Dear Senators LODGE, Broadsword & Werk, and
Representatives BLOCK, Nielsen & Henbest:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Health & Welfare: 16.03.09 Medicaid Benefits Plan - Therapists.

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 10-17-08. 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 11-17-08.

_____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 334-2475, or send a written request to the address or FAX number indicated on the memorandum enclosed.

MEMORANDUM

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

FROM: Research & Legislation Staff - Paige Alan Parker

DATE: September 29, 2008

SUBJECT: Department of Health and Welfare - IDAPA 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-0803) (Proposed))

By this Proposed and Temporary Rule docket, the Department of Health and Welfare amends IDAPA 16.03.09 (Docket No. 16-0309-0803)(hereinafter "proposed rule").

The Department states that since Medicare no longer certifies therapists who only work with children and does not certify speech-language pathologists at all, rule changes are required to clarify which providers of therapy services can be enrolled as independent Medicaid providers, under what circumstance Medicare certification is required and to reflect Medicare's decision to extend the required physician recertification period for a therapy services plan of care. The Department also states that the rule is being made to reform Medicaid's mental health program to help minimize duplication in service, eliminate overlapping components and contradictory requirements, better match benefits to needs and better ensure program resources are appropriately used and delivered.

According to the Department, the proposed rule is authorized pursuant to sections 56-202(b), 56-203(g) and (I) and 56-250 through 56-257, Idaho Code. Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority. Section 56-203, Idaho Code, provides the Department with various powers, including to define persons entitled to medical assistance in such terms as will meet requirements for federal participation in medical assistance payments and to determine the amount, duration and scope of care and services to be purchased as medical assistance on behalf of needy eligible individuals. Sections 56-250 through 56-257, Idaho Code, are part of the Idaho Medicaid Simplification Act, adopted by the Legislature in 2006. Pursuant to section 56-253(8), Idaho Code, the Department's Director is given the authority to promulgate rules consistent with the Act.

According to the Department, no fee or charge is imposed by the proposed rule. The Department states that the incorporation of new evidenced-based benefits and best practices over the next three years will slow the expenditure growth of Medicaid-paid mental health service

while improving quality and maintaining access. The Department states that cost containment will be achieved by establishing clear assessment criteria and by reducing inappropriate utilization. The Department states that there is no anticipated fiscal impact related to the changes to rules associated with occupational therapy and speech-language pathology services.

According to the Department, negotiated rulemaking was not conducted but that stakeholder meetings were conducted that included the Mental Health Providers Association, National Alliance for the Mentally Ill, Office of Consumer Affairs and Technical Assistance, Idaho Federation of Families, Idaho Psychological Association, National Association of Social Workers, and various mental health services providers and participants. No meetings were held with regard to changes to therapy services because the professional associations whose members provide these services favor the proposed rule.

The Department states that public hearings will be held on Friday, October 10th in Pocatello, Wednesday, October 15th in Coeur d'Alene, and Friday, October 17th in Boise. All written comments must be delivered to the Department on or before October 22, 2008.

ANALYSIS

Stylistic and housekeeping changes will not be discussed herein. Organizational changes will be discussed only when substantive.

The proposed rule provides a new definition for "collateral contact," as the "coordination of care communication that is initiated by a medical or qualified professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team." New to the definition is what "collateral contact" is to be used for: "coordinate care between professionals who are serving the participant," "relay medical results and explanations to members of the participant's interdisciplinary team," or "conduct an intermittent treatment plan review with the participant and his interdisciplinary team." Section 010.16.

Twelve new definitions are added to Mental Health Clinic Services - Definitions, section 707. Of these, only "serious emotional disturbance" is defined in statute at section 16-2403, Idaho Code, dealing with children's mental health services. The proposed rule's definition of "serious emotional disturbance" basically tracks the statute's definition, but modifies that definition by deleting the statement, "a disorder shall be considered to 'result in a serious disability' if it causes substantial impairment of functioning in family, school or community," and by adding "conduct disorder" and "development disorder" as conditions that, alone, do not constitute a serious emotional disturbance but that may co-exist with such a disturbance. Section 707.14. Defining terms in rule that are contrary to established statutory definitions should be discouraged.

Of the remaining definitions, "interdisciplinary team," "licensed practitioner of the healing arts," "psychotherapy," and "serious mental illness" are also defined in other rules

promulgated by the Department or by another agency. None of these terms are identically defined. Varying definitions between rule chapters is not inherently confusing if the definition is operational to the specific chapter, but an effort toward consistency should be maintained.

The definition of "interdisciplinary team" in the proposed rule ("[g]roup that consists of two (2) or more individuals in addition to the participant, the participant's legal guardian, and the participant's natural supports, including professionals from several fields who combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan") is more detailed than the definition in IDAPA 16.03.13.010.11, dealing with "Prior Authorization for Behavioral Health Services" ("the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration"). Section 707.05.

To the list of "licensed practitioner of the healing arts"stated in IDAPA 16.06.12.010.13, "Rules Governing the Idaho Child Care Program (ICCP)" (licensed physician, physician assistant, nurse practitioner or clinical nurse specialist), the proposed rule adds the qualification that "[t]he nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication." Section 707.06.

"Psychotherapy" is defined in IDAPA 24.14.01.010.03, "Rules of the State Board of Social Work Examiners," as "[t]reatment methods using a specialized, formal interaction between a Clinical Social Worker and an individual, couple, family, or group in which a therapeutic relationship is established, maintained, or sustained to understand unconscious processes, intrapersonal, interpersonal, and psychosocial dynamics, and the diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions." In contrast, the proposed rule uses the abbreviated definition: "A method of treating and managing psychiatric disorders through the use of evidence-based psychotherapeutic modalities that focus on behavioral and cognitive aspects of a participant's abilities." Section 707.11.

The proposed rule states that its definition of "serious mental illness" is in accordance with the Federal Register, Volume 58, page 29422 (June 24, 1999). The date of this citation is in error and should be May 20, 1993. The proposed rule does not specifically list the disorders that are included within its definition, stating, instead, that the person "[c]urrently 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-IV-TR . . . ." Federal Register at Vol. 58, p. 29425, states that "[t]hese disorders include any mental disorder (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-III-R 'V' codes, substance use disorders and developmental disorders, which are excluded, unless then co-occur with another diagnosable serious mental illness." In contrast to IDAPA 16.07.33.010.16, "Adult Mental Health Services," specifically lists schizophrenia, paranoia and other psychotic disorders, bipolar disorders (mixed, manic and depressive), major depressive disorders (single episode or recurrent), schizoaffective disorders and obsessive-compulsive disorders. The proposed rule also lists the criteria required

to qualify as a "serious mental illness":

> Must have a functional impairment which 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. 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.

Section 707.15.

The other newly defined terms in the proposed rule are: "comprehensive diagnostic assessment," "functional assessment," "intake assessment," "objective," "recovery model," "restraints" and "treatment plan review." Many of these terms have been previously used in the Department's rule without definition. All appear to be context appropriate. Of interest, "restraints" includes not only "the use of physical, mechanical, or chemical interventions to modify participant behavior" but also "the use of seclusion to attempt to modify participant behavior." Section 707.13.

New mental health services participant eligibility requirements are mandated by the proposed rule. Eligibility must be established through described assessment services and include an intake assessment, a functional assessment and a comprehensive psychiatric diagnostic interview exam. Section 708. Additional requirements for establishing eligibility for mental health clinic services are a history and physical examination completed by the participant's primary care physician within the last 12 months immediately proceeding the initiation of these services (and annually thereafter), a referral to the mental health clinic by a Healthy Connections physician (if the participant belongs to the Healthy Connections program), and establishment that the requested services are therapeutically appropriate and can be provided by the clinic. Section 708.01 through .03.

The proposed rule establishes a six month timeframe for treatment plans. A prior authorization from the Department is required if the interdisciplinary team determines that the treatment plan should continue after six months. Sections 709. And 709.05. The proposed rule clarifies that the statement of overall goals are to be developed by the participant or his legal guardian and that the treatment plan must reflect those goals. In addition, the treatment plan must address the identified emotional, behavioral and skill training needs, must be specific to the type of interventions used and must specify the frequency and anticipated duration of therapeutic services. Section 709.02.a. The treatment plan must be signed by the participant and his legal guardian indicating their agreement with the identified service needs. Section 709.02.b.ii.

The intake assessment is the vehicle by which the participant's diagnosis is documented under the proposed rule. The treatment plan is a direct response to the intake and assessment

process. Section 709.02.c. The issues for which treatment is being sought are prioritized in the treatment plan. Section 709.02.d. The treatment plan must: include tasks that are specific, time-limited activities and interventions designed to accomplish the recommended and agreed to objectives; specify the anticipated place of service, frequency of services, type of services and the person responsible to provide the service; and include discharge criteria and aftercare plans. Section 709.02.e and f.

Intermittent treatment plan reviews must be conducted when medically necessary and with the participant or his legal guardian at least every 120 days. The proposed rule clarifies that those participating in the review include the participant's legal guardian and interdisciplinary team. Section 709.03. Changes in the duration of services must be reviewed and signed by a physician. Section 709.04.

Under the proposed rule, an intake assessment is a reimbursable evaluation service. Sections 710.a.i and ii of the proposed rule describe who must perform the intake assessment and the contents of that assessment. In doing so, these sections paraphrase to a large extent the definition of "intake assessment" found at section 707.04. This duplication using similar, but not identical language is confusing.

The functional assessment is a reimbursable evaluation service when the comprehensive diagnostic evaluation indicates that the participant may benefit from rehabilitative skill training. Section 710.02.b. That section describes who must perform the functional assessment and the contents of the assessment that largely duplicates the definition of "functional assessment" found at section 707.03 and that may generate confusion since the language varies between these sections.

A comprehensive psychiatric diagnostic interview exam (formerly termed a "psychiatric diagnostic interview exam") delivered by qualified registered occupational therapists in conjunction with the development of an individualized treatment plan is no longer a reimbursable service under the proposed rule. Section 710.03.c.

The proposed rule clarifies that the focus of family psychotherapy includes methods to create changes for unhealthy patterns within the family structure as it relates to the participant. Section 710.05. The proposed rule also clarifies that emergency services provided to an eligible participant prior to intake and evaluation must be fully documented in the participant's medical record in order to be a reimbursable service. Section 710.06.a.

The proposed rule no longer requires collateral contact to "provide interpretation or explanation of results of psychiatric evaluations, medical examinations and procedures, other accumulated data to family or other responsible persons" in order to be a reimbursable service but does require that collateral contact be necessary to gather and exchange information with members of the participant's interdisciplinary team. Section 710.07.

Pharmacological management must be specified on the participant's individualized treatment plan and must include the frequency and duration of treatment in order to be a reimbursable service. Section 710.08. In order to be reimbursable, nursing services must be included as part of the participant's individualized treatment plan. Section 710.09.

Provider agencies must properly document a Healthy Connections referral in the participant's medical record. Section 714.01. The proposed rule specifies treatment staff-to-participant ratios for group treatment: 1:1 for children under six years (no group work allowed); 1:6 for child age six to age 12 (group not to exceed 12 participants); and 1:10 for children over age 12 (group not to exceed 12 participants). Section 714.03.

The proposed rule provides that family participation requirements be observed when services are provided to children. For children under age six, the legal guardian must be present and available for consultation; for children age six to age 12, the legal guardian must be "actively involved" - not required to participate in the training session but present and available for consultation; and for children over age 12, the legal guardian may participate as appropriate, unless the interdisciplinary team recommends and documents that the legal guardian not be involved. Section 714.04.

Physician involvement is clarified by the proposed rule. Section 714.07. The physician must see the participant at least once annually; must review and sign the individualized treatment plan as an indicator that the services are medically necessary; and must sign all intermittent treatment plan reviews that represent substantial changes in the goals, objectives or services.

The proposed rule provides a detailed discussion on the use of restraints. Section 714.12. Restraints and seclusion must only be used when the participant's behavior poses a threat of physical harm to himself or others. (Note, "seclusion" is included within the definition of "restraints" at section 707.13). If an agency intends to use restraints to deal with maladaptive participant behavior, it must: incorporate the use into the participant's individualized treatment plan; develop and implement specified written policies and procedures; complete a specified incident report for each use; and have a qualified staff person develop a behavior modification plan following the use of restraints which must be approved by the interdisciplinary team. The proposed rule specifies that restraints cannot be used for punishment, staff convenience or the lack of staff's ability to manage the participant's behavior and that aversive techniques or interventions are not allowed under any circumstances.

The proposed rule clarifies that clinic facilities must successfully pass the annual inspection by the local fire authority. Section 714.15.d.i.

The proposed rule adds "licensed associate marriage and family therapist" to the list of individuals authorized to deliver treatment services to Medicaid participants and deletes a "registered occupational therapist" from that list. Section 715.01. Added to the list of qualified staff persons who may develop an individualized treatment plan is a "licensed associate marriage

and family therapist. Deleted from that list is a "licensed social worker." Section 715.03. A "licensed associate marriage and family therapist" must be supervised as described in IDAPA 25.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists," to provided psychotherapy. Section 715.05.j.

The proposed rule changes the frequency in which extended therapy services must be reordered (subject to exceptions) from 30 days to 90 days. Section 733.01.a.

The proposed rule clarifies that therapists must be licensed by the appropriate state licensing board in order to be reimbursed on a fee-for-service basis. Exceptions to the Medicare certification requirement are provider types that Medicare does not certify, such as speech-language pathologists, and providers that only treat pediatric participants and do not expect to treat Medicare participants. The proposed rule further clarifies that only those independent providers who have been enrolled as Medicaid providers can bill the Department directly for their services. Section 735.

SUMMARY

Except as discussed above, the Department's proposed rule appears to be authorized under sections 56-202(b), 56-203 and 56-253(8), Idaho Code.

cc: Pat Guidry, Department of Health and Welfare
Tamara Prisock, Department of Health and Welfare, Administrative Procedures Section

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0803

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

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

FRIDAY OCTOBER 10, 2008 1:00 pm MDT	WEDNESDAY OCTOBER 15, 2008 1:00 pm PDT	FRIDAY OCTOBER 17, 2008 9:00 am MDT
H & W Region VI Office Room 210 421 Memorial Dr. Pocatello, ID	H & W Region I Office Large Conference Room 1120 Ironwood Drive Coeur d'Alene, ID	Medicaid Central Office Conference Room D&E 3232 Elder Street Boise, ID

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.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In the 2008 legislature, a rule change was approved in this chapter that allows Medicaid to enroll occupational therapists and speech-language pathologists as independent Medicaid providers. Current rules allow physical therapists, occupational therapists, and speech-language pathologists to be independent Medicaid providers, but they must first obtain Medicare certification. Medicare no longer certifies therapists who only work with children, and they do not certify speech-language pathologists at all. Rule changes are being made to further clarify which providers of therapy services can be enrolled and reimbursed as Medicaid providers, and under what circumstances Medicare certification is required. Rule changes were also made to reflect Medicare's decision to extend the required physician recertification period for a therapy services plan of care.

Rules changes are also being made to reform Medicaid's mental health program to: (1) help minimize duplication of mental health services, (2) eliminate overlapping components and contradictory requirements, (3) better match mental health benefits to participant's needs, and (4) better ensure that mental health program resources are appropriately used and services are delivered by qualified providers.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: NA

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

These rule changes reflect year one of a three-year planning process to incorporate new evidenced-based benefits and best practices. Also included are changes which improve the management of existing benefits, incorporating standards and applying appropriate limits. As rules are further defined, costs and cost-containment details will be identified. The overall impact is anticipated to slow the expenditure growth of Medicaid-paid mental health services while improving quality and maintaining access. Cost containment will be achieved by establishing clear assessment criteria and reducing inappropriate utilization. There is no anticipated fiscal impact related to the changes to rules associated with occupational therapy and speech language pathology services.

NEGOTIATED RULEMAKING: Pursuant to 67-5220(2), Idaho Code, negotiated rulemaking was not conducted

However, the Department conducted stakeholder meetings that included the Mental Health Providers Association, National Alliance for the Mentally Ill, Office of Consumer Affairs and Technical Assistance, Idaho Federation of Families, Idaho Psychological Association, National Association of Social Workers, and various participants receiving mental health services and providers of mental health services. The Department did not hold meetings regarding the changes to therapy services because the professional associations whose members provide these services are in favor of the clarifications found in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Pat Guidry at (208) 364-1813.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 22, 2008.

DATED this 5th day of August, 2008.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5564 phone (208) 334-6558 fax
dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0803

010. DEFINITIONS -- A THROUGH H.
For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. AABD. Aid to the Aged, Blind, and Disabled. (3-30-07)

02. Abortion. The medical procedure necessary for the termination of pregnancy endangering the life of the woman, or the result of rape or incest, or determined to be medically necessary in order to save the health of the woman. (3-30-07)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-30-07)

04. Ambulatory Surgical Center (ASC). Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (3-30-07)

05. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (3-30-07)

06. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-30-07)

07. Audit Reports. (3-30-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-30-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-30-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-30-07)

08. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-30-07)

09. Basic Plan. The medical assistance benefits included under this chapter of rules. (3-30-07)

10. Buy-In Coverage. The amount the State pays for Part B of Title XVIII of the Social Security Act on behalf of the participant. (3-30-07)

11. Certified Registered Nurse Anesthetist (CRNA). A Registered Nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations. (3-30-07)

12. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-30-07)

13. CFR. Code of Federal Regulations. (3-30-07)

14. Clinical Nurse Specialist. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-30-07)

15. CMS. Centers for Medicare and Medicaid Services. (3-30-07)

16. Collateral Contact. ~~*Contact made with a parent, guardian, or other individual having a primary relationship to the patient by an appropriately qualified treatment professional. The contact must be ordered by a physician, contained in the treatment plan, directed at the medical treatment of the patient, and documented in the progress notes or continuous service record.*~~ Coordination of care communication that is initiated by a medical or qualified professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. This service must appear on the treatment plan and must be documented in the progress notes of the participant's medical record. Collateral contact is used to: ~~*(3-30-07)*~~( )

a. Coordinate care between professionals who are serving the participant; ( )

b. Relay medical results and explanations to members of the participant's interdisciplinary team; or ( )

c. Conduct an intermittent treatment plan review with the participant and his interdisciplinary team. ( )

17. Co-Payment. The amount a participant is required to pay to the provider for specified services. (3-30-07)

18. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-30-07)

19. Customary Charges. Customary charges are the rates charged to Medicare participants and to

patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in Chapter 3, Sections 310 and 312, PRM. (3-30-07)

20. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-30-07)

21. Director. The Director of the Idaho Department of Health and Welfare or his designee. (3-30-07)

22. Dual Eligibles. Medicaid participants who are also eligible for Medicare. (3-30-07)

23. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a ~~*medical assistance*~~ Medicaid participant. ~~*(3-30-07)*~~( )

24. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-30-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-30-07)

b. Serious impairment to bodily functions. (3-30-07)

c. Serious dysfunction of any bodily organ or part. (3-30-07)

25. EPSDT. Early and Periodic Screening, Diagnosis, and Treatment. (3-30-07)

26. Facility. Facility refers to a hospital, nursing facility, or intermediate care facility for persons with mental retardation. (3-30-07)

27. Federally Qualified Health Center (FQHC). An entity that meets the requirements of 42 U.S.C Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. (3-30-07)

28. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-30-07)

29. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to an existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-30-07)

30. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-30-07)

31. Home Health Services. Services ordered by a physician and performed by a licensed nurse, registered physical therapist, or home health aide as defined in IDAPA 16.03.07, "Rules for Home Health Agencies." (3-30-07)

32. Hospital. A hospital as defined in Section 39-1301, Idaho Code. (3-30-07)

33. Hospital-Based Facility. A nursing facility that is owned, managed, or operated by, or is otherwise

a part of a licensed hospital. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

707. MENTAL HEALTH CLINIC SERVICES - DEFINITIONS.

01. Adult. An adult is an individual who is eighteen (18) years of age or older for the purposes of Mental Health Clinic and other outpatient mental health services. (3-30-07)

02. Comprehensive Diagnostic Assessment. A thorough assessment of the participant's current condition and complete medical and psychiatric history. The comprehensive diagnostic assessment must incorporate information typically gathered in an intake assessment process if an intake assessment has not been completed by the provider agency conducting the comprehensive diagnostic assessment. The comprehensive diagnostic assessment must include: ( )

a. A current mental status examination; ( )

b. A description of the participant's readiness and motivation to engage in treatment, participate in the development of his treatment plan and adhere to his treatment plan; and ( )

c. The five (5) axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity, and expected duration of treatment services. ( )

03. Functional Assessment. In rehabilitative mental health, this assessment is used to provide supplemental information to the comprehensive diagnostic assessment and provides information on the current or required capabilities needed by a participant to maintain himself in his chosen environment. It is a description and evaluation of the participant's practical ability to complete tasks that support activities of daily living, family life, life in the community, and promote independence. This assessment assists participants to better understand what skills they need to achieve their rehabilitation goals. ( )

04. Intake Assessment. An initial assessment of the participant that is conducted by an agency staff person who has been trained to perform mental status examinations and solicit sensitive health information for the purpose of identifying service needs prior to developing an individualized treatment plan. The intake assessment must contain a description of the reason(s) the participant is seeking services and a description of the participant's current symptoms, present life circumstances across all environments, recent events, resources, and barriers to mental health treatment. If this is the initial screening process then it must be used to determine whether mental health services are a medical necessity for the participant. ( )

05. Interdisciplinary Team. Group that consists of two (2) or more individuals in addition to the participant, the participant's legal guardian, and the participant's natural supports, including professionals from several fields who combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan. ( )

06. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication. ( )

02~~7~~. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. (3-30-07)

08. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and identifies specific behavior changes. ( )

0~~3~~9. Psychiatric Nurse, Licensed Master's Level. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (3-30-07)

***0~~4~~*10. Psychological Testing**. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (3-30-07)

11. Psychotherapy. A method of treating and managing psychiatric disorders through the use of evidenced-based psychotherapeutic modalities that focus on behavioral and cognitive aspects of a participant's abilities. ( )

12. Recovery Model. An evidence-based treatment model that supports healing and transformation, enabling a participant with a mental health problem to live a meaningful life in a community of his choice while striving to achieve his full potential. It includes services for participants to build their skills to promote and manage their overall wellness. ( )

13. Restraints. Restraints include the use of physical, mechanical, or chemical interventions to modify participant behavior. It also includes the use of seclusion to attempt to modify participant behavior. ( )

14. Serious Emotional Disturbance (SED). In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is: ( )

a. An emotional or behavioral disorder, according to the DSM-IV-TR which results in a serious disability; and ( )

b. Requires sustained treatment interventions; and ( )

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. ( )

d. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. ( )

15. Serious Mental Illness (SMI). In accordance with Volume 58 of the Federal Register, 29422-02, June 24, 1999, a person with SMI: ( )

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-IV-TR; and ( )

b. Must have a functional impairment which 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. 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. ( )

***0~~5~~*16. Social History**. A social history contains a description of the reason(s) the participant is seeking services, a description of his current symptoms, present life circumstances, recent events, his resources, and barriers to mental health treatment. (3-30-07)

17. Treatment Plan Review. The practice of holding a meeting among members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant while providing feedback and suggestions intended to help team members and the participant to accomplish the participant's goals as identified on the participant's treatment plan. ( )

708. MENTAL HEALTH CLINIC SERVICES - PARTICIPANT ELIGIBILITY.
~~*If an individual who is not eligible for medical assistance receives intake services from any staff not having the required degree(s) as provided in Subsection 715.03 of these rules, and later becomes eligible for medical assistance, a new intake assessment and individualized treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement.*~~ Eligibility must be established through the assessment services described under Subsections 710.03.a. through 710.03.c. of these rules. The following are requirements for establishing eligibility for mental health clinic services. ~~*(3-30-07)*~~( )

01. History and Physical Examination. The participant must have a history and physical examination that has been completed by his primary care physician within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Mental health services must not be delayed due to the scheduling of the history and physical examination. ( )

02. Healthy Connections Referral. A participant who belongs to the Healthy Connections program must be referred to the mental health clinic by his Healthy Connections physician. ( )

03. Establishment of Service Needs. The initial assessment of the participant must establish that the services requested by the participant or his legal guardian are therapeutically appropriate and can be provided by the clinic. ( )

04. Conditions That Require New Intake Assessment and Individualized Treatment Plan. If an individual who is not eligible for Medicaid receives intake services from any staff who does not have the qualifications required under Subsection 715.03 of these rules, and later becomes eligible for Medicaid, a new intake assessment and individualized treatment plan are required, which must be developed by a professional listed at IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. ( )

709. MENTAL HEALTH CLINIC SERVICES - WRITTEN INDIVIDUALIZED TREATMENT PLAN.
A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Timeframes for treatment plans must not exceed six (6) months. After six (6) months of treatment, if the interdisciplinary team determines that the treatment plan should continue, the provider must obtain a prior authorization from the Department. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules.
~~*(3-30-07)*~~( )

01. Individualized Treatment Plan Development. The individualized treatment plan must be developed by the following: (3-30-07)

a. The ~~*clinic*~~ treatment staff providing the services; and ~~*(3-30-07)*~~( )

b. The ~~*adult*~~ participant, if capable, and ~~*the adult participant's*~~ his legal guardian~~*, or in the case of a minor the minor's parent or legal guardian*~~. The participant ~~*or his parent or*~~ and his legal guardian may also choose others to participate in the development of the plan. ~~*(3-30-07)*~~( )

02. Individualized Treatment Plan Requirements. An individualized treatment plan must include, at a minimum, the following: (3-30-07)

a. Statement of the overall goals as identified by the participant or his legal guardian and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized~~*, and must be directly related to the clinic service needs that are identified in the assessment*~~ must reflect the goals chosen by the participant or his legal guardian and address the emotional, behavioral, and skill training needs identified by the participant or his legal guardian through the intake and assessment process. The treatment goals must be specific to the type of interventions used and must specify the frequency and anticipated duration of therapeutic services. ~~*(3-30-07)*~~( )

b. Documentation of who participated in the development of the individualized treatment plan. (3-30-07)

i. The authorizing physician must sign and date the plan within thirty (30) calendar days of the initiation of treatment. (3-30-07)

ii. The ~~*adult*~~ participant~~, *the adult participant's*~~ and his legal guardian~~, or in the case of a minor the minor's parent or legal guardian~~ must sign the treatment plan indicating their agreement with service needs identified and their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the ~~*adult*~~ participant and his legal guardian~~ or to his parent or legal guardian if the participant is a minor~~. ~~*(3-30-07)*~~( )

iii. Other individuals who participated in the development of the treatment plan must sign the plan. (3-30-07)

iv. The author of the treatment plan must sign and date the plan and include his title and credentials. ~~*(3-30-07)*~~( )

c. ~~*The diagnosis of the participant must be documented by an examination and be made by a licensed physician or other licensed practitioner of the healing arts, licensed psychologist, licensed clinical professional counselor, licensed clinical social worker, or licensed marriage and family therapist within the scope of his practice under state law; and*~~ The treatment plan must be created in direct response to the findings of the intake and assessment process. ~~*(3-30-07)*~~( )

d. ~~*A problem*~~ The treatment plan must include a prioritized list of issues for which treatment is being sought, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services. ~~*(3-30-07)*~~( )

e. Tasks that are specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan that are recommended by the participant's interdisciplinary team and agreed to by the participant or his legal guardian. Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to provide the service. ( )

f. Discharge criteria and aftercare plans must also be identified on the treatment plan. ( )

03. Treatment Plan Reviews. The agency staff must conduct intermittent treatment plan reviews ~~*by the clinic and the participant must occur*~~ when medically necessary. The intermittent treatment plan reviews must be conducted with~~*in*~~ the participant or his legal guardian at least every one hundred twenty (120) days~~ and every one hundred twenty (120) days thereafter~~. During the reviews, the ~~*clinic*~~ agency staff providing the services, ~~*and*~~ the participant, and any other members of the participant's interdisciplinary team as identified by the participant or his legal guardian must review the progress the participant has made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the ~~*adult*~~ participant or his legal guardian~~, or in the case of a minor his parent or legal guardian~~ and ~~*clinic*~~ agency staff providing the services. ~~*(3-30-07)*~~( )

04. Physician Review of Treatment Plan. Each individualized treatment plan must be reviewed and be completely rewritten and signed by a physician at least annually. Changes in the types, duration, or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan. ~~*(3-30-07)*~~( )

05. Continuation of Services. Continuation of services after ~~*the first year*~~ six (6) months must be based on documentation of the following: ~~*(3-30-07)*~~( )

a. Description of the ways the participant has specifically benefited from ~~*clinical*~~ mental health services, and why he continues to need additional ~~*clinical*~~ mental health services; and ~~*(3-30-07)*~~( )

b. The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue. (3-30-07)

710. MENTAL HEALTH CLINIC SERVICES - COVERAGE AND LIMITATIONS.
All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual. (3-30-07)

01. Clinic Services -- Mental Health Clinics (MHC). Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 229. (3-30-07)

02. Services or Supplies in Mental Health Clinics That Are Not Reimbursed. Any service or supplies not included as part of the allowable scope of ~~*the Medical Assistance Program*~~ Medicaid. ~~*(3-30-07)*~~( )

03. Evaluation and Diagnostic Services in Mental Health Clinics. (3-30-07)

a. ~~*Social History*~~ An intake assessment is a reimbursable evaluation ~~*and diagnostic*~~ service. ~~*(1-1-08)T*~~( )

i. The intake assessment must be conducted by staff trained to perform mental status examinations and to conduct interviews intended to solicit sensitive health information for the purpose of identifying a participant's treatment needs and developing an individualized treatment plan. ( )

ii. The intake assessment must be documented in the participant's medical record and must contain a current mental status examination and a review of the participant's strengths and needs. ( )

b. Functional assessment is a reimbursable evaluation service when the comprehensive diagnostic evaluation indicates that the participant may benefit from rehabilitative skill training. A functional assessment must be conducted by a qualified staff person capable of assessing a participant's strengths and needs. The functional assessment must describe and evaluate the participant's practical ability to complete tasks that support activities of daily living, family life, life in the community, and that promote independence. ( )

c. A comprehensive psychiatric diagnostic interview exam is a reimbursable service when delivered by one (1) of the following licensed professionals: ( )

i. Psychiatrist; ( )

ii. Physician; ( )

iii. Practitioner of the healing arts; ( )

iv. Psychologist; ( )

v. Clinical Social Worker; ( )

vi. Clinical Professional Counselor; or ( )

vii. Licensed Marriage and Family Therapist. ( )

~~*b*~~**d.** Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. The psychological report must contain the reason for the performance of this service. Agency staff may deliver this service if they meet one (1) of the following qualifications: (1-1-08)T

i. Licensed Psychologist; (3-30-07)

ii. Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of

Psychologist Examiners"; or (3-30-07)

iii. A qualified therapist listed in Subsection 715.03 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. (3-30-07)

~~*c. A psychiatric diagnostic interview exam may be provided as a reimbursable service when delivered by one (1) of the following licensed professionals:* (1-1-08)T~~

~~*i. Psychiatrist;* (3-30-07)~~

~~*ii. Physician;* (3-30-07)~~

~~*iii. Practitioner of the healing arts;* (3-30-07)~~

~~*iv. Psychologist;* (3-30-07)~~

~~*v. Clinical Social Worker;* (3-30-07)~~

~~*vi. Clinical Professional Counselor; or* (3-30-07)~~

~~*vii. Licensed Marriage and Family Therapist.* (3-30-07)~~

~~*d. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of an individualized treatment plan are reimbursable.* (1-1-08)T~~

04. Psychotherapy Treatment Services in Mental Health Clinics. Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan as described in Section 709 of these rules. (1-1-08)T

05. Family Psychotherapy. Family psychotherapy services must be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. The focus of family psychotherapy is on the dynamics within the family structure as it relates to the participant and methods to create change for unhealthy patterns. ~~(1-1-08)T~~( )

a. Family psychotherapy services with the participant present must: (1-1-08)T

i. Be face-to-face with at least one (1) family member present in addition to the participant; (1-1-08)T

ii. Focus the treatment services on goals identified in the participant's individualized treatment plan; and (1-1-08)T

iii. Utilize an evidence-based treatment model. (1-1-08)T

b. Family psychotherapy without the participant present must: (1-1-08)T

i. Be face-to-face with at least one (1) family member present; (1-1-08)T

ii. Focus the services on the participant; and (1-1-08)T

iii. Utilize an evidence-based treatment model. (1-1-08)T

06. Emergency Psychotherapy Services. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (1-1-08)T

a. Emergency services provided to an eligible participant prior to intake and evaluation is a

reimbursable service but must be fully documented in the participant's medical record; and ~~(3-30-07)~~( )

b. Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations even when contact does not result in the hospitalization of the participant. (3-30-07)

07. Collateral Contact. Collateral contact, as defined in Section 010 of these rules, is ~~*covered by Medicaid if*~~ a reimbursable service when it is included on the individualized treatment plan and it is necessary to gather and exchange information~~, *provide interpretation or explanation of results of psychiatric evaluations, medical examinations and procedures, other accumulated data to family or other responsible persons*,~~ with members of the participant's interdisciplinary team, or advise them how to assist the participant. ~~(1-1-08)T~~( )

a. Collateral contact ~~*may*~~ can be provided face-to-face by agency staff ~~*qualified to deliver clinical*~~ providing treatment services. Face-to-face contact is defined as two (2) or more people meeting in person at the same time: ~~(1-1-08)T~~( )

b. Collateral contact ~~*may*~~ can be provided by telephone by agency staff ~~*qualified to deliver clinical*~~ providing treatment services when this is the most expeditious and effective way to exchange information. ~~(1-1-08)T~~( )

08. Pharmacological Management. Pharmacological management is a reimbursable service when consultations ~~*must be*~~ are provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. ~~(3-30-07)~~( )

a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the participant's individualized treatment plan; and ~~(3-30-07)~~( )

b. Pharmacological management, if provided, must be ~~*part of the*~~ specified on the participant's individualized treatment plan and must include the frequency and duration of the treatment ~~*must be specified*~~. ~~(3-30-07)~~( )

09. Nursing Services. Nursing services~~,~~ are reimbursable when physician ordered and supervised, ~~*can be*~~ and included as part of the participant's individualized treatment plan. ~~(3-30-07)~~( )

a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (3-30-07)

b. The frequency and duration of the treatment must be specified on the participant's individualized treatment plan. (3-30-07)

10. Limits on Mental Health Clinic Services. Services provided by Mental Health Clinics are limited to twenty-six (26) services per calendar year. This is for any combination of evaluation, diagnosis and treatment services. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and individualized treatment plan development provided to an eligible participant in a calendar year. (1-1-08)T

711. MENTAL HEALTH CLINIC SERVICES - EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.

01. Inpatient Medical Facilities. ~~*The Medical Assistance Program*~~ Medicaid will not pay for mental health clinic services rendered to ~~*medical assistance*~~ eligible participants residing in inpatient medical facilities including nursing homes, hospitals, or public institutions as defined in 42 CFR 435.1009; or ~~(3-30-07)~~( )

02. Non-Reimbursable. ~~*Any service not adequately documented in the participant's record by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department.*~~ The Department will not reimburse a service unless the

participant's medical record includes the signature and credential of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact. ~~*(3-30-07)*~~( )

03. Non-Eligible Staff. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 715.03 of these rules is not be eligible for reimbursement by the Department. (3-30-07)

04. Recoupment. If a record is determined not to meet minimum requirements as set forth herein, any payments made on behalf of the participant are subject to recoupment. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

713. ~~*MENTAL HEALTH CLINIC SERVICES - PROVIDER RESPONSIBILITIES*~~ (RESERVED).

~~***01. Effectiveness of Services.*** *Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's one hundred twenty (120) day review.* *(3-30-07)*~~

~~***02. Healthy Connections Referral.*** *Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program.* *(3-30-07)*~~

714. MENTAL HEALTH CLINIC SERVICES - PROVIDER AGENCY REQUIREMENTS.
Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements: (3-30-07)

01. Healthy Connections Referral. Provider agencies must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program and document the referral in the participant's medical record. Provider agencies must document compliance with the requirements under Subsection 708.01 of these rules. ( )

02. Effectiveness of Services. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included in the participant's treatment plan review. ( )

03. Staff to Participant Ratio. The following treatment staff-to-participant ratios for group treatment services must be observed: ( )

a. For children under six (6) years of age, the ratio must be 1:1. No group work is allowed. ( )

b. For children six (6) to twelve (12) years of age, the ratio must be 1:6 for groups. Group size must not exceed twelve (12) participants. ( )

c. For children over age twelve (12) years of age, the ratio must be 1:10 ratio for groups. Group size must not exceed twelve (12) participants. ( )

04. Family Participation Requirement. The following standards must be observed for services provided to children: ( )

a. For children under six (6) years of age, the participant's legal guardian must be present during the delivery of mental health services. The legal guardian does not have to participate in the treatment session, but must be present and available for consultation with the staff providing the service; ( )

b. For children six (6) to twelve (12) years of age, the participant's legal guardian must be actively involved. The legal guardian does not have to participate in the treatment session but must be present and available for consultation with the staff providing the service; ( )

c. For children over age twelve (12) years of age, the participant's legal guardian may participate as appropriate. If the interdisciplinary team recommends that the legal guardian not be involved in any aspect of the treatment, then the reasons for excluding the legal guardian must be documented in the medical record. ( )

0~~1~~5. Mental Health Clinic. Each location of the agency must meet the requirements under this rule. (3-30-07)

0~~2~~6. Physician Requirement for Clinic Supervision. In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician. (3-30-07)

a. The contract must specifically require that the physician spend as much time in the clinic as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice. (3-30-07)

b. The supervising physician of the clinic may also serve as the supervising physician of a participant's care. (3-30-07)

0~~3~~7. Physician Requirement for Supervision of a Participant's Care. Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met: (3-30-07)

a. The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided; (3-30-07)

b. The physician must see the participant at least once annually to determine the medical necessity and appropriateness of clinic services; ~~(3-30-07)~~( )

c. The physician must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed; and ~~(3-30-07)~~( )

d. The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services and must sign all intermittent treatment plan reviews that represent substantial changes in the goals, objectives, or services. ~~(3-30-07)~~( )

0~~4~~8. Intake Assessment. All treatment in mental health clinics must be based on an ~~individualized~~ intake assessment of the participant's needs, ~~including a current mental status examination,~~ defined in Section 707 of these rules and provided under the direction of a licensed physician. ~~(3-30-07)~~( )

0~~5~~9. Criminal History Checks. (3-30-07)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Criminal History and Background Checks."(3-30-07)

b. Once an employee, subcontractor, or agent of the agency has met the requirements specified in Subsection 009.02.a. of these rules, he may begin working for the agency on a provisional basis. (3-30-07)

c. Once an employee, subcontractor, or agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction. (3-30-07)

~~06~~**10.** **Agency Employees and Subcontractors**. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (3-30-07)

~~07~~**11.** **Supervision**. The agency must ensure that staff providing clinical services are supervised according to the following guidelines: (3-30-07)

a. Standards and requirements for supervision set by the Bureau of Occupational Licenses are met; (3-30-07)

b. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (3-30-07)

c. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-30-07)

12. **Restraints and Seclusion**. Restraints and seclusion must only be used when the participant's behavior poses a threat of physical harm to himself or others. If an agency intends to use restraints to deal with maladaptive participant behavior the following conditions must be in place: ( )

a. Use of physical prompts, restraints, and seclusion to manage maladaptive participant behavior must be incorporated into the participant's individualized treatment plan. ( )

b. The agency must develop and implement written policies and procedures outlining: ( )

i. Medical necessity of restraints; ( )

ii. Conditions or triggers which will prompt use of restraints; ( )

iii. Type(s) of restraints which will be used; ( )

iv. How long a restraint may be used; ( )

v. Treatment staff in the clinic who will be authorized to employ restraints; ( )

vi. The training or certification of staff qualified to employ restraints; ( )

vii. How the agency will monitor use of restraints so as to not result in physical, mental, or emotional injury to the participant; and ( )

viii. Agency notification requirements for use of restraints to include notification of the participant's parent or legal guardian, and physician. ( )

c. The agency will complete an incident report for each use of restraints documenting the following: ( )

i. Type of restraint; ( )

ii. Restraint start time; ( )

iii. Triggering condition or behavior; ( )

iv. Staff member employing restraint; ( )

v. Restraint end time; ( )

vi. Participant response to the restraint intervention; and ( )

vii. Alternate methods attempted and results prior to the use of restraints or seclusion. ( )

d. Following the use of restraints or seclusion, a behavior modification plan must be developed by a qualified staff person and approved by the interdisciplinary team. ( )

e. Restraints or seclusion cannot be used for punishment, staff convenience, or lack of staff's ability to manage the participant's behavior. ( )

f. Adversive techniques or interventions are not allowed under any circumstances. ( )

***08*13. Continuing Education**. The agency must ensure that all staff complete twenty (20) hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (3-30-07)

***09*14. Ethics**. (3-30-07)

a. The provider must adopt, adhere to and enforce a Code of Ethics on its staff who are providing Medicaid reimbursable services. The Code of Ethics must be similar to or patterned after one (1) of the following: (3-30-07)

i. US Psychiatric Rehabilitation Association Code of Ethics found at http://www.uspra.org/i4a/pages/index.cfm?pageid=3601; (3-30-07)

ii. National Association of Social Workers Code of Ethics found at http://www.naswdc.org/pubs/code/default.asp; (3-30-07)

iii. American Psychological Association Code of Ethics found at http://www.apa.org/ethics/code.html; (3-30-07)

iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx. (3-30-07)

v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/lrm_plan/ethics/ethicscode2001.asp. (3-30-07)

b. The Provider must develop a schedule for providing ethics training to its staff. (3-30-07)

c. The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four (4) hours every four (4) years thereafter. (3-30-07)

d. Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the Code must be submitted to the Department upon request. (3-30-07)

1*0*5. Building Standards For Mental Health Clinics. (3-30-07)

a. Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (3-30-07)

b. Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (3-30-07)

c. Capacity. Clinics must provide qualified staff as listed in Subsection 715.01 of ~~*this*~~ these rules to

meet a staff to participant ratio required under Subsection 714.03 of this rule that ensures safe, effective and clinically appropriate interventions. ~~(3-30-07)~~( )

d. Fire and Safety Standards. (3-30-07)

i. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority and successfully pass the inspection. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and ~~(3-30-07)~~( )

ii. The clinic facility must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (3-30-07)

iii. In clinic facilities where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (3-30-07)

iv. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (3-30-07)

v. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (3-30-07)

vi. Flammable or combustible materials must not be stored in the clinic facility; and (3-30-07)

vii. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (3-30-07)

viii. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (3-30-07)

ix. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 714.1~~0~~5.d. of this rule; and ~~(3-30-07)~~( )

x. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved in writing by the local fire or building authority. (3-30-07)

xi. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (3-30-07)

xii. Furnishings, decorations or other objects must not obstruct exits or access to exits. (3-30-07)

e. Emergency Plans and Training Requirements. (3-30-07)

i. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (3-30-07)

ii. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (3-30-07)

iii. All employees must participate in fire and safety training upon employment and at least annually

thereafter; and (3-30-07)

iv. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (3-30-07)

v. A brief summary of the fire drill and the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (3-30-07)

f. Food Preparation and Storage. (3-30-07)

i. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared using sanitary methods. (3-30-07)

ii. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and served over one hundred forty (140F) degrees Fahrenheit. (3-30-07)

iii. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. (3-30-07)

iv. When meals are prepared or provided for by the clinic, meals must be nutritional. (3-30-07)

g. Housekeeping and Maintenance Services. (3-30-07)

i. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (3-30-07)

ii. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (3-30-07)

iii. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (3-30-07)

iv. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and (3-30-07)

v. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (3-30-07)

vi. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (3-30-07)

h. Firearms. No firearms are permitted in the clinic facility. (3-30-07)

i. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (3-30-07)

j. Lighting. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided. (3-30-07)

k. Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department. (3-30-07)

715. MENTAL HEALTH CLINIC SERVICES - AGENCY STAFF QUALIFICATIONS.

01. Staff Qualifications. The mental health clinic must assure that each agency staff person delivering ~~*clinical*~~ treatment services to eligible ~~*medical assistance*~~ Medicaid participants has, at a minimum, one (1) or more of the following qualifications: ~~*(3-30-07)*~~( )

a. Licensed Psychiatrist; (3-30-07)

b. Licensed Physician or Licensed Practitioner of the healing arts; (3-30-07)

c. Licensed Psychologist; (3-30-07)

d. Psychologist Extender, registered with the Bureau of Occupational Licenses; (3-30-07)

e. Licensed Masters Social Worker; (3-30-07)

f. Licensed Clinical Social Worker; (3-30-07)

g. Licensed Social Worker; (3-30-07)

h. Licensed Clinical Professional Counselor; (3-30-07)

i. Licensed Professional Counselor; (3-30-07)

j. Licensed Marriage and Family Therapist; (3-30-07)

k. Licensed Associate Marriage and Family Therapist; ( )

~~*k*~~**l.** Certified Psychiatric Nurse, R.N., as described in Subsection 707.03 of these rules; or ~~*(3-30-07)*~~( )

~~*l*~~**m.** Licensed Professional Nurse, R.N.~~*; or*~~ ~~*(3-30-07)*~~( )

~~***m.*** *Registered Occupational Therapist, O.T.R.* *(3-30-07)*~~

02. Support Staff. For the purposes of this rule, support staff is any person who does not meet the qualifications of professionals as listed in Subsection 715.01 of this rule. The agency may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid. (3-30-07)

03. Qualified ~~*Therapist*~~ Interdisciplinary Treatment Planning Staff. The ~~*social history and*~~ individualized treatment plan development is reimbursable if conducted by a ~~*primary therapist*~~ qualified staff person who, at a minimum, has one (1) or more of the following qualifications: ~~*(3-30-07)*~~( )

a. Licensed Psychologist; (3-30-07)

b. Psychologist Extender, registered with the Bureau of Occupational Licenses; (3-30-07)

c. Licensed Masters Social Worker~~*, or Licensed Clinical Social Worker, or Licensed Social Worker*~~; ~~*(3-30-07)*~~( )

d. Licensed Clinical Social Worker; ( )

~~*d*~~**e.** Certified Psychiatric Nurse, R.N.; (3-30-07)

~~*e*~~**f.** Licensed Clinical Professional Counselor~~*or Licensed Professional Counselor*~~; ~~*(3-30-07)*~~( )

g. Licensed Professional Counselor; ( )

~~f~~h. Licensed Physician ~~*or Licensed Psychiatrist*~~; ~~*(3-30-07)*~~( )

i. Licensed Psychiatrist; ( )

~~g~~j. Licensed Marriage and Family Therapist; ~~*or*~~ ~~*(3-30-07)*~~( )

k. Licensed Associate Marriage and Family Therapist; or ( )

~~h~~l. Licensed Professional Nurse. ~~(~~R.N~~)~~. ~~*(3-30-07)*~~( )

04. Non-Qualified Staff. Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Sections 710 or 715 of these rules, is not eligible for reimbursement under the ~~*Medical Assistance Program*~~ Medicaid. ~~*(3-30-07)*~~( )

05. Staff Qualifications for Psychotherapy Services. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 710.0~~5~~4~~.a.~~ through 710.~~5~~4~~.c.~~ of these rules must have, at a minimum, one (1) or more of the following degrees: ~~*(3-30-07)*~~( )

a. Licensed Psychiatrist; (3-30-07)

b. Licensed Physician; (3-30-07)

c. Licensed Psychologist; (3-30-07)

d. Licensed Clinical Social Worker; (3-30-07)

e. Licensed Clinical Professional Counselor; (3-30-07)

f. Licensed Marriage and Family Therapist; (3-30-07)

g. Certified Psychiatric Nurse (RN), as described in Subsection 707.03 of these rules; (3-30-07)

h. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 715.~~1~~05.a. through 715.~~1~~0.g. of this rule; ~~*(3-30-07)*~~( )

i. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ~~*or*~~ ~~*(3-30-07)*~~( )

j. Licensed Associate Marriage and Family Therapist whose provision of psychotherapy is supervised as described in IDAPA 25.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or ( )

~~j~~k. A Psychologist Extender, registered with the Bureau of Occupational Licenses. (3-30-07)

716. MENTAL HEALTH CLINIC SERVICES - RECORD REQUIREMENTS FOR PROVIDERS.

01. ~~*Social Histories*~~ Intake Assessments. ~~*Social histories*~~ Intake assessments must be contained in all participant medical records. ~~*(3-30-07)*~~( )

02. Informed Consent. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For minors, informed consent must be obtained from the minor's parent or legal guardian. (3-30-07)

03. Documentation. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. (3-30-07)

04. Data. All data gathered must be directed towards formulation of a written diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (3-30-07)

05. Mental Health Clinic Record-Keeping Requirements. (3-30-07)

a. Maintenance. Each mental health clinic will be required to maintain records on all services provided to ~~*medical assistance*~~ Medicaid participants. ~~*(3-30-07)*~~( )

b. Record Contents. The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Section 709 of this rule. (3-30-07)

c. Requirements. The records must: (3-30-07)

i. Specify the exact type of treatment provided; and (3-30-07)

ii. Who the treatment was provided by; and (3-30-07)

iii. Specify the duration of the treatment and the time of day delivered; and (3-30-07)

iv. Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and (3-30-07)

v. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

733. THERAPY SERVICES - PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by or under the supervision of a licensed therapist if such services are ordered by the attending physician, nurse practitioner, or physician assistant as part of a plan of care. (4-2-08)

01. Physician Orders. (4-2-08)

a. All therapy must be ordered by a physician, nurse practitioner, or physician assistant. Such orders must include at a minimum, the service to be provided, the frequency, and, where applicable, the duration of each therapeutic session. (4-2-08)

b. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every ~~*thirty*~~ ninety (~~*3*~~90) days for all participants with the following exceptions: ~~*(4-2-08)*~~( )

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. (4-2-08)

ii. Therapy for individuals with chronic medical conditions, as documented by physician, nurse practitioner, or physician assistant, must be reordered at least every six (6) months. (4-2-08)

02. Level of Supervision. (4-2-08)

a. General supervision of therapy assistants is required when therapy services are provided by outpatient hospitals, nursing facilities, home health agencies, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, and providers of school-based services. (4-2-08)

b. Direct supervision of therapy assistants is required when therapy services are provided by independent practitioners. (4-2-08)

c. All therapy services provided in a developmental disabilities agency must be provided by the therapist in accordance with IDAPA 16.04.11, "Developmental Disabilities Agencies." (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

735. THERAPY SERVICES - PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (4-2-08)

02. Payment Procedures. Payment procedures are as follows: (3-30-07)

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Rules for Home Health Agencies." (4-2-08)

b. Therapists identified by Medicare as independent practitioners, licensed by the appropriate state licensing board and enrolled as Medicaid providers will be reimbursed on a fee-for-service basis. ~~*The maximum fee paid will be based upon the Department's fee schedule, available from the Medicaid Central Office, see Section 005 of these rules.*~~ Exceptions to the requirement for Medicare certification include:

i. Provider types that Medicare does not certify as is the case for speech-language pathologists; and ( )

ii. Providers that only treat pediatric participants and do not expect to treat Medicare participants. ( )

iii. Only ~~*these*~~ those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid, the contact information for which is found in Section 005 of these rules. ~~*(4-2-08)*~~( )

c. Therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (4-2-08)

d. Payment for therapy services rendered to participants in long-term care facilities or Developmental Disabilities Agencies is included in the facility or agency reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (4-2-08)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (4-2-08)