artificially replace a missing portion of the body; or (3-17-22)

b. Prevent or correct physical deformities or malfunctions; or (3-17-22)

c. Support a weak or deformed portion of the body. (3-17-22)

d. Computerized communication devices are not included in this definition of a prosthetic device. (3-17-22)

10. **Provider**. Any individual, partnership, association, corporation, or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department ~~in accordance with~~ under Section 205 of these rules. ~~(3-17-22)~~(7-1-23)T

11. **Provider Agreement**. A written agreement between the provider and the Department, entered into ~~in accordance with~~ under Section 205 of these rules. ~~(3-17-22)~~(7-1-23)T

12. **Provider Reimbursement Manual (PRM)**. A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated ~~by reference~~ in Section 004 of these rules. ~~(3-17-22)~~(7-1-23)T

~~**13.** **Prudent Layperson**. A person who possesses an average knowledge of health and medicine.~~ ~~(3-17-22)~~

14. Psychologist, Licensed. A person licensed to practice psychology according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

15. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist who meets ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

16. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-17-22)

17. Qualified Interpreter. A ~~qualified interpreter~~ person who meets the definition of qualified interpreter ~~consistent with~~ under 28 CFR 35.104. ~~(3-17-22)~~(7-1-23)T

18. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). (3-17-22)

19. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (3-17-22)

~~20~~19. Registered Nurse (RN). A person who meets all the applicable requirements and is licensed to practice as an ~~Licensed Registered Nurse~~ RN according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(7-1-23)T

~~21~~0. Rural Health Clinic (RHC). An outpatient entity that meets the requirements of 42 USC Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally-defined, medically underserved areas, or designated health professional shortage areas. ~~(3-17-22)~~(7-1-23)T

~~22~~1. Rural Hospital-Based Nursing Facilities. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (3-17-22)

~~23~~2. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-17-22)

24. State Plan. The contract between the state and federal government under 42 USC Section 1396a(a). (3-17-22)

25. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-17-22)

26. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (3-17-22)

27. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-17-22)

28. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-17-22)

29. Third Party. Includes a person, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ~~(3-17-22)~~(7-1-23)T

~~30~~29. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi, or common carrier. ~~(3-17-22)~~(7-1-23)T

013. MEDICAL CARE ADVISORY COMMITTEE (MCAC).
The Director of the Department will appoint a ~~Medical Care Advisory Committee~~ MCAC to advise ~~and counsel~~ on ~~all aspects of~~ health and medical services. ~~(3-17-22)~~(7-1-23)T

01. Membership. The ~~Medical Care Advisory Committee~~ MCAC will include~~, but not be limited to,~~ the following: ~~(3-17-22)~~(7-1-23)T

a. Licensed physicians and other ~~representatives of the~~ health professionals ~~who are~~ familiar with the medical needs of low-income ~~population groups~~ individuals and ~~with~~ the resources available and required for their care; and ~~(3-17-22)~~(7-1-23)T

b. Members of ~~consumer groups, including medical assistance~~ stakeholder organizations and Medicaid participants ~~and consumer organizations~~. ~~(3-17-22)~~(7-1-23)T

02. Organization. The ~~Medical Care Advisory Committee~~ MCAC will: ~~(3-17-22)~~(7-1-23)T

a. Consist of not more than twenty-two (22) members; ~~and~~ ~~(3-17-22)~~(7-1-23)T

b. Be appointed by the Director to the ~~Medical Care Advisory Committee~~ MCAC to serve three (3) year terms, whose terms are to overlap; ~~and~~ ~~(3-17-22)~~(7-1-23)T

c. Elect a chairman and a vice-chairman to serve a two (2) year term; ~~and~~ ~~(3-17-22)~~(7-1-23)T

d. Meet at least quarterly; and (3-17-22)

e. Submit an activity report ~~of its activities~~ and recommendations to the Director at least ~~once each year~~ annually. ~~(3-17-22)~~(7-1-23)T

03. Policy Function. The ~~Medical Care Advisory Committee~~ MCAC must be given opportunity to participate in medical assistance policy development and program administration. ~~(3-17-22)~~(7-1-23)T

04. Staff Assistance. The ~~Medical Care Advisory Committee~~ MCAC must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. ~~(3-17-22)~~(7-1-23)T

014. -- 099. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 100-199)

100. ELIGIBILITY FOR MEDICAL ASSISTANCE.
~~Idaho Department of Health and Welfare Rules,~~ IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and ~~Idaho Department of Health and Welfare Rules,~~ IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," are applicable in determining eligibility for medical assistance.
~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-17-22)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-17-22)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; ~~and~~ ~~(3-17-22)~~(7-1-23)T

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification~~.~~; and ~~(3-17-22)~~(7-1-23)T

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-17-22)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-17-22)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-17-22)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-17-22)

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-17-22)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other qualified professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-17-22)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-17-22)

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. ~~(3-17-22)~~(7-1-23)T

09. ~~Services Delivered Via Telehealth~~ Virtual Care. Services delivered via ~~telehealth~~virtual care ~~as defined in~~under Title 54, Chapter 57, Idaho Code, must be identified as such ~~in accordance with~~under billing requirements published in the Idaho Medicaid Provider Handbook. ~~Telehealth~~Virtual care services billed without being identified as such are not covered. Virtual care ~~S~~services ~~delivered via telehealth~~ may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee-for-service reimbursement is not available for ~~an electronic mail message (e-mail), or facsimile transmission (fax)~~asynchronous services except remote monitoring. ~~(3-17-22)~~(7-1-23)T

10. Services Subject to Electronic Visit Verification (EVV). Services requiring EVV compliance are subject to quality review. Services billed without the minimum essential EVV elements, ~~as defined by~~under Section 1903(l)(2) of the Social Security Act, may be denied, delayed, or subject to sanctions or recoupment, or both, ~~in accordance with~~under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."
~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (3-17-22)

a. Each participant may consult a participating physician or provider of their choice for care and receive covered services by presenting their identification card to the provider, subject to restrictions imposed by participation in Healthy Connections or enrollment in a ~~Prepaid Ambulatory Health Plan (~~PAHP~~)~~.
~~(3-17-22)~~(7-1-23)T

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System (EVS) and transfer the required information onto the appropriate claim form. Where the ~~Electronic Verification System (~~EVS~~)~~ indicates that a participant is enrolled in Healthy Connections, the provider must comply with referral or follow-up communication requirements ~~defined in~~under Section 210 of these rules.
~~(3-17-22)~~(7-1-23)T

c. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department. (3-17-22)

d. The Department is to process each claim received and make payment directly to the provider. (3-17-22)

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in ~~Appendix D of~~ the Idaho Medicaid Provider Handbook.
~~(3-17-22)~~(7-1-23)T

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (3-17-22)

a. The provider's actual charge for service; or (3-17-22)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-17-22)

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-17-22)

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (3-17-22)

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services that are not included in other ~~Idaho~~ Department ~~of Health and Welfare R~~rules, but allowed under Idaho's Medical Assistance Program ~~according to the provisions of~~under 42 CFR Section 447.325.
~~(3-17-22)~~(7-1-23)T

05. Review of Records. (3-17-22)

a. The Department, ~~or its duly authorized agent,~~ the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review ~~pertinent~~ records of providers receiving Medicaid reimbursement for covered services. ~~(3-17-22)~~(7-1-23)T

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (3-17-22)

i. The necessity for the care; or (3-17-22)

ii. That treatment was rendered ~~in accordance with~~under accepted medical standards of practice; or ~~(3-17-22)~~(7-1-23)T

iii. That charges were not in excess of the provider's usual and customary rates; or (3-17-22)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (3-17-22)

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (3-17-22)

i. Withholding payments to the provider until access to the requested information is granted; or (3-17-22)

ii. Suspending the provider's number. (3-17-22)

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge, or at a nominal charge, are reimbursed fair compensation that is the same as reasonable cost. (3-17-22)

07. Procedures for Medicare Cross-Over Claims. (3-17-22)

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (3-17-22)

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information ~~on the computer tape~~ that is received from the Medicare Part B Carrier on a weekly basis. ~~(3-17-22)~~(7-1-23)T

c. If a provider does not accept a Medicare assignment, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. (3-17-22)

d. For all other services, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (3-17-22)

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

235. PATIENT "ADVANCE DIRECTIVES."

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R~~.~~N~~.~~ supervisors must: ~~(3-17-22)~~(7-1-23)T

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved ~~advance directive form "Your Rights As A Patient To Make Medical Treatment Decisions"~~Advance Directive Registration Form) which defines their rights under state law to make decisions concerning their medical care. ~~(3-17-22)~~(7-1-23)T

i. The provider must explain that the participant has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the participant has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (3-17-22)

ii. The provider will inform the participant of their rights to formulate advance directives, such as "Living Will" or "Durable Power of Attorney For Health~~C~~care," or both. ~~(3-17-22)~~(7-1-23)T

iii. The provider must comply with Subsection 235.02 of this rule. (3-17-22)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the participant's rights regarding "Durable Power of Attorney for Health~~C~~care," "Living Will," and the participant's right to accept or refuse medical and surgical treatment. ~~(3-17-22)~~(7-1-23)T

c. Document in the participant's medical record whether the participant has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health~~C~~care," or both), or have a copy of the Department's approved ~~a~~Advance ~~d~~Directive Registration ~~f~~Form ~~("Your Rights as a Patient to Make Medical Treatment Decisions")~~ attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health~~C~~care," or both). ~~(3-17-22)~~(7-1-23)T

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that participant has executed an ~~"A~~advance ~~D~~directive.~~"~~ ~~(3-17-22)~~(7-1-23)T

e. If the provider cannot comply with the patient's "Living Will" or "Durable Power of Attorney for Health~~C~~care," or both, as a matter of conscience, the provider will assist the participant in transferring to a facility or agency that can comply. ~~(3-17-22)~~(7-1-23)T

f. Provide education to their staff and the community on issues concerning advance directives. (3-17-22)

02. When ~~"~~Advance Directives~~"~~ Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care RN supervisors, must give information concerning "~~A~~advance ~~D~~directives" to adult participants in the following situations: ~~(3-17-22)~~(7-1-23)T

a. Hospitals must give the information at the time of the participant's admission as an inpatient unless Subsection 235.03 of this rule applies. (3-17-22)

b. Nursing facilities must give the information at the time of the participant's admission as a resident. (3-17-22)

c. Home health providers must give the information to the participant in advance of the participant coming under the care of the provider. (3-17-22)

d. The personal care RN supervisors will inform the participant when the RN completes the RN

Assessment and Care Plan. The RN supervisor will inform the Qualified Intellectual Disabilities Professional (QIDP) and the personal care attendant of the participants decision regarding "~~A~~advance ~~D~~directives." ~~(3-17-22)~~(7-1-23)T

e. A hospice provider must give information at the time of initial receipt of hospice care by the participant. (3-17-22)

03. Information Concerning ~~"~~Advance Directives~~"~~ at the Time an Incapacitated Individual Is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether they have executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient ~~in accordance with~~under state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once they are no longer incapacitated. ~~(3-17-22)~~(7-1-23)T

04. Provider Agreement. A "Memorandum of Understanding Regarding Advance Directives" is incorporated within the provider agreement. By signing the Medicaid provider agreement, the provider is not excused from its obligation regarding advance directives ~~to the general public per~~under Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

455. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and supplies necessary to safely care for the patient. Such services are reimbursed as follows: (3-17-22)

a. ASC service payments represent reimbursement for the costs of goods and services recognized by the Medicare program ~~as described in~~under 42 CFR, Part 416. Payment ~~levels~~ will be determined by the Department. Any surgical procedure covered by the Department, but which is not covered by Medicare will have a reimbursement rate established by the Department. ~~(3-17-22)~~(7-1-23)T

b. ASC services include the following: (3-17-22)

i. Nursing, technician, and related services; (3-17-22)

ii. Use of ASC facilities; (3-17-22)

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; (3-17-22)

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (3-17-22)

v. Administration, record-keeping, and housekeeping items and services; and ~~(3-17-22)~~(7-1-23)T

vi. Materials for anesthesia. (3-17-22)

c. ASC services do not include the following services: (3-17-22)

i. Physician services; (3-17-22)

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); (3-17-22)

iii. Prosthetic and orthotic devices; (3-17-22)

iv. Ambulance services; (3-17-22)

v. ~~Durable medical equipment~~DME typically used in the participant's place of residence, but may be suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, or ICF/IID; and ~~(3-17-22)~~(7-1-23)T

vi. Any other service not specified in Subsection 455.01.b. of this rule. (3-17-22)

02. Payment for Ambulatory Surgical Center Services. Payment is made at a rate established ~~in accordance with~~under Section 230 of these rules. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

511. ABORTION PROCEDURES: PARTICIPANT ELIGIBILITY.
The Department will fund abortions ~~under the Medical Assistance Program only~~ under circumstances where the abortion is necessary to save the life of the woman, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency or child protective services.
~~(3-17-22)~~(7-1-23)T

512. -- 513. (RESERVED)

514. ABORTION PROCEDURES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Required Documentation in the Case of Rape or Incest. In the case of rape or incest, the following documentation must be provided to the Department: (3-17-22)

a. A copy of the court determination of rape or incest; or (3-17-22)

b. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency~~.~~ or child protective services; or ~~(3-17-22)~~(7-1-23)T

c. Where the rape or incest was not reported to a law enforcement agency or child protective services, a ~~licensed~~ physician must certify in writing ~~that, in the physician's~~their professional opinion~~,~~ that the woman was unable~~, for reasons related~~due to her health, to file a report ~~the rape or incest to a law enforcement agency~~. The certification must contain the name and address of the woman. ~~(3-17-22)~~(7-1-23)T

02. Required Documentation in the Case ~~Where the Abortion is Necessary~~ to Save ~~the~~a Woman's Life ~~of the Woman~~. In the case where the abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

524. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Identification of Services. The required services must be covered under the legal scope of practice as identified by the appropriate State rules of the NPP. (3-17-22)

02. Deliverance of Services. The services must be delivered under physician supervision, if required by ~~Idaho Statute~~state regulations where the service is provided. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

549. LM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn - Coverage. Antepartem, intrapartum, and up to six (6) weeks of postpartum maternity and newborn care are covered. (3-17-22)

02. Maternity and Newborn - Limitations. Maternal or newborn services provided after the sixth postpartum week are not covered ~~when provided by a CPM~~. ~~(3-17-22)~~(7-1-23)T

03. Medication - Coverage and Limitations. LM providers may administer medication and bill Medicaid if the medication is a Medicaid-covered service, and is also listed in the LM formulary ~~in~~under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

573. CHIS: COVERAGE AND LIMITATIONS.

01. Excluded for Medicaid Payment. ~~The following are excluded for Medicaid payment:~~ ~~(3-17-22)~~(7-1-23)T

i. Vocational services; (3-17-22)

ii. Educational services; and (3-17-22)

iii. Recreational services. (3-17-22)

02. Service Delivery. The CHIS allowed under the Medicaid ~~s~~State ~~p~~Plan authority include evaluations, diagnostic and therapeutic treatment services provided on an outpatient basis. These services help improve individualized functional skills, develop replacement behaviors, and promote self-sufficiency of the participant. CHIS may be delivered in the community, the participant's home, or in a DDA ~~in accordance with~~under the requirements of ~~this chapter~~these rules. Duplication of services is not reimbursable. ~~(3-17-22)~~(7-1-23)T

03. Required Recommendation. CHIS must be recommended by a physician or other licensed practitioner of the healing arts within ~~his or her~~their scope of practice, under state law. (3-17-22)

a. The CHIS provider may not seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated recommendation. (3-17-22)

b. The recommendation is only required to be completed once and must be received prior to submitting the initial prior authorization request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days~~,~~ then a~~nd~~ new recommendation must be received. ~~(3-17-22)~~(7-1-23)T

04. Required Screening. Needs are determined through the current version of the Vineland Adaptive Behavior Scales or other Department-approved screening tools that are conducted by the family's chosen CHIS provider, and the Department, ~~or its designee,~~ and are administered ~~in accordance with~~under the protocol of the tool. The screening tool is only required to be completed once and must be completed prior to submitting the initial prior authorization request. The following apply: ~~(3-17-22)~~(7-1-23)T

a. If a screening tool has been completed by the Department~~, or its designee,~~ a new screening is not required. ~~(3-17-22)~~(7-1-23)T

b. If the participant has been determined eligible by the Department, a new screening tool is not required. (3-17-22)

c. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, a new screening must be completed. (3-17-22)

d. The screening cannot be billed more than once unless an additional screening is required ~~in accordance with~~under guidelines as outlined in the Medicaid Provider Handbook. ~~(3-17-22)~~(7-1-23)T

05. Services. All CHIS recommended on a participant's assessment and clinical treatment plan must be prior authorized by the Department~~, or its contractor~~. The following CHIS are available for eligible participants and are reimbursable services when provided ~~in accordance with~~under these rules: ~~(3-17-22)~~(7-1-23)T

a. Habilitative Skill Building. This direct intervention service includes techniques used to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) participants. ~~(3-17-22)~~(7-1-23)T

ii. As the number and needs of the participants increase, the participant ratio in the group must be adjusted ~~accordingly~~from three (3) to two (2). ~~(3-17-22)~~(7-1-23)T

iii. Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. (3-17-22)

b. Behavioral Intervention. This service utilizes direct intervention techniques used to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs. These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation. Services include individual or group interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) participants. ~~(3-17-22)~~(7-1-23)T

ii. As the number and severity of the participants with behavioral issues increase, the participant ratio in the group must be adjusted ~~accordingly~~from three (3) to two (2). ~~(3-17-22)~~(7-1-23)T

iii. Group services should only be delivered when the participant's objectives relate to benefiting from group interaction. (3-17-22)

c. Interdisciplinary Training. This is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is to be utilized for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, behavioral or mental health professional. (3-17-22)

d. Crisis Intervention. This service may include providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis typically not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of

any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: (3-17-22)

i. Hospitalization; (3-17-22)

ii. Out-of-home placement; ~~(3-17-22)~~(7-1-23)T

iii. Incarceration; or (3-17-22)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-17-22)

e. Assessment and Clinical Treatment Plan (ACTP). The ACTP is a comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. The qualified provider conducts an assessment to evaluate the participant's strengths, needs, and functional abilities across environments. This process guides the development of intervention strategies and recommendations for services related to the participant's identified needs. The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant's parent or legal guardian. The ACTP must be completed on a Department-approved form as referenced in the Medicaid Provider Handbook and contain the following minimum standards: ~~(3-17-22)~~(7-1-23)T

i. Clinical interview(s) must be completed with the parent or legal guardian; (3-17-22)

ii. Administer or obtain an objective and validated comprehensive skills or developmental assessment approved by the Department. The most current version of the assessment must be used and the assessment must have been completed within the last three-hundred and sixty-five (365) days; (3-17-22)

iii. Review of assessments, reports, and relevant history; (3-17-22)

iv. Observations in at least one (1) environment; (3-17-22)

v. A reinforcement inventory or preference assessment; (3-17-22)

vi. A transition plan; and (3-17-22)

vii. Be signed by the individual completing the assessment and the parent or legal guardian. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

602. SCREENING MAMMOGRAPHIES: COVERAGE AND LIMITATIONS.

01. Screening Mammographies. ~~Screening mammographies are limited to one (1) per year for women who are forty (40) or more years of age~~Align with the "A" and "B" recommendations of the United States Preventative Services Taskforce. ~~(3-17-22)~~(7-1-23)T

02. Diagnostic Mammographies. ~~Diagnostic mammographies a~~Are not subject to the limitations of screening mammographies. Diagnostic mammographies are covered when a physician or licensed practitioner of the healing arts orders the procedure for a participant of any age. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

640. DIABETES EDUCATION AND TRAINING SERVICES: DEFINITIONS.
~~For purposes of these rules, a~~A Certified Diabetes Educator is a state-licensed health professional who is certified by

the Certification Board for Diabetes Care and Education or the Association of Diabetes Care and Education Specialists (ADCES). ~~(3-17-22)~~(7-1-23)T

641. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
The medical necessity for diabetes education and training are evidenced by the following: (3-17-22)

01. ~~Recent Diagnosis~~Participants with Diabetes. Are eligible for a Diabetes Management Program when: (7-1-23)T

a. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or ~~(3-17-22)~~(7-1-23)T

~~02~~b. ~~Uncontrolled Diabetes.~~ ~~Uncontrolled~~ diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or ~~(3-17-22)~~(7-1-23)T

~~03~~c. ~~Recent Manifestations.~~ ~~Recent~~ manifestations ~~resulting~~ from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. ~~(3-17-22)~~(7-1-23)T

02. Participants with Pre-Diabetes. Are eligible for the National Diabetes Prevention Program when they meet the program's guidance. (7-1-23)T

642. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only training and education services that are reasonable and necessary ~~for treatment of a current injury or illness~~ will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, exercise, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. ~~(3-17-22)~~(7-1-23)T

02. No Substitutions. The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the participant, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. (3-17-22)

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

644. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Outpatient diabetes education and training services will be covered under one (1) of the following conditions: ~~(3-17-22)~~(7-1-23)T

01. ~~Meets Program Standards~~Diabetes Management Program. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association or ~~the National Diabetes Prevention Program~~Association of Diabetes Care and Education Specialists by a certified diabetic educator. ~~(3-17-22)~~(7-1-23)T

02. ~~Conducted by a Certified Diabetic Educator~~The National Diabetes Prevention Program. The ~~education and training services are provided by a Certified Diabetic Educator through a formal~~provider meets the requirements for the program. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

709. OUTPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Community-Based Outpatient Behavioral Health Services. The Community-Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) or the Idaho State Plan are ~~medically necessary rehabilitation~~covered services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. ~~These services include:~~ ~~(3-17-22)~~(7-1-23)T

~~**a.** Assessments and Planning; (3-17-22)~~

~~**b.** Psychological and Neurological Testing; (3-17-22)~~

~~**c.** Psychotherapy (Individual, Group, and Family); (3-17-22)~~

~~**d.** Pharmacologic Management; (3-17-22)~~

~~**e.** Partial Care Treatment; (3-17-22)~~

~~**f.** Behavioral Health Nursing; (3-17-22)~~

~~**g.** Drug Screening; (3-17-22)~~

~~**h.** Community-Based Rehabilitation; (3-17-22)~~

~~**i.** Substance Use Disorder Treatment Services; and (3-17-22)~~

~~**j.** Case Management. (3-17-22)~~

02. Prior Authorization. Some behavioral health services may require prior authorization from the IBHP contractor. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. (3-17-22)

a. Home health services must be ordered by a physician, or a licensed practitioner of the healing arts. Orders must include ~~at a minimum,~~ the provider's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. Orders for medical supplies, equipment, and appliances are detailed in Section 753 of these rules. ~~(3-17-22)~~(7-1-23)T

b. Home health services required for extended periods must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. (3-17-22)

02. Face-to-Face Encounter for Home Health Services, Medical Supplies, Equipment, and Appliances. (3-17-22)

a. To initiate home health services, medical supplies, equipment, and appliances, the participant's physician, or a licensed practitioner of the healing arts ~~as authorized in this rule,~~ must document a face-to-face encounter related to the primary reason the patient requires home health services. Documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME

coverage manual. ~~(3-17-22)~~(7-1-23)T

i. For home health services, the face-to-face encounter must have occurred no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. (3-17-22)

ii. For home health medical supplies, equipment, and appliances, the face-to-face encounter must have occurred no more than six (6) months before the start of services. (3-17-22)

b. The face-to-face encounter may occur ~~via telehealth, as defined in~~virtually under Subsection 210.09 of these rules. ~~(3-17-22)~~(7-1-23)T

c. The face-to-face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or licensed practitioner of the healing arts. (3-17-22)

03. Home Health Plan of Care. (3-17-22)

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment and must be signed by the licensed, qualified professional who established the plan. (3-17-22)

b. All home health plans of care must be reviewed by the ordering provider at least every sixty (60) days for services, and annually for medical supplies, equipment, and appliances. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, independent practitioners, and home health agencies. Therapy services provided by a home health agency under a home health plan of care must meet the requirements ~~found in~~under Sections 730 through 739 of these rules, and the requirements ~~found in~~under Sections 720 through 729 of these rules. ~~(3-17-22)~~(7-1-23)T

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Idaho Medicaid Provider Handbook are covered with the following limitations: (3-17-22)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (3-17-22)

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one (1:1) patient contact. (3-17-22)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or ~~physician assistant~~PA. ~~(3-17-22)~~(7-1-23)T

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. (3-17-22)

e. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, or take responsibility for the service. The therapist has full responsibility for the service provided. (3-17-22)

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (3-17-22)

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (3-17-22)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. (3-17-22)

b. Services that address developmentally acceptable error patterns. (3-17-22)

c. Services that do not require the skills of a therapy professional. (3-17-22)

d. Massage, work hardening, and conditioning. (3-17-22)

e. Services ~~that are~~ not medically necessary, ~~as defined in~~under Section 011 of these rules. ~~(3-17-22)~~(7-1-23)T

f. Duplicate services, ~~as defined~~ under Section 730 of these rules. ~~(3-17-22)~~(7-1-23)T

g. Acupuncture (with or without electrical stimulation). (3-17-22)

h. Biofeedback, unless provided to treat urinary incontinence. (3-17-22)

i. Services that are ~~considered to be~~ experimental or investigational. ~~(3-17-22)~~(7-1-23)T

j. Vocational Program. (3-17-22)

04. Service Limitations. (3-17-22)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (3-17-22)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (3-17-22)

c. Exceptions to service limitations. (3-17-22)

i. Therapy provided by home health agencies is subject to the limitations on home health services ~~contained in~~under Section 722 of these rules. ~~(3-17-22)~~(7-1-23)T

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (3-17-22)

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) ~~in accordance with~~under the EPSDT requirements ~~contained~~ in Sections 881 through 883 of these rules, and ~~in~~ Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. ~~(3-17-22)~~(7-1-23)T

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a

clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. (3-17-22)

e. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out a safe and effective maintenance program. (3-17-22)

f. ~~Telehealth~~Virtual care modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on ~~telehealth~~virtual care in the provider handbook to promote quality services and program integrity. ~~(3-17-22)~~(7-1-23)T

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a physician, nurse practitioner, or ~~physician assistant~~PA as part of a plan of care. ~~(3-17-22)~~(7-1-23)T

01. Orders. (3-17-22)

a. All therapy must be ordered by a physician, nurse practitioner, or ~~physician assistant~~PA. ~~(3-17-22)~~(7-1-23)T

b. ~~In the event that~~If services are required for extended periods, ~~these services~~they must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions:~~(3-17-22)~~(7-1-23)T

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (3-17-22)

ii. Therapy for individuals with long-term medical conditions, as documented by physician, nurse practitioner, or ~~physician assistant~~PA, must be reordered at least every three hundred sixty-five (365) days. ~~(3-17-22)~~(7-1-23)T

c. Therapy services provided under a home health plan of care must comply with the order requirements in Section 723 of these rules. (3-17-22)

02. Level of Supervision. Supervision of physical therapist assistants and occupational therapist assistants by the physical therapist or occupational therapist must be done ~~according to the~~under rules of the applicable licensure board. ~~(3-17-22)~~(7-1-23)T

03. Face-to-Face Encounter for Home Health Therapy Services. Therapy services provided under a home health plan of care must comply with ~~the face-to-face encounter~~ requirements in Subsection 723.02 of these rules.

~~(3-17-22)~~(7-1-23)T

04. Therapy Plan of Care. All therapy services must be provided under a therapy plan of care that is based on an evaluation and is established prior to beginning treatment. (3-17-22)

a. The plan of care must be signed by the person who established the plan, and sent to the ordering provider within thirty (30) days of the evaluation to continue therapy services. ~~(3-17-22)~~(7-1-23)T

b. The plan of care must be consistent with the therapy evaluation and ~~must~~ contain~~, at a minimum~~: ~~(3-17-22)~~(7-1-23)T

i. Diagnoses; (3-17-22)

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and (3-17-22)

iii. Type, frequency, and duration of therapy services. (3-17-22)

c. Therapy services provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROCEDURAL REQUIREMENTS.

01. Orders. (3-17-22)

a. All medical supplies, equipment, and appliances must be ordered by a physician or non-physician practitioner acting within the scope of their licensure. Such orders must meet the requirements ~~described~~ in the CMS/ Medicare DME coverage manual. ~~(3-17-22)~~(7-1-23)T

b. ~~In the event that~~If medical equipment and supplies are required for extended periods, these must be reordered as necessary, but at least annually, for all participants. ~~(3-17-22)~~(7-1-23)T

c. The following information to support the medical necessity of the item(s) must be included in the order and accompany all requests for prior authorization, or be kept on file with the DME provider for items that do not require prior authorization: (3-17-22)

i. The participant's medical diagnosis, including current information on the medical condition that requires the use of the supplies or medical equipment, or both; (3-17-22)

ii. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; (3-17-22)

iii. For medical equipment, a full description of the equipment needed. All modifications or attachments to the basic equipment must be supported; (3-17-22)

iv. For medical supplies, the type and quantity of supplies necessary must be identified; and (3-17-22)

v. Documentation of the participant's medical necessity for the item, that meets coverage criteria. (3-17-22)

vi. Additional information may be requested by the Department for specific equipment or supplies. (3-17-22)

02. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with ~~the face-to-face encounter~~ requirements in Subsection 723.02 of these rules. ~~(3-17-22)~~(7-1-23)T

03. Plan of Care Requirements for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with ~~the home health plan of care~~ requirements in Subsection 723.03 of these rules. ~~(3-17-22)~~(7-1-23)T

04. Prior Authorizations. (3-17-22)

a. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (3-17-22)

i. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. An exception may be allowed on a case-by-case basis, when events beyond the provider's control prevented the request's submission. ~~(3-17-22)~~(7-1-23)T

ii. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely

because the authorization was not requested or obtained in a timely manner. ~~An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it.~~ ~~(3-17-22)~~(7-1-23)T

b. An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid ~~at the time~~when the service was provided, but was subsequently found eligible under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled," or IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. ~~(3-17-22)~~(7-1-23)T

c. A valid prior authorization request is a written, faxed, or electronic request from a provider ~~of Medicaid~~ for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. ~~(3-17-22)~~(7-1-23)T

05. Notification of Changes to Prior Authorization Requirements. The Department will provide sixty (60) days notice of any substantive ~~and significant~~ changes to requirements for prior authorization in its provider handbook. The Department will provide a method to allow providers to provide input and comment on proposed changes. ~~(3-17-22)~~(7-1-23)T

06. Equipment Rental -- Purchase Procedures. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: (3-17-22)

a. Rental payments, including intermittent payments, are to be automatically applied to the purchase of the equipment. (3-17-22)

b. The Department may choose to continue to rent certain equipment without purchasing it. Such items include apnea monitors, ventilators, and other respiratory equipment. (3-17-22)

c. The total monthly rental cost of a DME item must not exceed one-tenth (1/10) of the total purchase price of the item. (3-17-22)

07. Notice of Decision. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. Hearings will be conducted ~~in accordance with~~under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting a participant's needs for sustaining ~~him~~them in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. ~~(3-17-22)~~(7-1-23)T

02. Children's Habilitation Intervention Services (CHIS). CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid-eligible students with identified developmental limitations that impact the student's functional skills and behaviors across an array of developmental domains. CHIS include habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services. ~~(3-17-22)~~(7-1-23)T

03. Educational Services. Services that are provided in buildings, rooms, or areas designated or used

as a school or an educational setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the school day and period of time for these students, which are included in the individual educational plan (IEP) for the student. (3-17-22)

04. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. (3-17-22)

05. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual who ~~are~~is not certified or credentialed in an evidence-based model. ~~(3-17-22)~~(7-1-23)T

06. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include sociology, special education, counseling, and psychology~~.~~, or other areas of academic study ~~as~~ referenced in the Medicaid Provider Handbook. ~~(3-17-22)~~(7-1-23)T

07. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (3-17-22)

08. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work ~~for~~with individuals with mental illness. http://www.psychrehabassociation.org. ~~(3-17-22)~~(7-1-23)T

~~**09. PRA Credential**. Certificate or certification in psychiatric rehabilitation based upon the primary population with whom the individual works in accordance with the requirements set by the PRA. (3-17-22)~~

~~10~~09. **Serious Mental Illness (SMI)**. ~~In accordance with~~Under 42 CFR 483.102(b)(1), a person with SMI: ~~(3-17-22)~~(7-1-23)T

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-~~V~~5-TR; and ~~(3-17-22)~~(7-1-23)T

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational, or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. ~~(3-17-22)~~(7-1-23)T

1~~1~~0. **Serious and Persistent Mental Illness (SPMI)**. A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-~~V~~5-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. ~~(3-17-22)~~(7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts and charter schools for covered rehabilitative and health-related services.

Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (3-17-22)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-17-22)

a. Vocational Services. (3-17-22)

b. Educational Services. Educational services (other than health-related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. ~~(3-17-22)~~(7-1-23)T

c. Recreational Services. (3-17-22)

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (3-17-22)

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-17-22)

a. Be recommended or referred by a physician or other licensed practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral; (3-17-22)

b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of these rules; (3-17-22)

c. Be directed toward a diagnosis; (3-17-22)

d. Include recommended interventions to address each need; and (3-17-22)

e. Include name, title, and signature of the person conducting the evaluation. (3-17-22)

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other ~~non-physician~~ practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral. The recommendations or referrals are valid up to three hundred sixty-five (365) days. ~~(3-17-22)~~(7-1-23)T

a. Behavioral Intervention. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan with the purpose of preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) students. ~~(3-17-22)~~(7-1-23)T

ii. As the number and severity of the students with behavioral issues increases, the student ratio in the group must be adjusted ~~accordingly~~from three (3) to two (2). ~~(3-17-22)~~(7-1-23)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group

interaction. (3-17-22)

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. (3-17-22)

i. Behavioral consultation cannot be provided as a direct intervention service. (3-17-22)

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. (3-17-22)

c. Crisis Intervention. Crisis intervention services may include providing training to staff directly involved with the student, delivering intervention directly with the eligible student, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. This service is provided on a short-term basis, typically not ~~to~~ exceeding thirty (30) school days and is available for students who have an unanticipated event, circumstance, or life situation that places a student at risk of at least one (1) of the following: ~~(3-17-22)~~(7-1-23)T

i. Hospitalization; (3-17-22)

ii. Out-of-home placement; (3-17-22)

iii. Incarceration; or (3-17-22)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-17-22)

d. Habilitative Skill Building. Habilitative skill building is a direct intervention service that includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a student. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible student. Services include individual or group interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) students. ~~(3-17-22)~~(7-1-23)T

ii. As the number and needs of the students increase, the student ratio in the group must be adjusted accordingly. (3-17-22)

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-17-22)

e. Interdisciplinary Training. Interdisciplinary training is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a student's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the student's needs. This service is to be utilized for collaboration, with the student present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, or behavioral or mental health professional. (3-17-22)

f. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician or non-physician practitioner, and prior authorized. Authorized items must be for use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. (3-17-22)

g. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope

of ~~his or her~~their practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. ~~(3-17-22)~~(7-1-23)T

h. Occupational Therapy and Evaluation. ~~Occupational therapy and evaluation~~These services for vocational assessment, training or vocational rehabilitation are not reimbursed. ~~(3-17-22)~~(7-1-23)T

i. Personal Care Services (PCS). School-based ~~personal care services~~PCS include medically oriented tasks having to do with the student's physical or functional requirements. ~~Personal care services~~PCS do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: ~~(3-17-22)~~(7-1-23)T

i. Basic personal care and grooming to include bathing, ~~care of the~~ hair care, assistance with clothing, and basic skin care; ~~(3-17-22)~~(7-1-23)T

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; (3-17-22)

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (3-17-22)

iv. Assisting the student with physician-ordered medications that are ordinarily self-administered, ~~in accordance with~~under IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; ~~(3-17-22)~~(7-1-23)T

v. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and meet the requirements ~~are met in accordance with~~under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. ~~(3-17-22)~~(7-1-23)T

j. Physical Therapy and Evaluation. (3-17-22)

k. Psychological Evaluation. (3-17-22)

l. Psychotherapy. (3-17-22)

m. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS are interventions to reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills. These services are intended to prevent placement of the student into a more restrictive educational situation. ~~(3-17-22)~~(7-1-23)T

n. Speech/Audiological Therapy and Evaluation. (3-17-22)

o. Social History and Evaluation. (3-17-22)

p. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home and school when: (3-17-22)

i. The student requires special transportation assistance, a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student; (3-17-22)

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-17-22)

iii. The student requires and receives another Medicaid-reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; ~~(3-17-22)~~(7-1-23)T

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-17-22)

v. The mileage, as well as the services performed by the attendant, are documented. See Section 855 of these rules for documentation requirements. (3-17-22)

q. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (3-17-22)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid-reimbursable health-related service being provided while the interpretive service is provided. ~~(3-17-22)~~(7-1-23)T

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-17-22)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (3-17-22)

01. Behavioral Intervention. ~~Behavioral intervention m~~Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: ~~(3-17-22)~~(7-1-23)T

a. Intervention Paraprofessional. ~~Intervention paraprofessionals may p~~Provides direct services. The specialist or professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: ~~(3-17-22)~~(7-1-23)T

i. Be at least eighteen (18) years of age; (3-17-22)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; and (3-17-22)

iii. Meet the paraprofessional requirements ~~as defined in~~under IDAPA 08.02.02, "Rules Governing Uniformity." ~~(3-17-22)~~(7-1-23)T

b. Intervention Technician. ~~Intervention technician is a~~A provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. Provisional status is limited to a single eighteen (18) successive month period. The specialist or professional must observe and review the direct services performed by the technician monthly, or more often as necessary, to ensure the technician demonstrates the necessary skills to correctly provide the direct service. An intervention technician under the direction of a qualified intervention specialist or professional, must: ~~(3-17-22)~~(7-1-23)T

i. Be an individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or (3-17-22)

ii. Hold a bachelor's degree from an accredited institution in a human services field or ~~a~~ has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. ~~(3-17-22)~~(7-1-23)T

c. Intervention Specialist. ~~Intervention specialists may p~~Provides direct services, completes assessments, and develops implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: ~~(3-17-22)~~(7-1-23)T

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in ~~IDAPA 08.02.02, "Rules Governing Uniformity," Sections 021-024~~in State Board of Education Policy Section IV.B; ~~or~~ ~~(3-17-22)~~(7-1-23)T

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019, or later, and does not have a gap of more than three (3) years of employment as an intervention specialist~~,~~; or ~~(3-17-22)~~(7-1-23)T

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (3-17-22)

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; (3-17-22)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-17-22)

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. (3-17-22)

d. Intervention Professional. ~~Intervention professionals may p~~Provides direct services, completes assessments, and develops implementation plans. Intervention professionals who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: ~~(3-17-22)~~(7-1-23)T

i. An individual who holds a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (3-17-22)

ii. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-17-22)

e. Evidence-Based Model (EBM) Intervention Paraprofessional. ~~EBM intervention paraprofessionals may p~~Provides direct services~~. EBM intervention paraprofessionals~~and must be supervised ~~in accordance with~~under the evidence-based model in which they are certified or credentialed. The EBM intervention specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An EBM intervention paraprofessional must: ~~(3-17-22)~~(7-1-23)T

i. Hold a high school diploma; and (3-17-22)

ii. Hold a para-level certification or credential in an evidence-based model approved by the Department. (3-17-22)

f. Evidence-Based Model (EBM) Intervention Specialist. ~~EBM intervention specialists may p~~Provides direct services, completes assessments, and develops implementation plans~~. EBM intervention specialists~~and must be supervised ~~in accordance with~~under the evidence-based model in which they are certified or credentialed. The EBM intervention professional must observe and review the direct services performed by the specialist to ensure the specialist demonstrates the necessary skills to correctly provide the direct service. The specialist may supervise the EBM intervention paraprofessional working within the same evidence-based model. An EBM intervention specialist must: ~~(3-17-22)~~(7-1-23)T

i. Hold a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-17-22)

ii. Hold a bachelors-level certification or credential in an evidence-based model approved by the Department. (3-17-22)

g. Evidence-Based Model (EBM) Intervention Professional. ~~EBM intervention professionals may p~~Provides direct services, completes assessments, ~~and~~ develops implementation plans~~.~~, ~~EBM intervention professionals~~and may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. An EBM intervention professional must: ~~(3-17-22)~~(7-1-23)T

i. Hold a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and (3-17-22)

ii. Hold a masters-level certification or credential in an evidence-based model approved by the Department. (3-17-22)

02. Behavioral Consultation. ~~Behavioral consultation m~~Must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program)~~;~~, and who meets one (1) of the following: ~~(3-17-22)~~(7-1-23)T

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in ~~IDAPA 08.02.02, "Rules Governing Uniformity"~~State Board of Education Policy Section IV.B; ~~(3-17-22)~~(7-1-23)T

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," excluding an ~~licensed registered nurse~~RN or audiologist; ~~(3-17-22)~~(7-1-23)T

c. An occupational therapist who is qualified and registered to practice in Idaho; (3-17-22)

d. An intervention professional, as defined in Subsection 855.01 of this rule; or (3-17-22)

e. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-17-22)

03. Crisis Intervention. ~~Crisis intervention m~~Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: ~~(3-17-22)~~(7-1-23)T

a. An intervention paraprofessional, ~~as defined in~~under Subsection 855.01 of this rule;

~~(3-17-22)~~(7-1-23)T

b. An intervention technician, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(7-1-23)T

c. An intervention specialist, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(7-1-23)T

d. An intervention professional, ~~as defined in~~under Subsection 855.01 of this rule;~~(3-17-22)~~(7-1-23)T

e. An EBM intervention paraprofessional, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(7-1-23)T

f. An EBM intervention specialist, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(7-1-23)T

g. An EBM intervention professional, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(7-1-23)T

h. A licensed physician, licensed practitioner of the healing arts; (3-17-22)

i. An advanced practice registered nurse; (3-17-22)

j. A licensed psychologist; (3-17-22)

k. A licensed clinical professional counselor or professional counselor; (3-17-22)

l. A licensed marriage and family therapist; (3-17-22)

m. A licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-17-22)

n. A psychologist extender registered with the ~~Bureau~~Division of Occupational and Professional Licenses; ~~(3-17-22)~~(7-1-23)T

o. An ~~licensed registered nurse (~~RN~~)~~; ~~(3-17-22)~~(7-1-23)T

p. A licensed occupational therapist; or (3-17-22)

q. An endorsed or certified school psychologist. (3-17-22)

04. Habilitative Skill Building. ~~Habilitative skill building m~~Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following under Subsection 855.01 of this rule: ~~(3-17-22)~~(7-1-23)T

a. An intervention paraprofessional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

b. An intervention technician~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

c. An intervention specialist~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

d. An intervention professional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

e. An EBM intervention paraprofessional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

f. An EBM intervention specialist~~, as defined in Subsection 855.01 of this rule~~; or ~~(3-17-22)~~(7-1-23)T

g. An EBM intervention professional~~, as defined in Subsection 855.01 of this rule~~. ~~(3-17-22)~~(7-1-23)T

05. Interdisciplinary Training. ~~Interdisciplinary Training m~~Must be provided by one (1) of the following under Subsection 855.01 of this rule: ~~(3-17-22)~~(7-1-23)T

a. An intervention specialist~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

b. An intervention professional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

c. An EBM intervention specialist~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(7-1-23)T

d. An EBM intervention professional~~, as defined in Subsection 855.01 of this rule~~. ~~(3-17-22)~~(7-1-23)T

06. Medical Equipment and Supplies. See Subsection 853.03 of these rules. ~~(3-17-22)~~(7-1-23)T

07. Nursing Services. ~~Nursing services m~~Must be provided by an ~~licensed registered nurse (~~RN~~)~~ or by a licensed practical nurse (LPN) licensed to practice in Idaho. ~~(3-17-22)~~(7-1-23)T

08. Occupational Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

09. Personal Care Services (PCS). ~~Personal care services m~~Must be provided by or under the direction of ~~a registered nurse licensed by the State of Idaho~~an RN. ~~(3-17-22)~~(7-1-23)T

a. Providers of PCS must have at least one (1) of the following qualifications: (3-17-22)

i. Licensed Registered Nurse (RN). ~~A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse;~~ ~~(3-17-22)~~(7-1-23)T

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; (3-17-22)

iii. Certified Nursing Assistant (CNA). A person currently certified by the State of Idaho; or (3-17-22)

iv. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. (3-17-22)

b. The ~~licensed registered nurse (~~RN~~)~~ must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care annually. Oversight provided by the RN must include all of the following: ~~(3-17-22)~~(7-1-23)T

i. Development of the written PCS plan of care; (3-17-22)

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and (3-17-22)

iii. Reevaluation of the plan of care as necessary, but at least annually. (3-17-22)

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (3-17-22)

10. Physical Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

11. Psychological Evaluation. ~~A psychological evaluation m~~Must be provided by a: ~~(3-17-22)~~(7-1-23)T

a. Licensed psychiatrist; (3-17-22)

b. Licensed physician; (3-17-22)

c. Licensed psychologist; (3-17-22)

d. Psychologist extender registered with the ~~Bureau~~Division of Occupational and professional Licenses; or ~~(3-17-22)~~(7-1-23)T

e. Endorsed or certified school psychologist. (3-17-22)

12. Psychotherapy. Provision of psychotherapy services must have~~, at a minimum~~, one (1) or more of the following credentials: ~~(3-17-22)~~(7-1-23)T

a. Psychiatrist, M~~.~~D~~.~~; ~~(3-17-22)~~(7-1-23)T

b. Physician, M~~.~~D~~.~~; ~~(3-17-22)~~(7-1-23)T

c. Licensed psychologist; (3-17-22)

d. Licensed clinical social worker; (3-17-22)

e. Licensed clinical professional counselor; (3-17-22)

f. Licensed marriage and family therapist; (3-17-22)

g. Certified psychiatric nurse (RN), ~~as described in~~under Subsection 707.13 of these rules; ~~(3-17-22)~~(7-1-23)T

h. Licensed professional counselor whose provision of psychotherapy is supervised ~~in compliance~~under with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ~~(3-17-22)~~(7-1-23)T

i. Licensed masters social worker whose provision of psychotherapy is supervised ~~as described in~~under IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ~~(3-17-22)~~(7-1-23)T

j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised ~~as described in~~under IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or ~~(3-17-22)~~(7-1-23)T

k. Psychologist extender, registered with the ~~Bureau~~Division of Occupational and Professional Licenses, whose provision of diagnostic services is supervised ~~in compliance with~~under IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ~~(3-17-22)~~(7-1-23)T

13. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following. Skills Building/Community-Based Rehabilitation Services (CBRS) provider who is not required to have a PRA credential or credential required for CBRS specialists must be one (1) of the following: ~~(3-17-22)~~(7-1-23)T

a. Licensed physician, licensed practitioner of the healing arts; (3-17-22)

b. Advanced practice registered nurse; (3-17-22)

c. Licensed psychologist; (3-17-22)

d. Licensed clinical professional counselor or professional counselor; (3-17-22)

e. Licensed marriage and family therapist; (3-17-22)

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-17-22)

g. Psychologist extender registered with the ~~Bureau~~Division of Occupational and professional Licenses; ~~(3-17-22)~~(7-1-23)T

h. Licensed registered nurse (RN); (3-17-22)

i. Licensed occupational therapist; (3-17-22)

j. Endorsed or certified school psychologist; (3-17-22)

k. Skills Building/Community Based Rehabilitation Services specialist~~. A Skills Building/CBRS specialist~~ who must: ~~(3-17-22)~~(7-1-23)T

i. Be an individual who has a bachelor's degree and holds a current PRA credential; or (3-17-22)

ii. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist to review treatment provided to student participants on an ongoing basis. The frequency of the one-to-one (1:1) supervision must occur at least monthly. Supervision can be conducted using ~~telehealth~~synchronous virtual care when it is equally effective as direct on-site supervision; and ~~(3-17-22)~~(7-1-23)T

iii. Have a credential required for CBRS specialists. (3-17-22)

14. Speech/Audiological Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

15. Social History and Evaluation. ~~Social history and evaluation m~~Must be provided by a ~~licensed registered nurse (~~RN~~)~~, psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. ~~(3-17-22)~~(7-1-23)T

16. Transportation. ~~Transportation m~~Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. ~~(3-17-22)~~(7-1-23)T

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist ~~as defined by~~under the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. ~~(3-17-22)~~(7-1-23)T

a. Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (3-17-22)

b. Physical Therapy (PT). Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision, and service requirements. ~~(3-17-22)~~(7-1-23)T

c. Speech-Language Pathology (SLP). Refer to IDAPA 24.23.01, "Rules of the Speech, ~~and~~ Hearing and Communication Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision, and service requirements for speech-language pathology~~. The guidelines~~

~~have been~~as incorporated ~~by reference~~ in Section 004 of these rules. ~~(3-17-22)~~(7-1-23)T

i. Supervision must be provided by an SLP professional ~~as defined~~ in Section 734 ~~of this chapter~~ of these rules. ~~(3-17-22)~~(7-1-23)T

ii. The professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

892. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.
When ordered by the participant's attending physician or licensed practitioner of the healing arts, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. (3-17-22)

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (3-17-22)

02. Maternity Nursing Visit. These services are only available to women unable to obtain a physician or licensed practitioner of the healing arts~~,~~ to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. ~~(3-17-22)~~(7-1-23)T

03. Nursing Services. Limited to two (2) visits during the covered period. (3-17-22)

04. Nutrition Services. ~~Nutritional services are~~As described in Sections 630 through 632 of these rules. ~~(3-17-22)~~(7-1-23)T

05. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care. (3-17-22)

06. Risk Reduction Follow-Up. (7-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

894. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Services must be: (3-17-22)

01. Risk Reduction Follow-Up. Provided by a licensed social worker~~s~~, ~~licensed registered nurses~~RN, nurse midwife, physician, NP, or PA either in independent practice or as employees of entities that have current provider agreements with the Department. ~~(3-17-22)~~(7-1-23)T

02. Individual and Family Social Services. Provided by a licensed social worker qualified to provide individual counseling ~~in accordance with the provisions of IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners."~~ ~~(3-17-22)~~(7-1-23)T

INCORPORATION BY REFERENCE SYNOPSIS

In compliance with Section 67-5223(4), Idaho Code, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

DEPARTMENT OF HEALTH AND WELFARE
IDAPA 16.03.09 – "Medicaid Basic Plan Benefits"
Proposed Rulemaking -- Docket No. 16-0309-2301

(Include a brief description that explains the differences between the version of the materials or documents that are currently incorporated by reference and the materials or documents that are being proposed for adoption in this rulemaking.)

(You may use the following table or write a brief summary of the differences)

Incorporated Document Version/URL	IDAPA Section Number	Current Version of Incorporated Document	Substantive Changes in New Incorporation by Reference Version
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013)	16.03.09. 004.02	American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR, 2022)	See below for the detailed summary of changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR, 2022) incorporated by reference under Section 004 of Medicaid chapter IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The changes for this incorporated manual reflect a major overhaul of the 2013 edition (DSM-5). The 970-page text of the updated Manual (*DSM-5-TR, 2022*) may be ordered from: American Psychiatric Association, 800 Maine Avenue, S.W., Suite 900, Washington, DC 20024.

Attention to Culture, Racism, and Discrimination in DSM-5-TR

The APA, in response to concerns from members and others in the mental health field that race, ethnoracial differences, racism and discrimination be handled appropriately in the Diagnostic and Statistical Manual of Mental Disorders (DSM), adopted multiple strategies to address these factors that impact psychiatric diagnosis in DSM-5-TR. These strategies include:

- A Cross-Cutting Review Committee on Cultural Issues, composed of 19 U.S. and international based experts in cultural psychiatry, psychology, and anthropology. Those experts reviewed the texts for cultural influences on disorder characteristics.
- An Ethnoracial Equity and Inclusion Work Group, composed of 10 mental health practitioners from diverse ethnic and racialized backgrounds with expertise in disparity-reduction practices, reviewed references to race, ethnicity, nationality, and related concepts throughout DSM-5-TR to avoid perpetuating stereotypes or including discriminatory clinical information.

As part of the changes implemented in DSM-5-TR is the use of language that challenges the view that races are discrete and natural entities:

- The term “racialized” is used instead of “race/racial” to highlight the socially constructed nature of race.
- The term “ethnoracial” is used in the text to denote the U.S. Census categories, such as Hispanic, White, or African American, that combine ethnic and racialized identifiers.
- The terms “minority” and “non-White” are avoided because they describe social groups in relation to a racialized “majority,” a practice that tends to perpetuate social hierarchies.
- The emerging term “Latinx” is used in place of Latino/Latina to promote gender-inclusive terminology.
- The term Caucasian is not used because it is based on obsolete and erroneous views about the geographic origin of a prototypical pan-European ethnicity.
- Prevalence data on specific ethnoracial groups were included when existing research documented reliable estimates based on representative samples.

In addition, information is provided on variations in symptom expression, attributions for disorder causes or precipitants, and factors associated with differential prevalence across demographic groups. Cultural norms that may affect the level of perceived pathology are also reported. Attention was paid to the risk of misdiagnosis when evaluating individuals from socially oppressed ethnoracial groups.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American PsychiatricAssociation (APA) will publish DSM-5-TR in 2022.

APA is a national medical specialty society whose more than 37,400 physician members specialize in the diagnosis, treatment, prevention, and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact APA Communications at 202-459-9732 or press@psych.org.

Coding and Recording Procedures

Since October 1, 2015, the official coding system in the United States has been the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). ICD-10-CM is a version of the World Health Organization's ICD-10 that has been modified for clinical use by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) and provides the only permissible diagnostic codes for mental disorders for clinical use in the United States.

The codes that appear in DSM are the ICD codes that are equivalent to the DSM diagnoses. In DSM-5 both ICD-9 and ICD-10 codes were included, given that at the time of DSM-5 release the ICD-9-CM system was still in use in the United States. DSM-5-TR will, however, include only ICD-10-CM codes since they are the only official coding system in the United States at this time.

Most disorders in DSM-5-TR have an alphanumeric ICD-10-CM code that appears preceding the name of the disorder (or coded subtype or specifier). The text sections "recording procedures" or "coding notes" describe the appropriate coding procedure for the DSM diagnoses.
The use of diagnostic codes is fundamental to medical record keeping. It facilitates data collection and retrieval and compilation of statistical information.

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DSM-5-TR and Diagnoses for Children

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision (DSM-5-TR), like DSM-5, features a lifespan approach to mental health. The organization of childhood conditions underscores how they can continue to manifest at various stages of life and may be impacted by the developmental continuum that influences many disorders.

Some of the diagnostic criteria were updated in DSM-5-TR to capture the experiences and symptoms of children more precisely. In addition, DSM-5-TR, like DSM-5, emphasized that similar to any medical issue, no child should ever be diagnosed without a careful, comprehensive evaluation, and no medication should be prescribed without equal vigilance. Parents play an integral role in this process, as many of the DSM criteria require that symptoms be observed by them or other individuals who interact regularly with the child.

More Precise Criteria

Existing criteria have been updated in DSM-5-TR to provide more precise descriptions and reflect the scientific advances and clinical experience of the last decade. Below are brief summaries of changes to select disorders.

Autism Spectrum Disorder

Criterion A phrase "as manifested by the following" was revised to read "as manifested by all of the following" to improve its clarity. The revision by the work group was made to maintain a high diagnostic threshold by requiring "all of the following," and not "any of the following" criteria, as could be mistakenly implied by the previous wording of the criterion.

Disruptive Mood Dysregulation Disorder

The text in the "Development and Course" section describing the age range at which disruptive mood dysregulation disorder can be diagnosed and for which validity is established was updated to "6–18 years," as noted in criterion G.

Posttraumatic Stress Disorder

For children 6 years and younger, the note that "witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures" in Criterion A.2 was removed for its redundancy, given that criterion A.2 already indicates that the events occurring to others must be witnessed in person.

Prolonged Grief Disorder

Prolonged Grief Disorder is a new disorder in DSM-5-TR. Specific language was added to the criteria to define the difference between children and adolescents versus adults. The intent of that is to reflect current scientific evidence and highlight the different reactions children or adolescents might have in such situations.

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AMERICAN PSYCHIATRIC ASSOCIATION

Section III

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision (DSM-5-TR) includes robust debate about the scientific evidence and clinical experience supporting the book's contents. This section, just as in DSM-5, offers tools and techniques to help clinicians enhance clinical practice, understand the cultural context of mental disorders, and facilitate further study of proposed emerging diagnoses.

Clinical Sequence

The Assessment Measures offers Level 1 and Level 2 cross-cutting self/informant- rated measures. Level 1 cross-cutting measures serve as a review of systems across mental disorders. Level 2 cross-cutting symptom measures provide selected means of obtaining more in-depth information on potentially significant symptoms to inform diagnosis, treatment planning, and follow-up. They are available online at www.psychiatry.org/dsm5.

Some of the changes regarding the Assessment Measures:

Sex "Male/Female" checkboxes:
In DSM-5-TR, all Sex "Male/Female" checkboxes at beginning of each measure were deleted to eliminate the use of binary classification.

Clinician-Rated Dimensions of Psychosis Symptom Severity measure:
The instructions for use of the measure were edited in keeping with criteria (severity specifiers) for schizophrenia spectrum and other psychotic disorders.

World Health Organization Disability Assessment Schedule 2.0:
Clarifications were added to the instructions on how to calculate the summary scores for the WHODAS 2.0 36-item full version.

Cultural Context

The cultural context section provides a comprehensive review of the cultural context of mental disorders and the cultural formulation interview (CFI) for clinical use. It includes basic information onintegrating culture and social context in clinical diagnoses, as well as cultural formulation, and cultural concepts of distress.
In DSM-5-TR, key terms that help to highlight the cultural context of illness experience are provided. Understanding this context is essential for effective diagnostic assessment and clinical management. Definitions and clarifications were provided for terms such as culture, race, and ethnicity.

Examples of the cultural concepts of distress were revised in DSM-5-TR to provide more clarifications and ensure that no stigmatizing or generalizing language was used.

The cultural formulation section presents an outline for a systematic person-centered cultural assessment that is designed to be used by any clinician providing services to any individual in any care setting. This section also includes an interview protocol, the cultural formulation interview, that operationalizes these components.

The cultural concepts of distress section describe the ways individuals express, report,and interpret experiences of illness and distress. Cultural concepts of distress include idioms, explanations or perceived causes, and syndromes.

Alternative DSM-5 Model for Personality Disorder

The alternative DSM-5 Model for personality disorders provides an alternative to the extant personality disorders classification in Section II. This section was not changed from DSM-5.

Conditions for Further Study

The chapter includes proposed criteria sets presented for conditions on which research is encouraged. It is hoped that such research will allow the field to better understand these conditions and inform future decisions about possible placement in the DSM. Persistent complex bereavement disorder, originally located in this section, has been moved to the chapter “trauma- and stressor-related disorders” in Section II as an official diagnosis. Based on thorough reviews finding sufficient evidence of validity, reliability, and clinical utility to justify its recognition as an official DSM diagnosis, it is now named “prolonged grief disorder” and the criteria have been appropriately reformulated.

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Highlights of Changes from DSM-IV-TR to DSM-5

Changes made to the DSM-5 diagnostic criteria and texts are outlined in this chapter in the same order in which they appear in the DSM-5 classification. This is not an exhaustive guide; minor changes in text or wording made for clarity are not described here. It should also be noted that Section I of DSM-5 contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments (in Section III).

Terminology

The phrase "general medical condition" is replaced in DSM-5 with "another medical condition" where relevant across all disorders.

Neurodevelopmental Disorders

Intellectual Disability (Intellectual Developmental Disorder)

Diagnostic criteria for intellectual disability (intellectual developmental disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score. The term mental retardation was used in DSM-IV. However, *intellectual disability* is the term that has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups. Moreover, a federal statue in the United States (Public Law 111-256, Rosa's Law) replaces the term "mental retardation with intellectual disability. Despite the name change, the deficits in cognitive capacity beginning in the developmental period, with the accompanying diagnostic criteria, are considered to constitute a mental disorder. The term *intellectual developmental disorder* was placed in parentheses to reflect the World Health Organization's classification system, which lists "disorders" in the International Classification of Diseases (ICD; ICD-11 to be released in 2015) and bases all "disabilities" on the International Classification of Functioning, Disability, and Health (ICF). Because the ICD-11 will not be adopted for several years, *intellectual disability* was chosen as the current preferred term with the bridge term for the future in parentheses.

Communication Disorders

The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some patients diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorder.

Autism Spectrum Disorder

Autism spectrum disorder is a new DSM-5 name that reflects a scientific consensus that four previously separate disorders are actually a single condition with different levels of symptom severity in two core

domains. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

Attention-Deficit/Hyperactivity Disorder

The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. However, several changes have been made in DSM-5: 1) examples have been added to the criterion items to facilitate application across the life span; 2) the cross-situational requirement has been strengthened to "several" symptoms in each setting; 3) the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12"; 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

Specific Learning Disorder

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit types in each area are included. The text acknowledges that specific types of reading deficits are described internationally in various ways as dyslexia and specific types of mathematics deficits as dyscalculia.

Motor Disorders

The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter: developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. The tic criteria have been standardized across all of these disorders in this chapter. Stereotypic movement disorder has been more clearly differentiated from body-focused repetitive behavior disorders that are in the DSM-5 obsessive-compulsive disorder chapter.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia

Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was

removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core "positive symptoms" is necessary for a reliable diagnosis of schizophrenia.

Schizophrenia subtypes

The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

Schizoaffective Disorder

The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met. This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition. The change was also made to improve the reliability, diagnostic stability, and validity of this disorder, while recognizing that the characterization of patients with both psychotic and mood symptoms, either concurrently or at different points in their illness, has been a clinical challenge.

Delusional Disorder

Criterion A for delusional disorder no longer has the requirement that the delusions must be nonbizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs. DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis "other specified schizophrenia spectrum and other psychotic disorder" is used.

Catatonia

The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition. In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition. In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as an other specified diagnosis.

Bipolar and Related Disorders

Bipolar Disorders

To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, "with mixed features," has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

Other Specified Bipolar and Related Disorder

DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days). A second condition constituting an other specified bipolar and related disorder is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at 4 or more days.

Anxious Distress Specifier

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

Depressive Disorders

DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. To address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. Based on strong scientific evidence, premenstrual dysphoric disorder has been moved from DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study," to the main body of DSM-5. Finally, DSM-5 conceptualizes chronic forms of depression in a somewhat modified way. What was referred to as dysthymia in DSM-IV now falls under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. An inability to find scientifically meaningful differences between these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV.

Major Depressive Disorder

Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C. The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier "with mixed features." The presence of mixed features in an episode of major depressive disorder in-

creases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained.

Bereavement Exclusion

In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 for several reasons. The first is to remove the implication that bereavement typically lasts only 2 months when both physicians and grief counselors recognize that the duration is more commonly 1–2 years. Second, bereavement is recognized as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss. When major depressive disorder occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder, which is now described with explicit criteria in Conditions for Further Study in DSM-5 Section III. Third, bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes. It is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non–bereavement-related major depressive episodes. Finally, the depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as non–bereavement-related depression. In the criteria for major depressive disorder, a detailed footnote has replaced the more simplistic DSM-IV exclusion to aid clinicians in making the critical distinction between the symptoms characteristic of bereavement and those of a major depressive episode. Thus, although most people experiencing the loss of a loved one experience bereavement without developing a major depressive episode, evidence does not support the separation of loss of a loved one from other stressors in terms of its likelihood of precipitating a major depressive episode or the relative likelihood that the symptoms will remit spontaneously.

Specifiers for Depressive Disorders

Suicidality represents a critical concern in psychiatry. Thus, the clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual. A new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression. A substantial body of research conducted over the last two decades points to the importance of anxiety as relevant to prognosis and treatment decision making. The “with anxious distress” specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

Anxiety Disorders

The DSM-5 chapter on anxiety disorder no longer includes obsessive-compulsive disorder (which is included with the obsessive-compulsive and related disorders) or posttraumatic stress disorder and acute stress disorder (which is included with the trauma- and stressor-related disorders). However, the sequential order of these chapters in DSM-5 reflects the close relationships among them.

Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)

Changes in criteria for agoraphobia, specific phobia, and social anxiety disorder (social phobia) include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. This change is based on evidence that individuals with such disorders often overestimate the danger in "phobic" situations and that older individuals often misattribute "phobic" fears to aging. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account. In addition, the 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize overdiagnosis of transient fears.

Panic Attack

The essential features of panic attacks remain unchanged, although the complicated DSM-IV terminology for describing different types of panic attacks (i.e., situationally bound/cued, situationally predisposed, and unexpected/uncued) is replaced with the terms unexpected and expected panic attacks. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including but not limited to anxiety disorders. Hence, panic attack can be listed as a specifier that is applicable to all DSM-5 disorders.

Panic Disorder and Agoraphobia

Panic disorder and agoraphobia are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria. The co-occurrence of panic disorder and agoraphobia is now coded with two diagnoses. This change recognizes that a substantial number of individuals with agoraphobia do not experience panic symptoms. The diagnostic criteria for agoraphobia are derived from the DSM-IV descriptors for agoraphobia, although endorsement of fears from two or more agoraphobia situations is now required, because this is a robust means for distinguishing agoraphobia from specific phobias. Also, the criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders (e.g., clinician judgment of the fears as being out of proportion to the actual danger in the situation, with a typical duration of 6 months or more).

Specific Phobia

The core features of specific phobia remain the same, but there is no longer a requirement that individuals over age 18 years must recognize that their fear and anxiety are excessive or unreasonable, and the duration requirement ("typically lasting for 6 months or more") now applies to all ages. Although they are now referred to as specifiers, the different types of specific phobia have essentially remained unchanged.

Social Anxiety Disorder (Social Phobia)

The essential features of social anxiety disorder (social phobia) (formerly called social phobia) remain the same. However, a number of changes have been made, including deletion of the requirement that individuals over age 18 years must recognize that their fear or anxiety is excessive or unreasonable, and duration criterion of "typically lasting for 6 months or more" is now required for all ages. A more significant change is that the "generalized" specifier has been deleted and replaced with a "performance only" specifier. The DSM-IV generalized specifier was problematic in that "fears include most social situations" was difficult to operationalize. Individuals who fear only performance situations (i.e., speaking

or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

Separation Anxiety Disorder

Although in DSM-IV, separation anxiety disorder was classified in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence," it is now classified as an anxiety disorder. The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behaviors may occur in the workplace as well as at school. Also, in contrast to DSM-IV, the diagnostic criteria no longer specify that age at onset must be before 18 years, because a substantial number of adults report onset of separation anxiety after age 18. Also, a duration criterion—"typically lasting for 6 months or more"—has been added for adults to minimize overdiagnosis of transient fears.

Selective Mutism

In DSM-IV, selective mutism was classified in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence." It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious. The diagnostic criteria are largely unchanged from DSM-IV.

Obsessive-Compulsive and Related Disorders

The chapter on obsessive-compulsive and related disorders, which is new in DSM-5, reflects the increasing evidence that these disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. New disorders include hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. The DSM-IV diagnosis of trichotillomania is now termed trichotillomania (hair-pulling disorder) and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5.

Specifiers for Obsessive-Compulsive and Related Disorders

The "with poor insight" specifier for obsessive-compulsive disorder has been refined in DSM-5 to allow a distinction between individuals with good or fair insight, poor insight, and "absent insight/delusional" obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true). Analogous "insight" specifiers have been included for body dysmorphic disorder and hoarding disorder. These specifiers are intended to improve differential diagnosis by emphasizing that individuals with these two disorders may present with a range of insight into their disorder-related beliefs, including absent insight/delusional symptoms. This change also emphasizes that the presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder. The "tic-related" specifier for obsessive-compulsive disorder reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder, because this comorbidity may have important clinical implications.

Body Dysmorphic Disorder

For DSM-5 body dysmorphic disorder, a diagnostic criterion describing repetitive behaviors or mental

acts in response to preoccupations with perceived defects or flaws in physical appearance has been added, consistent with data indicating the prevalence and importance of this symptom. A "with muscle dysmorphia" specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with body dysmorphic disorder. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5 this presentation is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

Hoarding Disorder

Hoarding disorder is a new diagnosis in DSM-5. DSM-IV lists hoarding as one of the possible symptoms of obsessive-compulsive personality disorder and notes that extreme hoarding may occur in obsessive-compulsive disorder. However, available data do not indicate that hoarding is a variant of obsessive-compulsive disorder or another mental disorder. Instead, there is evidence for the diagnostic validity and clinical utility of a separate diagnosis of hoarding disorder, which reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them. Hoarding disorder may have unique neurobiological correlates, is associated with significant impairment, and may respond to clinical intervention.

Trichotillomania (Hair-Pulling Disorder)

Trichotillomania was included in DSM-IV, although "hair-pulling disorder" has been added parenthetically to the disorder's name in DSM-5.

Excoriation (Skin-Picking) Disorder

Excoriation (skin-picking) disorder is newly added to DSM-5, with strong evidence for its diagnostic validity and clinical utility.

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder and Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

DSM-IV included a specifier "with obsessive-compulsive symptoms" in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders. Given that obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes new categories for substance-/medication-induced obsessive-compulsive and related disorder and for obsessive-compulsive and related disorder due to another medical condition. This change is consistent with the intent of DSM-IV, and it reflects the recognition that substances, medications, and medical conditions can present with symptoms similar to primary obsessive-compulsive and related disorders.

Other Specified and Unspecified Obsessive-Compulsive and Related Disorders

DSM-5 includes the diagnoses other specified obsessive-compulsive and related disorder, which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or unspecified obsessive-compulsive and related disorder. Body-focused repetitive behavior disorder is characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. Obsessional jealousy is characterized by nondelusional preoccupation with a partner's perceived infidelity.

Trauma- and Stressor-Related Disorders

Acute Stress Disorder

In DSM-5, the stressor criterion (Criterion A) for acute stress disorder is changed from DSM-IV. The criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly. Also, the DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., "the person's response involved intense fear, helplessness, or horror") has been eliminated. Based on evidence that acute posttraumatic reactions are very heterogeneous and that DSM-IV's emphasis on dissociative symptoms is overly restrictive, individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.

Adjustment Disorders

In DSM-5, adjustment disorders are reconceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or nontraumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV). DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct have been retained, unchanged.

Posttraumatic Stress Disorder

DSM-5 criteria for posttraumatic stress disorder differ significantly from those in DSM-IV. As described previously for acute stress disorder, the stressor criterion (Criterion A) is more explicit with regard to how an individual experienced "traumatic" events. Also, Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable or aggressive behavior and reckless or self-destructive behavior. Posttraumatic stress disorder is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

Reactive Attachment Disorder

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder. Both of these disorders are the result of social neglect or other situations that limit a young child's opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders.

Dissociative Disorders

Major changes in dissociative disorders in DSM-5 include the following: 1) derealization is included in the name and symptom structure of what previously was called depersonalization disorder and is now called *depersonalization/derealization disorder*, 2) dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis, and 3) the criteria for dissociative identity disorder have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

Dissociative Identity Disorder

Several changes to the criteria for dissociative identity disorder have been made in DSM-5. First, Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder. Second, Criterion A now specifically states that transitions in identity may be observable by others or self-reported. Third, according to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences. Other text modifications clarify the nature and course of identity disruptions.

Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. In DSM-IV, there was significant overlap across the somatoform disorders and a lack of clarity about their boundaries. These disorders are primarily seen in medical settings, and nonpsychiatric physicians found the DSM-IV somatoform diagnoses problematic to use. The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic Symptom Disorder

DSM-5 better recognizes the complexity of the interface between psychiatry and medicine. Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors *may or may not* have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum, and the arbitrarily high symptom count required for DSM-IV somatization disorder did not accommodate this spectrum. The diagnosis of somatization disorder was essentially based on a long and complex symptom count of medically unexplained symptoms. Individuals previously diagnosed with somatization disorder will usually meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.

In DSM-IV, the diagnosis undifferentiated somatoform disorder had been created in recognition that somatization disorder would only describe a small minority of "somatizing" individuals, but this disorder did not prove to be a useful clinical diagnosis. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

Medically Unexplained Symptoms

DSM-IV criteria overemphasized the importance of an absence of a medical explanation for the somatic symptoms. Unexplained symptoms are present to various degrees, particularly in conversion disorder,

but somatic symptom disorders can also accompany diagnosed medical disorders. The reliability of medically unexplained symptoms is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind -body dualism. The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). Medically unexplained symptoms do remain a key feature in conversion disorder and pseudocyesis because it is possible to demonstrate definitively in such disorders that the symptoms are not consistent with medical pathophysiology.

Hypochondriasis and Illness Anxiety Disorder

Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

Pain Disorder

DSM-5 takes a different approach to the important clinical realm of individuals with pain. In DSM-IV, the pain disorder diagnoses assume that some pains are associated solely with psychological factors, some with medical diseases or injuries, and some with both. There is a lack of evidence that such distinctions can be made with reliability and validity, and a large body of research has demonstrated that psychological factors influence all forms of pain. Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Psychological Factors Affecting Other Medical Conditions and Factitious Disorder

Psychological factors affecting other medical conditions is a new mental disorder in DSM-5, having formerly been included in the DSM-IV chapter "Other Conditions That May Be a Focus of Clinical Attention." This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings. The variants of psychological factors affecting other medical conditions are removed in favor of the stem diagnosis.

Conversion Disorder (Functional Neurological Symptom Disorder)

Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

Feeding and Eating Disorders

In DSM-5, the feeding and eating disorders include several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence." In addition, brief descriptions and preliminary diagnostic criteria are provided for several conditions under other specified feeding and eating disorder; insufficient informa-

tion about these conditions is currently available to document their clinical characteristics and validity or to provide definitive diagnostic criteria.

Pica and Rumination Disorder
The DSM-IV criteria for pica and for rumination disorder have been revised for clarity and to indicate that the diagnoses can be made for individuals of any age.

Avoidant/Restrictive Food Intake Disorder
DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. The DSM-IV disorder was rarely used, and limited information is available on the characteristics, course, and outcome of children with this disorder. Additionally, a large number of individuals, primarily but not exclusively children and adolescents, substantially restrict their food intake and experience significant associated physiological or psychosocial problems but do not meet criteria for any DSM-IV eating disorder. Avoidant/restrictive food intake disorder is a broad category intended to capture this range of presentations.

Anorexia Nervosa
The core diagnostic criteria for anorexia nervosa are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated. In DSM-IV, this requirement was waived in a number of situations (e.g., for males, for females taking contraceptives). In addition, the clinical characteristics and course of females meeting all DSM-IV criteria for anorexia nervosa except amenorrhea closely resemble those of females meeting all DSM-IV criteria. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. The wording of the criterion has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

Bulimia Nervosa
The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly. The clinical characteristics and outcome of individuals meeting this slightly lower threshold are similar to those meeting the DSM-IV criterion.

Binge-Eating Disorder
Extensive research followed the promulgation of preliminary criteria for binge eating disorder in Appendix B of DSM-IV, and findings supported the clinical utility and validity of binge-eating disorder. The only significant difference from the preliminary DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to at least once weekly over the last 3 months, which is identical to the DSM-5 frequency criterion for bulimia nervosa.

Elimination Disorders
No significant changes have been made to the elimination disorders diagnostic class from DSM-IV to DSM-5. The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.

Sleep-Wake Disorders

Because of the DSM-5 mandate for concurrent specification of coexisting conditions (medical and mental), sleep disorders related to another mental disorder and sleep disorder related to a general medical condition have been removed from DSM-5, and greater specification of coexisting conditions is provided for each sleep-wake disorder. This change underscores that the individual has a sleep disorder warranting independent clinical attention, in addition to any medical and mental disorders that are also present, and acknowledges the bidirectional and interactive effects between sleep disorders and coexisting medical and mental disorders. This reconceptualization reflects a paradigm shift that is widely accepted in the field of sleep disorders medicine. It moves away from making causal attributions between coexisting disorders. Any additional relevant information from the prior diagnostic categories of sleep disorder related to another mental disorder and sleep disorder related to another medical condition has been integrated into the other sleep-wake disorders where appropriate.

Consequently, in DSM-5, the diagnosis of primary insomnia has been renamed insomnia disorder to avoid the differentiation of primary and secondary insomnia. DSM-5 also distinguishes narcolepsy, which is now known to be associated with hypocretin deficiency, from other forms of hypersomnolence. These changes are warranted by neurobiological and genetic evidence validating this reorganization. Finally, throughout the DSM-5 classification of sleep-wake disorders, pediatric and developmental criteria and text are integrated where existing science and considerations of clinical utility support such integration. This developmental perspective encompasses age-dependent variations in clinical presentation.

Breathing-Related Sleep Disorders

In DSM-5, breathing-related sleep disorders are divided into three relatively distinct disorders: obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation. This change reflects the growing understanding of pathophysiology in the genesis of these disorders and, furthermore, has relevance to treatment planning.

Circadian Rhythm Sleep-Wake Disorders

The subtypes of circadian rhythm sleep-wake disorders have been expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour sleep-wake type, whereas the jet lag type has been removed.

Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome

The use of DSM-IV "not otherwise specified" diagnoses has been reduced by designating rapid eye movement sleep behavior disorder and restless legs syndrome as independent disorders. In DSM-IV, both were included under dyssomnia not otherwise specified. Their full diagnostic status is supported by research evidence.

Sexual Dysfunctions

In DSM-IV, sexual dysfunctions referred to sexual pain or to a disturbance in one or more phases of the sexual response cycle. Research suggests that sexual response is not always a linear, uniform process and that the distinction between certain phases (e.g., desire and arousal) may be artificial. In DSM-5, gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder.

To improve precision regarding duration and severity criteria and to reduce the likelihood of overdiag-

nosis, all of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria. These changes provide useful thresholds for making a diagnosis and distinguish transient sexual difficulties from more persistent sexual dysfunction.

Genito-Pelvic Pain/Penetration Disorder
Genito-pelvic pain/penetration disorder is new in DSM-5 and represents a merging of the DSM-IV categories of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research.

Subtypes
DSM-IV included the following subtypes for all sexual disorders: lifelong versus acquired, generalized versus situational, and due to psychological factors versus due to combined factors. DSM-5 includes only lifelong versus acquired and generalized versus situational subtypes. Sexual dysfunction due to a general medical condition and the subtype due to psychological versus combined factors have been deleted due to findings that the most frequent clinical presentation is one in which both psychological and biological factors contribute. To indicate the presence and degree of medical and other nonmedical correlates, the following associated features are described in the accompanying text: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

Gender Dysphoria

Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder. In DSM-IV, the chapter "Sexual and Gender Identity Disorders" included three relatively disparate diagnostic classes: gender identity disorders, sexual dysfunctions, and paraphilias. Gender identity disorder, however, is neither a sexual dysfunction nor a paraphilia. Gender dysphoria is a unique condition in that it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical (at least for some adolescents and most adults). In contrast to the dichotomized DSM-IV gender identity disorder diagnosis, the type and severity of gender dysphoria can be inferred from the number and type of indicators and from the severity measures.

The experienced gender incongruence and resulting gender dysphoria may take many forms. Gender dysphoria thus is considered to be a multicategory concept rather than a dichotomy, and DSM-5 acknowledges the wide variation of gender -incongruent conditions. Separate criteria sets are provided for gender dysphoria in children and in adolescents and adults. The adolescent and adult criteria include a more detailed and specific set of polythetic symptoms. The previous Criterion A (cross-gender identification) and Criterion B (aversion toward one's gender) have been merged, because no supporting evidence from factor analytic studies supported keeping the two separate. In the wording of the criteria, "the other sex" is replaced by "some alternative gender." Gender instead of sex is used systematically because the concept "sex" is inadequate when referring to individuals with a disorder of sex development.

In the child criteria, "strong desire to be of the other gender" replaces the previous "repeatedly stated desire" to capture the situation of some children who, in a coercive environment, may not verbalize the desire to be of another gender. For children, Criterion A1 ("a strong desire to be of the other gender or

an insistence that he or she is the other gender . . .)" is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative.

Subtypes and Specifiers

The subtyping on the basis of sexual orientation has been removed because the distinction is not considered clinically useful. A posttransition specifier has been added because many individuals, after transition, no longer meet criteria for gender dysphoria; however, they continue to undergo various treatments to facilitate life in the desired gender. Although the concept of posttransition is modeled on the concept of full or partial remission, the term remission has implications in terms of symptom reduction that do not apply directly to gender dysphoria.

Disruptive, Impulse-Control, and Conduct Disorders

The chapter on disruptive, impulse-control, and conduct disorders is new to DSM-5. It brings together disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Otherwise Specified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). These disorders are all characterized by problems in emotional and behavioral self-control. Because of its close association with conduct disorder, antisocial personality disorder has dual listing in this chapter and in the chapter on personality disorders. Of note, ADHD is frequently comorbid with the disorders in this chapter but is listed with the neurodevelopmental disorders.

Oppositional Defiant Disorder

Four refinements have been made to the criteria for oppositional defiant disorder. First, symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that the disorder reflects both emotional and behavioral symptomatology. Second, the exclusion criterion for conduct disorder has been removed. Third, given that many behaviors associated with symptoms of oppositional defiant disorder occur commonly in normally developing children and adolescents, a note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder. Fourth, a severity rating has been added to the criteria to reflect research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

Conduct Disorder

The criteria for conduct disorder are largely unchanged from DSM-IV. A descriptive features specifier has been added for individuals who meet full criteria for the disorder but also present with limited prosocial emotions. This specifier applies to those with conduct disorder who show a callous and unemotional interpersonal style across multiple settings and relationships. The specifier is based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.

Intermittent Explosive Disorder

The primary change in DSM-5 intermittent explosive disorder is the type of aggressive outbursts that should be considered: physical aggression was required in DSM-IV, whereas verbal aggression and nondestructive/noninjurious physical aggression also meet criteria in DSM-5. DSM-5 also provides more

specific criteria defining frequency needed to meet criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences. Furthermore, because of the paucity of research on this disorder in young children and the potential difficulty of distinguishing these outbursts from normal temper tantrums in young children, a minimum age of 6 years (or equivalent developmental level) is now required. Finally, especially for youth, the relationship of this disorder to other disorders (e.g., ADHD, disruptive mood dysregulation disorder) has been further clarified.

Substance-Related and Addictive Disorders

Gambling Disorder

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

Criteria and Terminology

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study"). Of note, the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so the criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5. Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include "in a controlled environment" and "on maintenance therapy" as the situation warrants.

Neurocognitive Disorders

Delirium

The criteria for delirium have been updated and clarified on the basis of currently available evidence.

Major and Mild Neurocognitive Disorder

The DSM-IV diagnoses of dementia and amnestic disorder are subsumed under the newly named entity

major neurocognitive disorder (NCD). The term dementia is not precluded from use in the etiological subtypes where that term is standard. Furthermore, DSM-5 now recognizes a less severe level of cognitive impairment, mild NCD, which is a new disorder that permits the diagnosis of less disabling syndromes that may nonetheless be the focus of concern and treatment. Diagnostic criteria are provided for both major NCD and mild NCD, followed by diagnostic criteria for the different etiological subtypes. An updated listing of neurocognitive domains is also provided in DSM-5, as these are necessary for establishing the presence of NCD, distinguishing between the major and mild levels of impairment, and differentiating among etiological subtypes.

Although the threshold between mild NCD and major NCD is inherently arbitrary, there are important reasons to consider these two levels of impairment separately. The major NCD syndrome provides consistency with the rest of medicine and with prior DSM editions and necessarily remains distinct to capture the care needs for this group. Although the mild NCD syndrome is new to DSM-5, its presence is consistent with its use in other fields of medicine, where it is a significant focus of care and research, notably in individuals with Alzheimer's disease, cerebrovascular disorders, HIV, and traumatic brain injury.

Etiological Subtypes

In DSM-IV, individual criteria sets were designated for dementia of the Alzheimer's type, vascular dementia, and substance-induced dementia, whereas the other neurodegenerative disorders were classified as dementia due to another medical condition, with HIV, head trauma, Parkinson's disease, Huntington's disease, Pick's disease, Creutzfeldt-Jakob disease, and other medical conditions specified. In DSM-5, major or mild vascular NCD and major or mild NCD due to Alzheimer's disease have been retained, whereas new separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson's disease, HIV infection, Huntington's disease, prion disease, another medical condition, and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

Personality Disorders

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III. For the general criteria for personality disorder presented in Section III, a revised personality functioning criterion (Criterion A) has been developed based on a literature review of reliable clinical measures of core impairments central to personality pathology. Furthermore, the moderate level of impairment in personality functioning required for a personality disorder diagnosis in DSM-5 Section III was set empirically to maximize the ability of clinicians to identify personality disorder pathology accurately and efficiently. With a single assessment of level of personality functioning, a clinician can determine whether a full assessment for personality disorder is necessary. The diagnostic criteria for specific DSM-5 personality disorders in the alternative model are consistently defined across disorders by typical impairments in personality functioning and by characteristic pathological personality traits that have been empirically determined to be related to the personality disorders they represent. Diagnostic thresholds for both Criterion A and Criterion B have been set empirically to minimize change in disorder prevalence and overlap with other personality disorders and to maximize relations with psychosocial impairment. A diagnosis of personality disorder—trait specified, based on moderate or greater impairment in personality functioning and the presence of pathological personality traits, replaces personality disorder not otherwise specified and provides a much more

informative diagnosis for patients who are not optimally described as having a specific personality disorder. A greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders.

Personality functioning and personality traits also can be assessed whether or not an individual has a personality disorder, providing clinically useful information about all patients. The DSM-5 Section III approach provides a clear conceptual basis for all personality disorder pathology and an efficient assessment approach with considerable clinical utility.

Paraphilic Disorders

Specifiers

An overarching change from DSM-IV is the addition of the course specifiers "in a controlled environment" and "in remission" to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual's status. There is no expert consensus about whether a long-standing paraphilia can entirely remit, but there is less argument that consequent psychological distress, psychosocial impairment, or the propensity to do harm to others can be reduced to acceptable levels. Therefore, the "in remission" specifier has been added to indicate remission from a paraphilic disorder. The specifier is silent with regard to changes in the presence of the paraphilic interest per se. The other course specifier, "in a controlled environment," is included because the propensity of an individual to act on paraphilic urges may be more difficult to assess objectively when the individual has no opportunity to act on such urges.

Change to Diagnostic Names

In DSM-5, paraphilias are not ipso facto mental disorders. There is a distinction between paraphilias and paraphilic disorders. A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention.

The distinction between paraphilias and paraphilic disorders was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm—or risk of harm—to others).

The change for DSM-5 is that individuals who meet both Criterion A and Criterion B would now be diagnosed as having a paraphilic disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B—that is, to those individuals who have a paraphilia but not a paraphilic disorder.

The distinction between paraphilias and paraphilic disorders is one of the changes from DSM-IV that applies to all atypical erotic interests. This approach leaves intact the distinction between normative and nonnormative sexual behavior, which could be important to researchers or to persons who have nonnormative sexual preferences, but without automatically labeling nonnormative sexual behavior as

psychopathological. This change in viewpoint is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilias. Thus, for example, DSM-IV pedophilia has become DSM-5 pedophilic disorder.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.DSM5.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact Eve Herold at 703-907-8640 or press@psych.org.

INCORPORATION BY REFERENCE SYNOPSIS

In compliance with Section 67-5223(4), Idaho Code, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

DEPARTMENT OF HEALTH AND WELFARE
IDAPA 16.03.09 – "Medicaid Basic Plan Benefits"
Proposed Rulemaking -- Docket No. 16-0309-2301

(Include a brief description that explains the differences between the version of the materials or documents that are currently incorporated by reference and the materials or documents that are being proposed for adoption in this rulemaking.)

(You may use the following table or write a summary of the differences)

Incorporated Document Version/URL	IDAPA Section Number	Current Version of Incorporated Document	Substantive Changes in New Incorporation by Reference Version
State Travel Policy and Procedures Updated January 17, 2023 https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx	16.03.09. 004.06	**Travel Policies and Procedures of the Idaho State Board of Examiners**	**State Travel Policy and Procedures**
Document is the same. The name was unclear before and made determining the correct document confusing.			