Dear Senators LODGE, Broadsword, Bock, and
Representatives MCGEACHIN, Bilbao, Rusche:

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

IDAPA 16.02.02 - Rules Pertaining To the Emergency Medical Services (EMS) Physician Commission (Docket No. 16-0202-1101);

IDAPA 16.02.25 - Rules Pertaining To The Fees Charged by the State Laboratory - Fee Rule (Docket No. 16-0225-1101);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1102);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1103);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1104);

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1103);

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1104);

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1105);

IDAPA 16.03.13 - Rules Pertaining To The Consumer-Directed Services (Docket No. 16-0313-1101).

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 08/29/2011. 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 09/27/2011.

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 334-4845, or send a written request to the address or FAX number indicated on the memorandum enclosed.

Legislative Services Office
Idaho State Legislature

Jeff Youtz
Director

Serving Idaho's Citizen Legislature

MEMORANDUM

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

FROM: Legislative Research Analyst - Ryan Bush

DATE: August 10, 2011

SUBJECT: Department of Health and Welfare

IDAPA 16.02.02 - Rules Pertaining To the Emergency Medical Services (EMS) Physician Commission (Docket No. 16-0202-1101)

IDAPA 16.02.25 - Rules Pertaining To The Fees Charged by the State Laboratory - Fee Rule (Docket No. 16-0225-1101)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1102)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1103)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1104)

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1103)

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1104)

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1105)

IDAPA 16.03.13 - Rules Pertaining To The Consumer-Directed Services (Docket No. 16-0313-1101)

(1) 16.02.02 - Emergency Medical Services (EMS) Physician Commission (Docket No. 16-0202-1101)

The Emergency Medical Services (EMS) Physician Commission submits notice of proposed rulemaking at IDAPA 16.02.02 - Rules of the Emergency Medical Services (EMS) Physician Commission. The Commission states that it is revising its standards manual that is incorporated by reference to ensure that the most recent edition of the manual has the force and effect of law. Specifically, this rulemaking incorporates by reference the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2012-1, and removes the incorporation by reference of edition 2011-1.

The Commission states that negotiated rulemaking was not conducted because the content of the proposed update already represents extensive input from stakeholders.

The proposed rule appears to be within the authority granted to the Commission in Section 56-1023, Idaho Code.

(2) 16.02.25 - Fees Charged by the State Laboratory - Fee Rule (Docket No. 16-0225-1101)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.02.25 - Fees Charged by the State Laboratory - Fee Rule. The Department states that in order to reduce the technicality of test names, specific test methods will no longer be listed. The Department further states that in order to streamline and simplify fees and make the rule more understandable, it is updating a consolidated list of laboratory tests and their respective fees and is adding general categories and fees to implement new testing methods. Specifically, this rulemaking accomplishes the following:

(1) Removes test methods incorporated by reference and removes the associated definitions;

(2) Eliminates certain laboratory tests and associated fees;

(3) Adds new laboratory tests and associated fees;

(4) Revises the names of certain laboratory tests;

(5) Raises the fees for certain laboratory tests;

(6) Lowers the fees for certain laboratory tests.

The Department states that negotiated rulemaking was not conducted because the changes simplify and clarify the content based on feedback from stakeholders. There is no negative fiscal impact resulting from this rulemaking.

The proposed rule appears to be within the authority granted to the Department in Sections 56-1003(3)(b) and 56-1007, Idaho Code.

(3) 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-1102)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.09 - Medicaid Basic Plan Benefits. The Department states that the proposed rulemaking is continuing rule changes published as temporary rules under Docket No. 16-0309-1004, in the September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, regarding changes in hospital floor reimbursement percentage and the reduction to outpatient hospital costs. The temporary rule under Docket No. 16-0309-1004 expired on June 30, 2011. The Department further states that the proposed rulemaking updates references to statutes in the Legal Authority section that were repealed, amended and added by House Bill No. 260. The proposed rule also revises the definition of customary hospital charges.

The Department states that negotiated rulemaking was not conducted because the rulemaking was in response to 2011 legislation. The Department states that the state general fund savings associated with this rulemaking are estimated to be $388,000 for the state fiscal year 2012 and was included in the Department's appropriations for state fiscal year 2012.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

(4) 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-1103)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.09 - Medicaid Basic Plan Benefits. The Department's rulemaking is prompted by House Bill No. 260 that was passed by the 2011 Legislature. The Department states the proposed rulemaking revises Medicaid eligible participants' dental services to align the rules with House Bill No. 260 as codified in Section 56-255(5)(c), Idaho Code. Specifically, this rulemaking sets forth the following: terms for dental services, dental coverage

for children, limitations of children's orthodontics, dental coverage and limitations for adults, dental coverage for pregnant women, benefit limitations, procedural requirements, provider qualifications and duties, provider reimbursement and quality assurance. The proposed rule appears to comply with the requirements of House Bill No. 260 as codified in Section 56-255(5)(c), Idaho Code.

The Department states that negotiated rulemaking was not conducted because the rulemaking was in response to 2011 legislation. The Department states the proposed rule changes are estimated to result in cost savings of $2,101,600 ($632,900 in state funds and $1,468,700 in federal funds) for state fiscal year 2012.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

(5) 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-1104)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.09 - Medicaid Basic Plan Benefits. The Department's rulemaking is prompted by House Bill No. 260 that was passed by the 2011 Legislature. The Department states that the rule changes are needed to continue cost saving measures begun in state fiscal year 2011 as well as to align the rules with House Bill No. 260 as codified in Sections 56-255, 56-257 and 56-260 through 56-266, Idaho Code. The purpose of House Bill No. 260 is to reduce health care costs in the Medicaid budget and improve the health care delivery system in Medicaid.

We contacted the Department with questions relating to two of the proposed rule changes. In regard to participant eligibility and coverage and limitations for podiatrist services found in Sections 541 and 542 on page 67, the Department notes that the acute and preventive foot care services defined in the chronic care guidelines are those acute and preventive services that arise in a patient who is already being treated for a chronic condition. In regard to mental health clinic services found in Section 713 on page 77, the Department notes that the provisions of Section 713 are an attempt to develop a utilization program for psychosocial rehabilitation services. The proposed rule, including the sections discussed above, appears to comply with the requirements of House Bill No. 260 as codified in Sections 56-255, 56-257 and 56-260 through 56-266, Idaho Code.

The Department states that negotiated rulemaking was not conducted because the rulemaking was done to bring this chapter of rules into compliance with House Bill No. 260 that was passed by the 2011 Legislature. The Department states that the proposed rule changes are estimated to result in cost savings of $1,417,000 to the state general fund for state fiscal year 2012. The Department has included the cost savings in the appropriations for state fiscal year 2012.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b), 56-253(8) and 56-264, Idaho Code.

(6) 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1103)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits. The Department's rulemaking is prompted by House Bill No. 260 that was passed by the 2011 Legislature. The Department states the proposed rulemaking revises Medicaid eligible participants' dental services to align the rules with House Bill No. 260 as codified in Section 56-255(5)(c), Idaho Code. The Department states that the proposed rule provides children access to prevention, diagnosis and treatment services defined in federal law and limits adult coverage to medically necessary services with the exception that pregnant women have access to dental services that reflect evidence-based practice. The proposed rule also sets forth benefit limitations, procedural requirements, provider qualifications and duties, provider reimbursement and quality assurance for dental services. Specifically, this rulemaking adds a selective contract for dental coverage, revises definitions, revises participant eligibility, revises dental coverage for children, eliminates coverage for certain dental procedures and revises adult dental services. The proposed

rule appears to comply with the requirements of House Bill No. 260 as codified in Section 56-255(5)(c), Idaho Code.

The Department states that negotiated rulemaking was not conducted because the rulemaking was in response to 2011 legislation. The Department states that the proposed rule changes are estimated to result in cost savings of $4,438,200 ($1,336,600 state funds and $3,101,600 federal funds) for state fiscal year 2012.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

(7) 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1104)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits. The Department's rulemaking is prompted by House Bill No. 260 that was passed by the 2011 Legislature. The Department states that the rule changes implement legislative intent language in House Bill No. 260 regarding nursing facilities and intermediate care facilities for people with intellectual disabilities. The Department further states that the proposed rule continues reimbursement methodologies for mental health clinics, developmental disability agencies and rehabilitative mental health service providers that were implemented in 2010. The Department notes that the proposed rule updates the legal authority section for repealed, amended and new statutes. Specifically, this rulemaking accomplishes the following:

(1) Establishes reimbursement and cost surveys for enhanced outpatient mental health services, psychosocial rehabilitative services, DDA services, adult developmental disabilities waiver services and service coordinators;

(2) Revises the date of discharge for nursing facilities;

(3) Revises rates and cost limits for nursing facilities;

(4) Revises rates for intermediate care facilities.

The proposed rule appears to comply with the requirements of House Bill No. 260.

The Department states that negotiated rulemaking was not conducted because the rulemaking was in response to 2011 legislation. The Department states that the proposed rule changes represent $1,023,740 of the $4,700,000 general fund savings related to pricing and inflation freeze changes identified in House Bill No. 260 and was included Department's state fiscal year 2012 appropriations.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b), 56-253(8) and 56-1610, Idaho Code.

(8) 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1105)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits. The Department's rulemaking is prompted by House Bill No. 260 that was passed by the 2011 Legislature. The Department states that the proposed rule changes are needed to continue cost saving measures begun during state fiscal year 2011 as well as to align the rules with House Bill No. 260 as codified in Sections 56-255, 56-257 and 56-260 through 56-266, Idaho Code. The purpose of House Bill No. 260 is to reduce health care costs in the Medicaid budget and improve the health care delivery system in Medicaid. Specifically, the proposed rule revises developmental disability services, refines the developmental disability individual budget modification process and reduces adult psychosocial rehabilitation hours. The proposed rule appears to comply with the requirements of House Bill No. 260 as codified in Sections 56-255, 56-257 and 56-260 through 56-266, Idaho Code.

The Department states that negotiated rulemaking was not conducted because the rulemaking was done to bring this chapter of rules into compliance with House Bill No. 260 that was passed by the 2011 Legislature. The Department states that the total estimated cost savings for state fiscal year 2012 to the state general fund for these rule changes is $10,863,000 and was included in the Department's appropriations for state fiscal year 2012.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b), 56-253(8) and 56-264, Idaho Code.

(9) 16.03.13 - Consumer-Directed Services (Docket No. 16-0313-1101)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.13 - Consumer-Directed Services. The Department's rulemaking is prompted by House Bill No. 260 that was passed by the 2011 Legislature. The Department states the proposed rulemaking aligns the rules with House Bill No. 260 as codified in Section 56-255(3)(f), Idaho Code, by requiring the Department to respond to requests for budget modifications for individual developmental disabilities only when health and safety issues are identified and meet the criteria as defined in rule. In addition, the proposed rulemaking updates legal authority and revises a definition. The proposed rule appears to comply with the requirements of House Bill No. 260 as codified in Section 56-255(3)(f), Idaho Code.

The Department states that negotiated rulemaking was not conducted because the rulemaking was done to bring this chapter of rules into compliance with House Bill No. 260 that was passed by the 2011 Legislature. The Department states that the total estimated cost savings to the state general fund for these rule changes for state fiscal year 2012 has already been included in the fiscal impact statement and the Department's appropriations for state fiscal year in the PARF under Docket No. 16-0310-1105.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

cc: Department of Health and Welfare
Tamara Prisock
Wayne Denny
Tamara Hogg
Robert Kellerman
Arla Farmer
Paul Leary
Paige Grooms

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.02 - RULES OF THE EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-1101

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 56-1013A and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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:

To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law.

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

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.

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the content of the proposed updates to the EMS Physician Commission Standards Manual already represents extensive input from stakeholders gathered during 2010.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2012-1, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being published in this chapter of rules due to its length and format.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Wayne Denny at (208) 334-4000.

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 August 24, 2011.

DATED this 28th day of June, 2011.

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

THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 16-0202-1101

004. INCORPORATION BY REFERENCE.
The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~1~~2-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the internet or from the EMS Bureau located at 650 W. State Street, Suite B-17, Boise, Idaho, 83702, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036.
~~*(4-7-11)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.25 - FEES CHARGED BY THE STATE LABORATORY

DOCKET NO. 16-0225-1101

NOTICE OF RULEMAKING - PROPOSED FEE 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 56-1003 and 56-1007, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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:

This proposed rulemaking is needed to streamline and simplify the fees for laboratory tests, make the rule more understandable and more user-friendly, and allow the Bureau greater flexibility to respond to public health concerns.

The fee sections will be updated with a consolidated list of laboratory tests offered by the Bureau of Laboratories and their respective fees, as well as general categories and fees to implement new testing methods in a timely manner to respond to public health concerns. To reduce the technicality of the test names, the specific test methods will no longer be listed in the tables found in the body of these rules. As a result, the test methods incorporated by reference are no longer needed and will be removed. The associated definitions will also be removed.

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

This rulemaking will increase a number of the fees charged for laboratory tests performed by the State Lab, while reducing others. The Director's authority to administer state laboratories is found in Section 56-1003(3)(b), Idaho Code. The authority to set fees is found in Section 56-1007, Idaho Code.

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.

No fiscal impact is associated with this rulemaking. The Bureau's calculations, based on SFY 2010 testing levels, indicate that the change in fees will not result in a decrease or increase of receipts.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the changes under this docket simplify and clarify the content, based on feedback from stakeholders since the chapter was put into place in the Spring of 2010.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules. Further, all the existing incorporations by reference are being removed from the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Tamara Hogg at (208) 334-2235 x262.

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 August 24, 2011.

DATED this 1st day of July, 2011.

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

THE FOLLOWING IS THE PROPOSED TEXT OF FEE DOCKET NO. 16-0225-1101

004. INCORPORATION BY REFERENCE.
There ~~following~~ are no documents incorporated by reference in this chapter of rules~~:~~. ~~(3-29-10)~~( )

~~**01. ASTM**. D3977-97 Standard Test Methods for Determining Sediment Concentration in Water Samples (2002). American Society for Testing and Materials (ASTM) International.~~ ~~(3-29-10)~~

~~**02. BAM**. Bacteriological Analytical Manual (BAM). U.S. Department of Health and Human Services, U.S. Food and Drug Administration (FDA).~~ ~~(3-29-10)~~

~~**03. EPA**. The following are analytical test methods published by the U.S. Environmental Protection Agency (EPA).~~ ~~(3-29-10)~~

~~**a.** Approved general-purpose methods.~~ ~~(3-29-10)~~

~~**b.** Approved industry specific methods.~~ ~~(3-29-10)~~

~~**c.** Oil and Grease Measurements.~~ ~~(3-29-10)~~

~~**d.** EPA 8000 Series Methods.~~ ~~(3-29-10)~~

~~**e.** Reference Method for the Determination of Fine Particulate Matter as PM 2.5 in the Atmosphere. 40 CFR Part 50, Appendix L, 2006.~~ ~~(3-29-10)~~

~~**f.** Reference Method for the Determination of Particulate Matter as PM 10 in the Atmosphere. 40 CFR Part 50, Appendix J, 1987.~~ ~~(3-29-10)~~

~~**04. NIOSH**. NIOSH Manual of Analytical Methods (NMAM®), 4th edition. P.C. Sclecht and P.F. O'Connor, editors. 1994. U.S. Department of Health and Human Services.~~ ~~(3-29-10)~~

~~**05. SM**. Standard Methods for the Examination of Water and Wastewater, 20th edition. Clesceri, Lenore S., Arnold E. Greenburg, and Andrew D. Eaton, Eds. 1998. American Public Health Association, American Water Works Association, and Water Environment Federation.~~ ~~(3-29-10)~~

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: (3-29-10)

~~***01. ASTM**. Refers to a standard analytical test method published by the American Society for Testing and Materials International, as incorporated by reference under Section 004 of these rules.* (3-29-10)~~

~~***02. BAM**. Refers to a bacteriological analytical test method published by the U.S. Food and Drug Administration, as incorporated by reference under Section 004 of these rules.* (3-29-10)~~

0~~3~~1. **Clinical Laboratory Tests**. Microbiological analysis for diagnosis of infectious diseases affecting human health. (3-29-10)

0~~4~~2. **Department**. Idaho Department of Health and Welfare. (3-29-10)

0~~5~~3. **Director**. The Director of the Idaho Department of Health and Welfare or designee. (3-29-10)

0~~6~~4. **Environmental Laboratory Tests**. Analysis of various samples from air, microbiological, organic, or inorganic sources. (3-29-10)

~~***07. EPA**. Refers to an analytical test method published by the U.S. Environmental Protection Agency, as incorporated by reference under Section 004 of these rules.* (3-29-10)~~

~~***08. NIOSH**. Refers to an analytical test method published by the National Institute for Occupational Safety and Health, as incorporated by reference under Section 004 of these rules.* (3-29-10)~~

~~***09. SM**. Refers to a standard method of water testing published in the Standard Methods for the Examination of Water and Wastewater, as incorporated by reference under Section 004 of these rules.* (3-29-10)~~

~~**1**~~0~~5~~. **State Health Official**. Administrator of the Department's Division of Public Health. (3-29-10)

011. -- 099. (RESERVED)

100. FEES FOR CLINICAL LABORATORY TESTS.

Fees for Clinical Laboratory Tests	
Clinical Test Name	**Fee**
~~*16S rDNA Sequence Analysis*~~	~~*$70.00*~~
~~*Antimicrobial Susceptibility*~~	~~*$62.00*~~
~~*Biochemical Identification System*~~	~~*$38.00*~~
Agglutination - Not Otherwise Specified	$9.00
Bacterial Primary Culture - Not Otherwise Specified	$51.00
Bordetella pertussis, Culture	$~~18~~27.00
~~*Bordetella pertussis, FA*~~	~~*$43.00*~~
Bordetella pertussis, ~~*RT*~~ PCR	$~~25~~42.00
~~*Campylobacter, Confirmation*~~	~~*$23.00*~~
~~*Campylobacter, DNA Probe*~~	~~*$77.00*~~
Chlamydia trachomatis and *Neisseria gonorrhoeae* by Nucleic Acid Amplification	$16.00
Cryptosporidium/Giardia, IFA	$69.00

Fees for Clinical Laboratory Tests	
Clinical Test Name	**Fee**
~~*Cytomegalovirus, IGG Antibody, IFA*~~	~~*$56.00*~~
~~*Cytomegalovirus, IGM Antibody, IFA*~~	~~*$56.00*~~
~~*Diphtheria, Primary Culture*~~	~~*$68.00*~~
Disk Diffusion Test	$~~8~~17.00
~~*Escherichia coli/Shiga Toxin PCR*~~	~~*$98.00*~~
~~*Escherichia coli 0157 Immunocard*~~	~~*$30.00*~~
~~*Escherichia coli 0157:H7, Confirmation*~~	~~*$17.00*~~
~~*Escherichia coli O157:H7, Culture*~~	~~*$11.00*~~
~~*Escherichia coli, Serotyping*~~	~~*$75.00*~~
Enzyme-Linked Immunoassay (EIA) - Not Otherwise Specified	15.00
Enteric Pathogens, Primary Culture ~~*(Salmonella, Shigella, Campylobacter)*~~	$~~24~~68.00
~~*Enteric Pathogens, Primary Culture (Aeromonas spp., Plesiomonas shigelloides, Bacillus cereus, Clostridium perfringens, Staphylococcus aureus, Vibrio spp., Yersinia spp., Listeria monocytogenes)*~~	~~*$63.00*~~
Enterovirus Isolation	$95.00
~~*E Test*~~	~~*$28.00*~~
~~*Fungus, LSU rDNA Sequence Analysis*~~	~~*$70.00*~~
Fluorescent Antibody (FA) - Not Otherwise Specified	$53.00
Hantavirus, IGG & IGM Antibody, EIA	$~~30~~167.00
~~*Hemagglutination Inhibition*~~	~~*$80.00*~~
Hepatitis B, Core Total Antibody, EIA	$15.00
Hepatitis B, Surface Antibody, EIA	$15.00
Hepatitis B, Surface Antigen Confirmation, EIA	$127.00
Hepatitis B, Surface Antigen, EIA	$15.00
Hepatitis C, Antibody, EIA	$20.00
Herpes Simplex Type 1 & Type 2, IGG Antibody, EIA	$35.00
Herpes Simplex Virus Isolation	$53.00
HIV-1/2 Plus O, Antibody, EIA	$15.00
HIV-1, Western Blot	$311.00
Influenza Virus, RT-PCR	$69.00
Legionella, Culture, Clinical	$120.00
Microsphere Immunoassay (MIA) - Not Otherwise Specified	$64.00
Mumps, IGG Antibody, EIA	$15.00
Mumps, IGM Antibody, IFA	$56.00

Fees for Clinical Laboratory Tests	
Clinical Test Name	**Fee**
Mumps, Virus Isolation	$88.00
Mycobacteria, AFS-Fluorochrome	$98.00
~~*Mycobacteria, Biochemical Test*~~	~~*$35.00*~~
Mycobacteria, Drug Susceptibility	$373.00
Mycobacteria, Primary Culture	$~~1~~157.00
Mycobacteria, Reference Culture	$1~~9~~30.00
Mycobacteria, Tuberculosis Quantiferon -TB Gold In Tube	$~~90~~85.00
~~*Mycobacteria, Zeihl-Neelsen Stain*~~	~~*$15.00*~~
~~*Neisseria gonorrhoeae, DNA Probe*~~	~~*$49.00*~~
Neisseria gonorrhoeae, Primary Culture	$~~12~~37.00
Norovirus, RT-PCR	$66.00
~~*Nucleic Acid Probe*~~	~~*$142.00*~~
~~*Parasite Exam, Blood or Tissue*~~	~~*$19.00*~~
Parasite Exam, Concentrate & Trichrome Stain	$~~76~~94.00
~~*Parasite Exam, Gross*~~	~~*$49.00*~~
~~*Parasite Exam, Microscopic*~~	~~*$20.00*~~
Plaque Reduction Neutralization Test (PRNT) - Not Otherwise Specified	$260.00
Polymerase Chain Reaction (PCR) - Not Otherwise Specified	$62.00
Pulsed Field Gel Electrophoresis	$90.00
Rabies, FA	$50.00
rDNA Sequence Analysis	$113.00
Reference Culture, Aerobe	$~~28~~49.00
Reference Culture, Anaerobe	$~~4~~81.00
~~*Reference Culture, Serotyping*~~	~~*$64.00*~~
Respiratory Virus Isolation	$94.00
Rubella, IGG Antibody, EIA	$15.00
Rubella, IGM Antibody, EIA	$~~82~~47.00
Rubeola (Measles), IGG Antibody, EIA	$15.00
Rubeola (Measles), IGM Antibody, EIA	$~~95~~37.00
~~*Salmonella, Serotyping*~~	~~*$37.00*~~
Serotyping	$73.00
Shiga Toxin, Immunoassay	$~~1~~21.00
~~*Shigella, Serogrouping*~~	~~*$30.00*~~

Fees for Clinical Laboratory Tests	
Clinical Test Name	**Fee**
~~*Shigella flexneri, Serogrouping*~~	~~*$30.00*~~
~~*St. Louis Encephalitis, RT-PCR*~~	~~*$52.00*~~
Staphylococcus aureus, Methicillin Resistant (MRSA), Identification/Confirmation	$~~2~~96.00
Staphylococcus aureus, Methicillin Resistant (MRSA), PCR	$~~152~~78.00
Syphilis, Treponema Pallidum Passive Agglutination	$~~3~~43.00
Syphilis, Venereal Disease Research Laboratory (VDRL)	$9.00
Syphilis, Venereal Disease Research Laboratory (VDRL), Quantitative	$6.00
Vancomycin Resistant *Enterococcus* (VRE)	$~~93~~119.00
Vancomycin-Intermediate/Resistant *Staphylococcus aureus* (VISA)	$~~93~~119.00
Varicella Zoster, IGG Antibody, EIA	$15.00
Varicella Zoster, IGM Antibody, IFA	$56.00
Varicella Zoster, Virus Isolation	$91.00
~~*West Nile Virus/St. Louis Encephalitis Virus, CDC MAC ELISA*~~	~~*$81.00*~~
Viral Culture - Not Otherwise Specified	$67.00
West Nile Virus, IGG Antibody Screen, EIA	$73.00
West Nile Virus, IGM Antibody Screen, EIA	$78.00
West Nile Virus/St. Louis Encephalitis Virus IGM Antibody, Microsphere Immunoassay	$~~49~~65.00
West Nile Virus/St. Louis Encephalitis Virus Plaque Reduction Neutralization Test (PRNT)	$278.00
~~*West Nile Virus, IGG Antibody Screen, EIA*~~	~~*$73.00*~~
~~*West Nile Virus, IGM Antibody Screen, EIA*~~	~~*$78.00*~~
West Nile Virus~~/~~St. Louis Encephalitis Virus/Western Equine Encephalitis, RT-PCR	$~~58~~156.00
~~*Western Equine Encephalitis, RT-PCR*~~	~~*$52.00*~~

~~*(3-29-10)*~~( )

101. -- 199. (RESERVED)

200. FEES FOR ENVIRONMENTAL LABORATORY TESTS.

01. Environmental Laboratory Tests, Air -- Table.

Fees for Environmental Laboratory Tests -- Air	
Air Test Name	**Fee**
PM10, EQPM-1102-150, Air	$~~8~~13.00

Fees for Environmental Laboratory Tests -- Air	
Air Test Name	**Fee**
PM25, RFPS-0499-129, Air	$20.00

~~(3-29-10)~~( )

02. Environmental Laboratory Tests, Microbiology -- Table.

Fees for Environmental Laboratory Tests -- Microbiology	
Microbiology Test Name	**Fee**
~~*Bacillus cereus, BAM14, Food or Vegetation*~~	~~$93.00~~
~~*Bacillus cereus, Enterotoxin*~~	~~$96.00~~
~~*Clostridium perfringens ENTER, PET-RPLA*~~	~~$95.00~~
~~*Campylobacter, BAM7, Food or Vegetation*~~	~~$75.00~~
~~*Clostridium perfringens, BAM16*~~	~~$22.00~~
~~*Computer Augmented Identification System*~~	~~$50.00~~
~~*Escherichia coli H7 Confirmation, Latex Agglutination*~~	~~$20.00~~
~~*Escherichia coli O157 Confirmation, Latex Agglutination*~~	~~$20.00~~
Escherichia coli O157:H7~~, 9260F~~	$100.00
~~*Escherichia coli O157:H7, Screen, BAM4A, Food or Vegetation*~~	~~$32.00~~
~~*Escherichia coli, SM 9221F, Soil*~~	~~$28.00~~
~~*Escherichia coli, SM 9221F, Water*~~	~~$26.00~~
~~*ECO, CLPP, Developmental, Water*~~	~~$22.00~~
~~*Fecal Coliform, SM 9221E, Soil*~~	~~$25.00~~
~~*Fecal Coliform, SM 9221E, Water*~~	~~$25.00~~
~~*Fecal Coliform, SM 9222D, Water*~~	~~$22.00~~
Heterotrophic Plate Count~~, SM 9215B-R2A~~	$25.00
~~*Heterotrophic Plate Count, SM 9215B-SPC*~~	~~$25.00~~
~~*Identification of Iron Bacteria, Water*~~	~~$33.00~~
Identification System, Water, Food or Vegetation	$50.00
Legionella, ~~*SM 9260J,*~~ Water	$~~35~~100.00
~~*Listeria Screen, BAM10, Food or Vegetation*~~	~~$75.00~~
Pathogen Screen, Water, Food, or Vegetation	$23.00
Pseudomonas aeruginosa, ~~*SM 9213F,*~~ Water	$~~7~~25.00
Salmonella Confirmation, Water	$75.00
~~*Quanti-Tray, SM 9223B*~~	~~$20.00~~
~~*Salmonella Screen, BAM5, Food or Vegetation, Water*~~	~~$23.00~~

Fees for Environmental Laboratory Tests -- Microbiology	
Microbiology Test Name	**Fee**
~~*Salmonella, SM 9260B, Water*~~	~~*$75.00*~~
~~*Staphylococcus aureus Confirmation, BAM12AUX, Food or Vegetation*~~	~~*$47.00*~~
~~*Staphylococcus aureus Isolation, BAM12, Food or Vegetation, Water*~~	~~*$15.00*~~
~~*Staphylococcal Enterotoxin*~~	~~*$130.00*~~
Total Coliform~~, *SM 9221B, Water*~~/E. coli, Presence/Absence	$~~29~~18.00
~~*Total Coliform, SM 9221BC, Drinking Water*~~	~~*$16.00*~~
~~*Total Coliform, SM 9222B, Water*~~	~~*$18.00*~~
~~*Total Coliform, SM 9223B-PA-CS*~~	~~*$11.00*~~
Total Coliform~~, *SM 9223B-PA-CT*~~/E. coli, Quantitative	$~~18~~20.00
Total Coliform~~, *SM 9223B-QT-CS*~~/Fecal Coliform/E. coli (MPN)	$~~15~~28.00
~~*Total Coliform, SM 9223B-QT-CT*~~	~~*$15.00*~~

~~*(3-29-10)*~~( )

03. Environmental Laboratory Tests, Inorganic -- Table.

Fees for Environmental Laboratory Tests -- Inorganic	
Inorganic Test Name	**Fee**
5-Day BOD, Water	$45.00
Alkalinity ($CaCO_3$), ~~*SM 2320B,*~~ Water	$14.00
Ammonia as N, Water	$18.00
~~*Arsenic Speciation*~~	~~*$150.00*~~
Arsenic, Water	$21.00
~~*BOD-5, SM 5210B, Water*~~	~~*$31.00*~~
Bromate, Water	$100.00
Bromide, Water	$32.00
Chemical Oxygen Demand, Water	$29.00
Chlorate, Water	$100.00
Chloride, Water	$19.00
Chlorite, Water	$150.00
Chlorophyll A~~, *SM 10200H, Water*~~ and Pheophytin A, ~~*SM 10200H,*~~ Water	$~~100~~75.00
Conductivity, ~~*SM 2510B,*~~ Water	$11.00
Corrosivity, Calculation, Water	$59.00
Cyanide, Total, ~~*SM 4500*~~ Water or Soil	$33.00
~~*Cyanide, Total, SM 4500, Water*~~	~~*$33.00*~~

Fees for Environmental Laboratory Tests -- Inorganic	
Inorganic Test Name	**Fee**
Cyanide, WAD, ~~SM 4500,~~ Water or Soil	$33.00
~~Cyanide, WAD, SM 4500, Water~~	~~$33.00~~
Direct Mercury Analysis	$44.00
~~EPA 180.1, Turbidity, Water~~	~~13.00~~
~~EPA 200.2 - Metals Digestion~~	~~$19.00~~
~~EPA 200.7, Dissolved, ICP (Metals Digestion is performed and charged for when turbidity is above 1 NTU)~~	~~$13.00~~
~~EPA 200.7, Drinking Water, ICP (Metals Digestion is performed and charged for when turbidity is above 1 NTU)~~	~~$13.00~~
~~EPA 200.7, Water, ICP (Metals Digestion is performed and charged for when turbidity is above 1 NTU)~~	~~$13.00~~
~~EPA 200.8, Uranium, Water~~	~~$44.00~~
~~EPA 200.8, Water, ICPMS - Excludes Uranium (Fee is for each individual metal tested)~~	~~$13.00~~
~~EPA 200.9, Dissolved, AA~~	~~$21.00~~
~~EPA 200.9, Water, AA~~	~~$21.00~~
~~EPA 200.9, Water, GFAA~~	~~$21.00~~
~~EPA 245.1, Mercury, Dissolved, CVAA~~	~~$29.00~~
~~EPA 245.1, Mercury, Water, CVAA~~	~~$29.00~~
~~EPA 245.7, Mercury, Water, CVAFS~~	~~$34.00~~
~~EPA 300.0, Chloride, Water~~	~~$19.00~~
~~EPA 300.0,~~ Fluoride, Water	$19.00
Hardness, Water	$22.00
Lead, Water	$21.00
Mercury, Water	$34.00
Metals Digestion, Water, Soil, or Solids	$19.00
Metals each (Aluminum, Antimony, Barium, Beryllium, Boron, Cadmium, Calcium, Chromium, Cobalt, Copper, Iron, Magnesium, Manganese, Molybdenum, Nickel, Potassium, Selenium, Silicon, Silver, Sodium, Strontium, Thallium, Tin, Vanadium, Zinc)	$13.00
Metals Speciation	$150.00
Nitrate + Nitrite as N, Water	$19.00
~~EPA 300.0,~~ Nitrate as N, Water	$19.00
Nitrite as N, Water	$19.00
~~EPA 300.0, Sulfate, Water~~	~~$19.00~~

Fees for Environmental Laboratory Tests -- Inorganic	
Inorganic Test Name	**Fee**
~~*EPA 300.1, Bromate, Water*~~	~~*$100.00*~~
~~*EPA 300.1, Bromide, Water*~~	~~*$32.00*~~
~~*EPA 300.1, Chlorate, Water*~~	~~*$100.00*~~
~~*EPA 300.1, Chlorite, Water*~~	~~*$150.00*~~
~~*EPA 350.1, Ammonia as N, Water*~~	~~*$18.00*~~
Orthophosphate as P, Water	$17.00
pH, Water	$10.00
Settleable Solids, Water	$16.00
Sulfate, Water	$19.00
Sulfide as H_2S, Water	$19.00
TCLP Extraction	$165.00
Total Dissolved Solids, Water	$15.00
~~*EPA 351.2,*~~ Total Kjeldahl Nitrogen, Soil	$53.00
~~*EPA 351.2,*~~ Total Kjeldahl Nitrogen, Water	$34.00
~~*EPA 353.2, Nitrate as N, Water*~~	~~*$19.00*~~
~~*EPA 353.2, Nitrate+Nitrite as N, Water*~~	~~*$17.00*~~
~~*EPA 365.1,*~~ Total Phosphorus, ~~*Lach,*~~ Water	$24.00
~~*EPA 376.2, Sulfide as H2S, Water*~~	~~*$19.00*~~
~~*EPA 410.2, COD, Water*~~	~~*$29.00*~~
~~*EPA 1311, TCLP Extraction*~~	~~*$165.00*~~
~~*EPA 3005A, Metals Digestion*~~	~~*$19.00*~~
~~*EPA 3050B, Metals Digestion*~~	~~*$19.00*~~
~~*EPA 7473, Mercury*~~	~~*$44.00*~~
~~*EPA 8231, Hach, COD, Water*~~	~~*$29.00*~~
~~*Hardness, SM 2340C, Water*~~	~~*$22.00*~~
~~*Nitrite as N, SM 4500, Water*~~	~~*$16.00*~~
~~*Orthophosphate as P, SM 4500, Dissolved*~~	~~*$17.00*~~
~~*Orthophosphate as P, SM 4500, Water*~~	~~*$17.00*~~
~~*PH, SM 4500H, Water,*~~	~~*$10.00*~~
~~*Pheophytin A, SM 10200H, Water (See Chlorophyll A, SM 10200H, Water and Pheophytin A, SM 10200H, Water)*~~	
~~*Settleable Solids, SM 2540F, Water*~~	~~*$16.00*~~
~~*SM 3111 (Pb, Co-TCLP, Cu-TCLP)*~~	~~*$14.00*~~

Fees for Environmental Laboratory Tests -- Inorganic	
Inorganic Test Name	**Fee**
~~*SM 6010B, Soil, ICP*~~	~~*$11.00*~~
~~*Total Dissolved Solids, SM 2540C, Water*~~	~~*$15.00*~~
Total Solids, ~~*SM 2540B,*~~ Water	$13.00
Total Suspended Sediment, ~~*ASTM 3977,*~~ Water	$14.00
Total Suspended Solids, ~~*SM 2540D,*~~ Water	$14.00
Turbidity, Water	$13.00
Uranium, Water	$44.00
Volatile Solids, ~~*SM 2540G,*~~ Water	$24.00

~~*(3-29-10)*~~( )

04. Environmental Laboratory Tests, Organic -- Table.

Fees for Environmental Laboratory Tests -- Organic	
Organic Test Name	**Fee**
1,2-dibromo-3-chloropropane/ethylene dibromide (DBCP/EDB/TCP), Water	$100.00
Benzene, Toluene, Ethylbenzene and Xylenes (BTEX)	$97.00
Carbamates, Water	$169.00
Chlorinated Herbicides, Water	$162.00
Diquat, Water	$117.00
ELISA, Water (Submitter provides test kit; cost is for the analysis of each ~~*test kit*~~ sample)	$1~~0~~2.00
Endothall, Water	$144.00
Glyphosate, Water	$142.00
Haloacetic Acids, Water	$150.00
Oil and Grease, Water	$44.00
Organochlorine Pesticides, Water	$135.00
Polychlorinated Biphenyls (PCBs)	$117.00
Polycyclic aromatic hydrocarbons (PAHs), Soil	$200.00
Semi-volatile Compounds, Water	$182.00
Semi-volatile, GC-MS Screen (Qualitative Results)	$125.00
Total Trihalomethanes (TTHMs)	$100.00
Trichloroethylene (TCE) Tetrachloroethylene (PCE), Air	$50.00
Unknown Identification	$100.00
Volatile Organic Compounds (VOC), Water and Soil	$187.00

Fees for Environmental Laboratory Tests -- Organic	
Organic Test Name	**Fee**
~~EPA 504.1, Water, GC-ECD~~	~~$100.00~~
~~EPA 508, Water, GC-ECD~~	~~$135.00~~
~~EPA 515.4, Water, GC-ECD~~	~~$162.00~~
~~EPA 524.2(4), Water, GCMS, P&T~~	~~$187.00~~
~~EPA 525.2, Water, GCMS~~	~~$182.00~~
~~EPA 531.2, Water, HPLC~~	~~$169.00~~
~~EPA 547, Water, HPLC~~	~~$142.00~~
~~EPA 548.1, Water, GCMS~~	~~$144.00~~
~~EPA 549.2, Water, HPLC~~	~~$117.00~~
~~EPA 552.2, HAAs, GC-ECD, Water~~	~~$150.00~~
~~EPA 1664, Oil and Grease, Water~~	~~$44.00~~
~~EPA 5035/8260, BTEX~~	~~$97.00~~
~~EPA 8081 PCBs~~	~~$117.00~~
~~EPA 8260, BTEX~~	~~$97.00~~
~~EPA 8260B, Soil, GCMS, P&T~~	~~$187.00~~
~~EPA 8260B, Water, GCMS, P&T~~	~~$187.00~~
~~EPA 8270, Soil, PAH~~	~~$349.00~~
~~Hazardous Waste Analysis~~	~~$50.00~~
~~TCE, PCE, NIOSH 1003, Air, FID~~	~~$50.00~~

~~(3-29-10)~~( )

COST/BENEFIT ANALYSIS FORM
Department of Health and Welfare
Administrative Procedures Section (APS)

Docket Number: 16-0225-1101 (Revise lab fee rules)

Agency Contact: Tamara Hogg
Phone: 334-2235 x-262

Rules Specialist: Frank Powell
Phone: 334-5775

Date Analysis Completed: 3/21/11

IDAPA Chapter Number and Title: IDAPA 16.02.25, "Fees Charged by the State Laboratory"

Fee Rule Status: ☒ **Proposed** ☐ **Temporary** **Effective date:** Sine Die, 2012

Instructions:

Section 67-5223(3), Idaho Code, adopted by the 2010 Legislature, requires that all proposed rules in which a fee or charge is imposed or increased must include a cost/benefit analysis of the rule change at the time the rule text is submitted for publication. This analysis needs to include an estimated cost to the agency to implement the rule and an estimated cost to be borne by citizens, or the private sector, or both. This statute change is effective July 1, 2010, and must be completed for fee rules published in the *Idaho Administrative Bulletin* after that date.

Cost/Benefit Analysis For This Rule Change:

The Bureau's calculations based on SFY 2010 testing levels indicate that the change in fees will not result in a net decrease or increase of receipts from Bureau clients. There will be no additional cost to the Department.

The cost of each laboratory test is maintained in the Bureau's Laboratory Information Management System (LIMS); therefore, the new fee for each test will need to be data entered in this system. The fiscal impact will be the time of the Bureau's Automated Program System Specialist to update the cost of the tests in the system.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1102

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is July 1, 2011.

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 Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511, and 56-1601 through 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

The Department is continuing rule changes published as temporary rules under Docket No. 16-0309-1004, in the September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, regarding changes in the definition for hospital floor reimbursement percentage and the reduction to outpatient hospital costs. House Bill 260, adopted by the 2011 Legislature, repealed, amended, and added statutes that are being referenced and updated in the Legal Authority section of these rules.

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

These rule changes implement statutory changes adopted by the 2011 Legislature and continue statutory changes made regarding hospital reimbursement.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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:

The state general fund savings associated with this rulemaking are estimated to be $388,000 for the state fiscal year 2012 and was included in the Department's appropriations for SFY 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Kellerman at (208) 364-1994.

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 August 24, 2011.

DATED this 8th day of July, 2011.

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

THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0309-1102

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), and 56-264, 56-1610, Idaho Code. ~~(3-30-07)~~(7-1-11)T

02. General Administrative Authority. Titles XIX and XXI of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-30-07)

03. Administration of the Medical Assistance Program. (3-30-07)

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-30-07)

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-30-07)

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. ~~(3-30-07)~~(7-1-11)T

04. Fiscal Administration. (3-30-07)

a. Fiscal administration of these rules is authorized by Titles XIX and XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-30-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

400. INPATIENT HOSPITAL SERVICES - DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled

discharge of an inpatient. (3-30-07)

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (3-30-07)

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (3-30-07)

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (3-30-07)

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of the principal year to assess the percent change between the years. (3-30-07)

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. (3-30-07)

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-30-07)

08. Critical Access Hospitals (CAH). A rural hospital with twenty five (25) or less beds as set forth in 42 CFR Section 485.620. (4-7-11)

09. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

10. Customary Hospital Charges. Customary hospital charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. (7-1-11)T

a. No more than ninety-one and seven-tenths percent (91.7%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 405.03.b. of these rules. ~~(3-29-10)~~(7-1-11)T

b. For in-state hospitals that are not specified in Section 56-1408, Idaho Code, no more than one hundred percent (100%) of covered charges will be reimbursed. (7-1-11)T

c. No more than one hundred one percent (101%) of covered charges will be reimbursed to Critical Access Hospitals (CAH) for in-state hospitals. (7-1-11)T

d. No more than eighty-seven and one-tenth percent (87.1%) of covered charges will be reimbursed to out-of-state hospitals. (7-1-11)T

11. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (3-30-07)

12. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from

the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.09.a. of these rules. (3-30-07)

13. Disproportionate Share Threshold. The disproportionate share threshold is: (3-30-07)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-30-07)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (3-30-07)

14. Excluded Units. Excluded units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (3-30-07)

15. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-30-07)

16. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-30-07)

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (3-30-07)

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments county assistance programs. (3-30-07)

17. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (3-30-07)

18. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term “inpatient days” includes administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, “Medicaid inpatient days” includes paid days not counted in prior DSH threshold computations. (4-7-11)

19. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (3-30-07)

20. On-Site. A service location over which the hospital exercises financial and administrative control. “Financial and administrative control” means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (3-30-07)

21. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process. (3-30-07)

22. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. (3-30-07)

23. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. (3-30-07)

a. For inpatient services rendered on or after November 1, 2002, the principal year is the provider's fiscal year ending in calendar year 1998 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement. (3-30-07)

b. For inpatient services rendered on or after January 1, 2007, the principal year is the provider's fiscal year ending in calendar year 2003. (4-7-11)

c. For inpatient services on or after July 1, 2010, the principal year will be the Medicare cost report period used to prepare the Medicaid cost settlement. (4-7-11)

24. Public Hospital. For purposes of Subsection 405.03.b. of these rules, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

25. Reasonable Costs. Except as otherwise provided in Section 405.03 of these rules, reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Medicaid cost limit. (3-30-07)

26. Reimbursement Floor Percentage. ~~*The floor calculation for hospitals with more than forty (40) beds is seventy-seven and four-tenths percent (77.4%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-one and seven-tenths percent (91.7%).* (3-29-10)~~(7-1-110T

a. The floor calculation for out-of-state hospitals is seventy-three and five-tenths percent (73.5%) of Medicaid costs. (7-1-11)T

b. The floor calculation for in-state CAH hospitals is one hundred one percent (101%) of Medicaid costs. (7-1-11)T

c. For in-state hospitals that are not specified in Section 56-1408, Idaho Code, the floor calculation is eighty-five percent (85%) of Medicaid costs. (7-1-11)T

d. For in-state hospitals that are specified in Section 56-1408, Idaho Code, the floor calculation is seventy-seven and four-tenths percent (77.4%) of Medicaid costs. (7-1-11)T

27. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

28. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be considered. (4-7-11)

29. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

415. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

01. Outpatient Hospital. The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year end cost settlement. (3-30-07)

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. (3-30-07)

b. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. (3-30-07)

c. Hospital-based ambulance services will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (3-30-07)

d. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: (3-30-07)

i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary hospital charges; or (3-30-07)

ii. The blended payment amount which is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or (3-30-07)

iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or (3-30-07)

iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. (3-30-07)

e. Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: (3-30-07)

i. The hospital's reasonable costs; or (3-30-07)

ii. The hospital's customary charges; or (3-30-07)

iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (3-30-07)

02. Reduction to Outpatient Hospital Costs. ~~*With the exception of Medicare designated sole community hospitals and rural primary care hospitals, all other hospital o*~~Outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. This reduction will only apply to the following provider classes: ~~*(3-30-07)*~~(7-1-11-)T

a. In-state hospitals specified in Section 56-1408(2), Idaho Code, that are not a Medicare-designated sole community hospital or rural primary care hospital. (7-1-11-)T

b. Out-of-state hospitals that are not a Medicare-designated sole community hospital or rural primary care hospital. (7-1-11-)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1103

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is July 1, 2011.

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 Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

House Bill 260 passed by the 2011 Legislature, directed the Department to limit benefits for Medicaid eligible participants' dental services. Section 56-255(5)(c), Idaho Code, provides children access to prevention, diagnosis and treatment services defined in federal law. Adult coverage is limited to medically necessary services with the exception that pregnant women have access to dental services that reflect evidence-based practice. This rulemaking reflects changes needed to meet statutory requirements.

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

These rule changes implement statutory changes adopted by the 2011 Legislature effective July 1, 2011.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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 are estimated to result in cost savings of $2,101,600 ($632,900 state funds, and $1,468,700 federal funds) for state fiscal year 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Arla Farmer at (208) 364-1958.

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 August 24, 2011.

DATED this 7th day of July, 2011.

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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT FOR DOCKET NO. 16-0309-1103

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 546. (3-30-07)

d. Optometrist services are described in Sections 550 through 556. (3-30-07)

05. Primary Care Case Management. Primary Care Case Management services are described in Sections 560 through 569 of these rules**.** (5-8-09)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 649 of these rules. (5-8-09)

a. Health Risk Assessment services are described in Sections 570 through 576. (3-30-07)

b. Child wellness services are described in Sections 580 through 586. (3-30-07)

c. Adult physical services are described in Sections 590 through 596. (3-30-07)

d. Screening mammography services are described in Sections 600 through 606. (3-30-07)

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (3-30-07)

f. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)

g. Nutritional services are described in Sections 630 through 636. (3-30-07)

h. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)

10. Substance Abuse Treatment Services. Services for substance abuse treatment are described in Sections 690 through 699 of these rules. (5-8-09)

11. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 719 of these rules. (5-8-09)

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 718. (3-30-07)

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. (5-8-09)

13. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)

14. Audiology Services. Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

16. Vision Services. Vision services are described in Sections 780 through 789 of these rules. (5-8-09)

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. ~~(5-8-09)~~(7-1-11)T

18. Essential Providers. The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 856. (3-30-07)

19. Transportation. The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency transportation services are described in Sections 870 through 876. (3-30-07)

20. EPSDT Services. EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)

21. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: DENTAL SERVICES
(Sections 800 -- 819)

800. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE ~~*UNDER THE BASIC PLAN*~~.
All participants who are eligible for Medicaid's Basic Plan dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles. (7-1-11)T

~~***01. Dental Coverage Under the Selective Contract**. Children and adults under the Medicaid Basic Plan, including pregnant women in the Low Income Pregnant Women coverage group, are covered under a selective contract with Blue Cross of Idaho for preventative dental visits, treatments, and restorative services. For more details on covered dental services go to http://www.bcidaho.com/about_us/idaho_smiles.asp. (5-8-09)~~

~~***02. Limitations on Orthodontics**. Orthodontics are limited to participants from birth to twenty one (21) years of age who meet the eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. The Malocclusion Index may be found in the Appendix A of these rules. (5-8-09)~~

801. DENTAL SERVICES: DEFINITIONS.
For the purposes of dental services covered in Sections 800 through 807 of these rules, the following definitions

apply: (7-1-11)T

01. Adult. A person who is past the month of his twenty-first birthday. (7-1-11)T

02. Child. A person from birth through the month of his twenty-first birthday. (7-1-11)T

03. Idaho Smiles. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. (7-1-11)T

04. Medicare/Medicaid Coordinated Plan (MMCP). Medical assistance in which Medicaid purchases services from a Medicare Advantage Organization (MAO) and provides other Medicaid-only services covered under the Medicaid Basic Plan in accordance with IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." (7-1-11)T

802. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children, adults, and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria for Medicaid's Basic Plan are eligible for Idaho Smiles dental benefits described in Section 803 of these rules. Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles. (7-1-11)T

803. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may require authorization from the Idaho Smiles contractor. (7-1-11)T

01. Dental Coverage for Children. Children are covered for dental services that include: (7-1-11)T

a. Preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, prosthodontic, and orthodontic treatments, dentures, crowns and oral surgery; (7-1-11)T

b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered. (7-1-11)T

02. Children's Orthodontics Limitations. Orthodontics are limited to children who meet the Basic Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. (7-1-11)T

03. Dental Coverage and Limitations for Adults. Adults who are not pregnant are limited to the dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table:

TABLE 803.03 - ADULT DENTAL SERVICES CODES

Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue

TABLE 803.03 - ADULT DENTAL SERVICES CODES	
Dental Code	**Description**
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abcess
D7511	Incision and drainage of abcess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

(7-1-11)T

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW plans are covered for preventative and problem-focused exams, diagnostic, restorative, endontic, periodontic, and oral surgery benefits. Specific information about pregnant women is available online at dental services. (7-1-11)T

05. Benefit Limitations. The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. (7-1-11)T

804. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. (7-1-11)T

01. Administer Idaho Smiles. The contractor is responsible for administering the Idaho Smiles program, including but not limited to dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. (7-1-11)T

02. Authorization. The contractor is responsible for authorization of covered dental services that

require authorization prior to claim payment. (7-1-11)T

03. Complaints and Appeals. Complaints and appeals are handled through a process between Idaho Smiles and the Department that is in compliance with state and federal requirements. (7-1-11)T

805. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (7-1-11)T

806. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department approved fee schedule. (7-1-11)T

807. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. (7-1-11)T

80~~1~~8. -- 819. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1104

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2011.

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 regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code, and House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

Rule changes are needed to continue cost saving measures begun during SFY 2011, as well as align the rules with House Bill 260 passed by the 2011 Legislature, and codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to comply with deadlines in amendments to governing law or federal programs, in particular, House Bill 260 (2011).

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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:

The estimated cost savings for these rule changes are as follows: $347,000 to continue cost saving measures begun in SFY 2011. In addition, under HB 260: $200,000 - chiropractic; $70,000 - audiology; and $800,000 - podiatry and vision.

The total estimated cost savings for SFY 2012 to the state general fund for these rule changes is: $1,417,000 and was included in the Department's appropriations for SFY 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Paul Leary at (208) 364-1836.

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 August 24, 2011.

DATED this 8th day of July, 2011.

Tamara Prisock
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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0309-1104

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**. Coordination of care communication that is initiated by a medical or qualified treatment professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. The communication is limited to interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or responsible persons or advising them how to assist participant. Collateral contact is used to:* *(5-8-09)*~~

~~***a.** Coordinate care between professionals who are serving the participant;* *(5-8-09)*~~

~~***b.** Relay medical results and explanations to members of the participant's interdisciplinary team; or* *(5-8-09)*~~

~~***c.** Conduct an intermittent treatment plan review with the participant and his interdisciplinary team.* *(5-8-09)*~~

1~~7~~6. **Co-Payment**. The amount a participant is required to pay to the provider for specified services. (3-30-07)

1~~8~~7. **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)

1~~9~~8. **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~~19. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-30-07)

2~~1~~0. **Director**. The Director of the Idaho Department of Health and Welfare or his designee. (3-30-07)

2~~2~~1. **Dual Eligibles**. Medicaid participants who are also eligible for Medicare. (3-30-07)

2~~3~~2. **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 Medicaid participant. (5-8-09)

2~~4~~3. 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)

2~~5~~4. EPSDT. Early and Periodic Screening, Diagnosis, and Treatment. (3-30-07)

2~~6~~5. Facility. Facility refers to a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities. (3-30-07)

2~~7~~6. 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)

2~~8~~7. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-30-07)

2~~9~~8. 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 that 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~~*29. Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. (3-30-07)

3~~1~~0. 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)

3~~2~~1. Hospital. A hospital as defined in Section 39-1301, Idaho Code. (3-30-07)

3~~3~~2. 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)

532. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. The Department will pay for a total of ~~*twenty-four*~~ six (~~*24*~~6) manipulation visits during any calendar year for remedial care by a chiropractor ~~*but only for treatment involving manipulation of the spine to correct a subluxation condition*~~.
~~*(3-30-07)*~~(7-1-11)T

533. (RESERVED)

534. CHIROPRACTIC SERVICES: PROVIDER QUALIFICATIONS.
A person who is qualified to provide chiropractic services is licensed by the Board of Chiropractic Physicians in the Idaho Board of Occupational Licensing, or is licensed according to the regulations in the state where the services are

provided. (7-1-11)T

53~~3~~5. -- 539. (RESERVED)

540. PODIATRIST SERVICES: DEFINITIONS.
~~*The Department will reimburse podiatrists for treatment of acute foot conditions.* (3-30-07)~~

01. Acute Foot Conditions. An ~~A~~acute foot condition~~s~~, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease. ~~*Preventive foot care may be provided if vascular restrictions or other systemic disease is threatened.* (3-30-07)~~(7-1-11)T

02. Chronic Foot Diseases. Chronic foot diseases, for the purpose of this provision, include:(7-1-11)T

a. Diabetes melitus; (7-1-11)T

b. Peripheral neuropathy involving the feet; (7-1-11)T

c. Chronic thrombophlebitis; and (7-1-11)T

d. Peripheral vascular disease; (7-1-11)T

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or (7-1-11)T

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. (7-1-11)T

541. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are: (7-1-11)T

01. Participants Who Have a Chronic Disease. Participants who have a chronic disease where the evidence-based guidelines recommend regular foot care. (7-1-11)T

02. Participants with an Acute Condition. Participants with an acute condition that, if left untreated, may cause an adverse outcome to the participant's health. (7-1-11)T

542. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.
Coverage for podiatrist services is limited to: (7-1-11)T

01. Services Defined in Chronic Care Guidelines. Acute and preventive foot care services defined in chronic care guidelines; and (7-1-11)T

02. Treatment of Acute Conditions. Treatment of acute conditions that if left untreated will result in chronic damage to the participant's foot. (7-1-11)T

543. (RESERVED)

544. PODIATRIST SERVICES: PROVIDER QUALIFICATIONS.
A qualified podiatrist is licensed by the Board of Podiatry in the Idaho Board of Occupational Licensing, or licensed according to the regulations in the state where the services are provided. (7-1-11)T

54~~1~~5. -- 553. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

562. HEALTHY CONNECTIONS: COVERAGE AND LIMITATIONS.

01. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: (3-30-07)

a. Family planning services; (3-30-07)

b. Emergency care (as defined by the Department for the purpose of payment and performed in an emergency department); (3-30-07)

c. Dental care; (4-2-08)

d. Podiatry (performed in the office); (3-30-07)

e. Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)

f. Optical/Ophthalmology/Optometrist services (performed in the office); (3-30-07)

g. Chiropractic (performed in the office); (3-30-07)

h. Pharmacy (prescription drugs only); (3-30-07)

i. Nursing home; (3-30-07)

j. ICF/ID services; (3-30-07)

k. Immunizations (not requiring an office visit); (4-2-08)

l. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)

m. Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)

n. One screening mammography per calendar year for women age forty (40) or older; (3-30-07)

o. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; (4-2-08)

p. In-home services, known as Personal Care Services and Personal Care Services Case Management; (4-2-08)

q. Laboratory services, including pathology; (4-2-08)

r. Anesthesiology services; and (4-2-08)

s. Radiology services. (4-2-08)

t. Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed. (7-1-11)T

02. Change in Services That Require a Referral. The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Case Management Fee. Reimbursement is as follows: (4-2-08)

a. PCPs will be paid a case management fee for primary care case management services based on the level of participants' health care needs and the PCP's availability. ~~(4-2-08)~~(7-1-11)T

b. PCPs enrolled in the chronic disease management pay-for-performance program will be paid an enhanced case management fee. (4-2-08)

c. The amount of the fees is determined by the Department ~~and specified in the provider agreement~~. ~~(4-2-08)~~(7-1-11)T

d. The amount of the fee is fixed and the same for all participating PCPs. (4-2-08)

02. Primary Care Case Management. Reimbursement is based on: ~~the number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee.~~ ~~(4-2-08)~~(7-1-11)T

a. The number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package; (7-1-11)T

b. The number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and (7-1-11)T

c. The amount of the case management fee is increased by fifty cents ($.50) per participant when the PCP's office offers extended hours of service equal to or exceeding forty-six (46) hours per week. The amount of extended hours must be verified by and on file with the Department prior to monthly case management fee generation for the increase to be paid. (7-1-11)T

03. Chronic Disease Management. Reimbursement is based on: (4-2-08)

a. The number of participants who have a targeted chronic disease multiplied by the amount of the enhanced case management fee for patient identification; and (4-2-08)

b. The number of instances that the PCP achieved Department specified best practices protocol for the disease being managed multiplied by the amount of the enhanced case management fee for reported quality indicators. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

615. ADDITIONAL ASSESSMENT AND EVALUATION SERVICES.
In addition to evaluations for services as defined in this Chapter, the Department will reimburse for the following evaluations if needed to determine eligibility for Medicaid Enhanced Plan Benefits. (3-30-07)

01. Enhanced Mental Health Services. Enhanced mental health services are not covered under the Basic Plan with the exception of assessment services. The assessment for determination of need for enhanced mental health services is subject to the requirements for comprehensive assessments at IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 11~~3~~4, and provider qualifications under Section 715 of these rules and under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 130 and 131. ~~(3-30-07)~~(7-1-11)T

02. Developmental Disability Agency Services (DDA). DDA services are not covered under the Basic Plan with the exception of assessment and evaluation services. The assessment and/or evaluation for the need

for DDA services is subject to the requirements for DDA services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 653.02, and IDAPA 16.04.11, "Developmental Disabilities Agencies," Sections 600 through 604. (3-30-07)

03. Service Coordination Services. Service coordination services are not covered under the Basic Plan, with the exception of assessment services. The assessment for the need for service coordination services is subject to the requirements for service coordination under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 727.03, as applicable to the service being requested, and provider qualifications under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 729. (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. (5-8-09)

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.*~~ **Comprehensive Diagnostic Assessment Addendum**. A supplement to the comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. ~~*(5-8-09)*~~(7-1-11)T

~~***04. Intake Assessment**. An agency's 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 document the indicators that mental health services are a medical necessity for the participant.* *(5-8-09)*~~

0~~5~~4. **Interdisciplinary Team**. Group that consists of two (2) or more individuals in addition to the participant, the participant's parent or legal guardian, and the participant's natural supports. This may include professionals from several fields or professions. Team members combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan. Professionals working with the participant to fulfill the goals and objectives on the treatment plan are members of the participant's interdisciplinary team whether they attend treatment plan meetings or not. At a minimum, professional members of the team include the medical professional authorizing the treatment plan and the specific agency staff member who is working with the participant. (5-8-09)

0~~6~~5. **Level of Care**. Clinical treatment decisions that determine service site, modality, urgency, and specific interventions needed to address the key presenting signs, symptoms, and environmental factors that indicate the severity of illness and the intensity of service needed by the participant. It also takes into account relevant external factors affecting clinical treatment decisions. (5-8-09)

0~~7~~6. **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 medications for psychiatric disorders. (5-8-09)

07. **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. **Neuropsychological Testing**. Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system; the data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)

09. **New Participant**. A participant is considered "new" if he has not received Medicaid-reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the twelve (12) months prior to the current treatment episode. (7-1-11)T

10. **Objective**. A milestone toward meeting the goal that is concrete, measurable, time-limited, and identifies specific behavior changes. (5-8-09)

11. **Occupational Therapy**. For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness. (5-8-09)

12. **Pharmacological Management**. The in-depth management of medications for psychiatric disorders for relief of a participant's signs and symptoms of mental illness, provided by a licensed practitioner of the healing arts. (5-8-09)

13. **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)

14. **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)

15. **Psychotherapy**. A method of treating and managing psychiatric disorders through the use of evidenced-based psychological treatment modalities that match the participant's ability to benefit from the service. The focus of the service is on behavioral, emotional, and cognitive aspects of a participant's functioning. (5-8-09)

16. **Restraints**. Restraints include the use of physical, mechanical, or chemical interventions, or other means to temporarily subdue or modify participant behavior. (5-8-09)

a. A restraint includes: (5-8-09)

i. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a participant to move his arms, legs, body, or head freely; or (5-8-09)

ii. A drug or medication when it is used as a restriction to manage the participant's behavior or restrict the participant's freedom of movement and is not a standard treatment or dosage for the participant's condition; (5-8-09)

b. A restraint does not include physical escorts or devices, such as orthopedically prescribed devices, to permit the participant to engage in activities without the risk of physical harm. (5-8-09)

17. **Seclusion**. Seclusion is the involuntary confinement of a participant alone in a room or area from

which the participant is prevented from leaving. (5-8-09)

18. Serious Emotional Disturbance (SED). In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is: (5-8-09)

a. An emotional or behavioral disorder according to the DSM-IV-TR, which results in a serious disability; and (5-8-09)

b. Requires sustained treatment interventions; and (5-8-09)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (5-8-09)

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. (5-8-09)

19. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI: (5-8-09)

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 (5-8-09)

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. 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. (5-8-09)

20. Serious and Persistent Mental Illness (SPMI). Participants must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-IV-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. (5-8-09)

21. Treatment Plan Review. The practice of obtaining input from members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant. This review should provide feedback and suggestions intended to help team members and the participant to accomplish the goals identified on the participant's individualized treatment plan. (5-8-09)

708. MENTAL HEALTH CLINIC SERVICES: PARTICIPANT ELIGIBILITY.
Eligibility must be established through the assessment services described under Subsections 709.03.a. and 709.03.b. of these rules. The following are requirements for establishing eligibility for mental health clinic services. (5-8-09)

01. History and Physical Examination. The participant must have documented evidence of a history and physical examination that has been completed by his primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service prior to the delivery of mental health services. A participant who is in crisis may receive mental health services as described under Subsection 709.06 of these rules prior to obtaining a history and physical examination. (5-8-09)

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. (5-8-09)

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. (5-8-09)

04. Conditions That Require New ~~*Intake*~~ Assessment and Individualized Treatment Plan. If an individual who is not eligible for Medicaid receives ~~*intake*~~ assessment 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*~~ comprehensive diagnostic assessment and individualized treatment plan are required, which must be developed by a professional listed under Subsection 715.03 of these rules. ~~*(5-8-09)*~~(7-1-11)T

709. 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 Medicaid. (5-8-09)

03. Evaluation and Diagnostic Services in Mental Health Clinics. Participants must obtain ~~*either an intake assessment or*~~ a comprehensive diagnostic assessment as the initial evaluation in mental health clinics~~*, depending on their clinical presentation*~~. ~~*(5-8-09)*~~(7-1-11)T

~~***a.***~~ ~~*An intake assessment is a reimbursable evaluation service when the following conditions are met:*~~ ~~*(5-8-09)*~~

~~***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.*~~ ~~*(5-8-09)*~~

~~***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.*~~ ~~*(5-8-09)*~~

~~***b***~~a. ~~*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 current mental status examination, 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. The assessment must include the five (5) axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity, and expected duration of treatment services. A comprehensive diagnostic assessment is a reimbursable service when: ~~*(5-8-09)*~~(7-1-11)T

i. A comprehensive diagnostic assessment is medically necessary in order to provide Basic Plan mental health services~~ *and staff determines that the intake assessment does not provide sufficient clinical information*~~; ~~*(5-8-09)*~~(7-1-11)T

ii. The participant is seeking Enhanced Plan services; ~~*or*~~ and ~~*(5-8-09)*~~(7-1-11)T

iii. When the assessment is performed by qualified staff identified under Subsection 715.02 of these rules. (5-8-09)

~~***c.***~~ ~~*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.*~~ ~~*(5-8-09)*~~

~~*d*~~b. 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: (5-8-09)

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)

~~*e*~~c. Neuropsychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question for participants whose clinical presentation indicates possible neurological involvement or central nervous system compromise from either a congenital or acquired etiology impacting the individual's functional capacities. The neuropsychological evaluation report must contain the reason for the performance of this service. Agency staff may deliver this service if they are a licensed psychologist or psychologist extender with specific competencies in neuropsychological testing. (5-8-09)

~~*f*~~d. Occupational therapy assessment may be provided as a reimbursable service when recommended by the treatment team. This service may include the administration of standardized and non-standardized assessments and must be provided by an occupational therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)

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 710 of these rules. (5-8-09)

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. (5-8-09)

a. Family psychotherapy services with the participant present must: (5-8-09)

i. Be face-to-face with at least one (1) family member present in addition to the participant; (5-8-09)

ii. Focus the treatment services on goals identified in the participant's individualized treatment plan; and (5-8-09)

iii. Utilize an evidence-based treatment model. (5-8-09)

b. Family psychotherapy without the participant present must: (5-8-09)

i. Be face-to-face with at least one (1) family member present; (5-8-09)

ii. Focus the services on the participant; and (5-8-09)

iii. Utilize an evidence-based treatment model. (5-8-09)

06. Emergency Psychotherapy Services. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (5-8-09)

a. Emergency services provided to an eligible participant prior to ~~*intake and evaluation is a reimbursable service but*~~ the completion of a comprehensive diagnostic assessment must be fully documented in the

participant's medical record; and ~~(5-8-09)~~(7-1-11)T

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 a reimbursable service when it is included on the individualized treatment plan and it is necessary for professional staff to share information with members of the participant's interdisciplinary team, or advise them how to assist the participant.* (5-8-09)~~

~~***a.*** *Collateral contact can be provided face-to-face by agency staff providing treatment services. Face-to-face contact is defined as two (2) or more people meeting in person at the same time:* (5-8-09)~~

~~***b.*** *Collateral contact can be provided by telephone by agency staff providing treatment services when this is the most expeditious and effective way to provide information.* (5-8-09)~~

0~~8~~7. **Pharmacological Management**. Pharmacological management is a reimbursable service when consultations 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. (5-8-09)

a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the participant's individualized treatment plan; and (5-8-09)

b. Pharmacological management, if provided, must be specified on the participant's individualized treatment plan and must include the frequency and duration of the treatment. (5-8-09)

0~~9~~8. **Nursing Services**. Nursing services are reimbursable when physician ordered and supervised, and included as part of the participant's individualized treatment plan. (5-8-09)

a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nursing Practice Act, Section 54-1402, 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)

~~1~~09. **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*~~ four (~~*12*~~4) hours per year is the maximum time allowed for ~~*a combination of any evaluative or*~~ diagnostic assessment services ~~*and individualized treatment plan development provided to an eligible participant in a calendar year*~~. Psychological and neuropsychological testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. ~~(5-8-09)~~(7-1-11)T

1~~1~~0. **Occupational Therapy Services**. Occupational therapy services are reimbursable when included as part of the participant's individualized treatment plan. Agency staff may deliver these services if they are an occupational therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." The practice of occupational therapy encompasses the evaluation, consultation, and treatment of individuals whose abilities to cope with the tasks of daily living are threatened or impaired. It includes a treatment program through the use of specific techniques that enhance functional performance and includes evaluation or assessment of the participant's: (5-8-09)

a. Self-care, functional skills, cognition, and perception; (5-8-09)

b. Sensory and motor performance; (5-8-09)

c. Play skills, vocational, and prevocational capacities; and (5-8-09)

d. Need for adaptive equipment. (5-8-09)

710. 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 twelve (12) months.*~~ Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules. ~~*(5-8-09)*~~(7-1-11)T

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

a. The treatment staff providing the services; and (5-8-09)

b. The participant, if capable, and his parent or legal guardian. The participant and his parent or legal guardian may also choose others to participate in the development of the plan. (5-8-09)

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 parent or 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 reflect the choices of the participant or his parent or legal guardian. The goals and objectives must address the emotional, behavioral, and skill training needs identified by the participant or his parent or legal guardian through the intake and assessment process. The tasks must be specific to the type of modality used and must specify the frequency and anticipated duration of therapeutic services. (5-8-09)

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 participant, when able, and his 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 participant and his parent or legal guardian. (5-8-09)

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. (5-8-09)

c. The treatment plan must be created in direct response to the findings of the ~~*intake and*~~ assessment process. ~~*(5-8-09)*~~(7-1-11)T

d. 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. (5-8-09)

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 parent or 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. (5-8-09)

f. Discharge criteria and aftercare plans must also be identified on the treatment plan. (5-8-09)

03. Treatment Plan Reviews. The agency staff must conduct intermittent treatment plan reviews when medically necessary. The intermittent treatment plan reviews must be conducted with the participant or his legal guardian at least every one hundred twenty (120) days. During the reviews, the agency staff providing the services, 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 participant or his legal guardian and agency staff providing the services. (5-8-09)

04. Physician Review of Treatment Plan. Each individualized treatment plan must be reviewed, ~~*and be completely rewritten*~~ updated, 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*~~ revision of the individualized treatment plan must be recorded on the treatment plan. ~~*(5-8-09)*~~(7-1-11)T

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

a. Description of the ways the participant has specifically benefited from mental health services, and why he continues to need additional mental health services; and (5-8-09)

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

(BREAK IN CONTINUITY OF SECTIONS)

713. ~~*(RESERVED)*~~ MENTAL HEALTH CLINIC SERVICES: RESPONSIBILITIES OF THE DEPARTMENT.

The Department will administer the provider agreement for the provision of mental health clinic services and is responsible for the following tasks: (7-1-11)T

01. Prior Authorization Process. Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to address the participant's needs in relation to those services. (7-1-11)T

02. Notice of Decision. At the point the Department makes a decision that a participant is ineligible for specific services, a notice of decision citing the reason(s) the participant is ineligible for those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (7-1-11)T

03. Responding to Requests for Services. When the Department receives from a provider a written request for services that must be prior authorized, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. (7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Assessments. A~~n intake assessment or~~ comprehensive diagnostic assessment must be contained in all participant medical records. ~~(5-8-09)~~(7-1-11)T

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 a minor child, informed consent must be obtained from the minor's parent or legal guardian. (5-8-09)

03. Documentation. All ~~intake histories, psychiatric evaluations, psychological~~ assessments and 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)~~(7-1-11)T

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 Medicaid participants. (5-8-09)

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 710 of this rule. (5-8-09)

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)

741. AUDIOLOGY SERVICES: PARTICIPANT ELIGIBILITY.

~~When specifically ordered by a physician, all participants are eligible for audiometric examination and testing once in each calendar year.~~ ~~(3-30-07)~~

01. All Participants. All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. (7-1-11)T

02. Participants Under the Age of 21. Participants under the age of twenty-one (21) are eligible for all services listed in Section 742 of these rules. (7-1-11)T

742. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.
All audiology services must be ordered by a physician or midlevel practitioner. The Department will pay for routine audiometric examination and testing once in each calendar year, and audiometric services and supplies in accordance with the following guidelines and limitations: ~~(3-30-07)~~(7-1-11)T

01. Non-Implantable Hearing Aids. When there is a documented hearing loss of at least thirty (30) decibels based on the standard Pure Tone Average (500, 1000, 2000 hertz), the Department will cover the purchase of ~~one (1)~~ non-implantable hearing aids ~~per~~ for participants ~~per lifetime~~ under the age of twenty-one (21) with the following requirements and limitations: ~~(4-2-08)~~(7-1-11)T

a. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. (3-30-07)

b. The following services may be covered in addition to the purchase of the hearing aid for participants under the age of twenty-one (21): batteries purchased on a monthly basis, follow-up testing, necessary repairs resulting from normal use after the second year, and the refitting of the hearing aid or additional ear molds no more often than forty-eight (48) months from the last fitting. ~~(3-30-07)~~(7-1-11)T

c. Lost, misplaced, stolen or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the replacement of any hearing aid. In addition, the Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse or use of the aid in a manner for which it was not intended. (3-30-07)

02. Implantable Hearing Aids. The Department may cover a surgically implantable hearing aid for participants under the age of twenty-one (21) when: ~~(4-2-08)~~(7-1-11)T

a. There is a documented hearing loss as described in Subsection 742.01 of this rule; (4-2-08)

b. Non-implantable options have been tried, but have not been successful; and (4-2-08)

c. The Department has determined that a surgically implanted hearing aid is medically necessary through the prior authorization process. The Department will consider the guidelines of private and public pay~~o~~ers, evidence-based national standards or medical practice, and the medical necessity of each participant's case. ~~(4-2-08)~~(7-1-11)T

03. Provider Documentation Requirements. The following information must be documented and kept on file by the provider: (4-2-08)

a. The participant's diagnosis; (4-2-08)

b. The results of the basic comprehensive audiometric exam which includes pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and (4-2-08)

c. The brand name and model type of the hearing aid needed. (4-2-08)

04. Allowance to Waive Impedance Test. The Department will allow a medical doctor to waive the impedance test based on his documented judgment. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

781. VISION SERVICES: PARTICIPANT ELIGIBILITY.
~~*Replacement of broken, lost, or missing glasses is the responsibility of the participant.* (3-30-07)~~

01. Children Under the Age of 21. Children under the age of twenty-one (21) are eligible for all services listed in Section 782 of these rules.
(7-1-11)T

02. Adults Age 21 and Over. Adults age twenty-one (21) and over are eligible for: (7-1-11)T

a. Services necessary to treat or monitor a chronic condition, such as diabetes, that may damage the eye; and (7-1-11)T

b. Acute conditions that if left untreated may cause permanent or chronic damage to the eye.
(7-1-11)T

782. VISION SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services and supplies in accordance with the guidelines and limitations listed below. (3-30-07)

01. Eye Examinations. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period for each eligible Medicaid participant to determine the need for glasses to correct a refractive error. Each eligible Medicaid participant, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive eyeglasses within Department guidelines. (3-30-07)

02. Lenses. Lenses, single vision or bifocal, will be purchased by the Department not more often than once every four (4) years except when there is documentation of a major visual change as defined by the Department. (3-30-07)

~~*a. Polycarbonate lenses will be purchased only when there is clear documented evidence that the thickness of the plastic lenses precludes their use (prescriptions above plus or minus two (2) diopters of correction). Documentation must be kept on file by both the examining and supplying providers.* (3-30-07)~~

~~*b.*~~ **a.** Scratch resistant coating is required for all plastic and polycarbonate lenses. (3-30-07)

~~*c.*~~ **b.** Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions as defined by the Department as defined in the Medical Vendor Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. (3-30-07)

~~*d.*~~ **c.** All ~~*C*~~contact lenses require prior authorization by the Department. Contact lenses will be covered only with documentation ~~*that an extreme condition requiring a*~~ of: (7-1-11)T

i. A need for correction equal to or greater than plus or minus ~~*four*~~ ten (~~*4*~~±10) diopters~~,~~; or (7-1-11)T

ii. An extreme medical condition that does not allow correction through the use of conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other extreme conditions as defined by the Department~~ *that preclude the use of conventional lenses. Prior authorization is required by the Department*~~.
~~*(3-30-07)*~~(7-1-11)T

03. Replacement Lenses. Replacement lenses will be purchased prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Idaho Medicaid Provider Handbook. (3-30-07)

04. Frames. Frames will be purchased according to the following guidelines: (3-30-07)

a. One (1) set of frames will be purchased by the Department not more often than once every four (4)

years for eligible participants; (3-30-07)

b. Except when it is documented by the physician that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. (3-30-07)

05. Fitting Fees. Fitting fees for either contact lenses or conventional frames and lenses are covered only when the participant is eligible under the Medicaid program guidelines to receive the supplies associated with the fitting fee. (7-1-11)T

056. Non-Covered Items. A Medicaid Provider may receive payment from a Medicaid participant for vision services that are either not covered by the State Plan, or include special features or characteristics that are desired by the participant but are not medically necessary. Non covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. Replacement of broken, lost, or missing glasses is the responsibility of the participant. ~~(3-30-07)~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

852. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts, charter schools, and the Idaho Infant Toddler Program, 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. (3-30-07)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-30-07)

a. Vocational Services. (3-30-07)

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. (3-30-07)

c. Recreational Services. (3-30-07)

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: (3-30-07)

a. Recommended or Referred by a Physician or Other Practitioner of the Healing Arts. Be recommended or referred by a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals; (3-30-07)

b. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective discipline as defined in Section 854 of these rules; (3-30-07)

c. Directed Toward Diagnosis. Be directed toward a diagnosis; and (3-30-07)

d. Recommend Interventions. Include recommended interventions to address each need. (3-30-07)

03. Reimbursable Services. School districts, charter schools, and the Idaho Infant Toddler program 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 practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, charter school, or Idaho Infant Toddler Program is seeking reimbursement. (3-30-07)

~~*a. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, or general parent education, or for the Individualized Education Program (IEP) development and review team meetings, even when the parent is present, is not reimbursed. The term collateral contact is defined in Subsection 010.16 of these rules.* (3-29-10)~~

~~*b*~~a. Developmental Therapy and Evaluation. Developmental therapy may be billed, including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. (3-30-07)

~~*c*~~b. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school or for the Idaho Infant Toddler Program at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school or Idaho Infant Toddler Program by the student. (3-30-07)

~~*d*~~c. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (3-30-07)

~~*e*~~d. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (3-30-07)

~~*f*~~e. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements such as basic personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding), or other tasks delegated by a licensed professional nurse (RN). (3-30-07)

~~*g*~~f. Physical Therapy and Evaluation. (3-30-07)

~~*h*~~g. Psychological Evaluation. (3-30-07)

~~*i*~~h. Psychotherapy. (3-30-07)

~~*j*~~i. Psychosocial Rehabilitation (PSR) Services and Evaluation. Psychosocial rehabilitation (PSR) services and evaluation services to assist the student in gaining and utilizing skills necessary to participate in school. Training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, study skills, and coping skills are types of interventions that may be reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. See IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 123 for a description of PSR services. (3-29-10)

~~*k*~~j. Intensive Behavioral Intervention (IBI). Intensive behavioral interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. Professionals may provide consultation to parents and to other staff who provide therapy for the child in other disciplines to assure successful integration and transition from IBI to other therapies and environments. (3-30-07)

~~*l*~~k. Speech/Audiological Therapy and Evaluation. (3-30-07)

~~*m*~~l. Social History and Evaluation. (3-30-07)

~~n~~**m.** Transportation Services. School districts, charter schools, and the Idaho Infant Toddler programs can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: (3-30-07)

i. The student requires special transportation assistance such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ordered by a physician; (3-30-07)

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-30-07)

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; (3-30-07)

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-30-07)

v. The mileage, as well as the services performed by the attendant, are documented. See Section 854 of these rules for documentation requirements. (3-30-07)

~~o~~**n.** Interpretive Services. Interpretive services needed by a student who 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: (3-30-07)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; (3-30-07)

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-30-07)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

854. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: (3-30-07)

01. Service Detail Reports. A service detail report which includes: (3-30-07)

a. Name of student; (3-30-07)

b. Name and title of the person providing the service; (3-30-07)

c. Date, time, and duration of service; (3-30-07)

d. Place of service, if provided in a location other than school; and (3-30-07)

e. Student's response to the service. (3-30-07)

02. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (3-30-07)

03. Documentation of Qualifications of Providers. (3-30-07)

04. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (3-30-07)

05. Parental Notification. School districts, charter schools, and the Idaho Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.06 of this rule. (3-30-07)

06. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district, charter school, or Idaho Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. (3-30-07)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts, charter schools, and the Idaho Infant Toddler program must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration o~~r~~f the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and
~~(3-30-07)~~(7-1-11)T

b. Notification to Primary Care Physician. School districts, charter schools, and the Idaho Infant Toddler program must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: (3-30-07)

i. Results of evaluations within sixty (60) days of completion; (3-30-07)

ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (3-30-07)

iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (3-30-07)

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district, charter school, or Idaho Infant Toddler Program must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (3-30-07)

d. Parental Consent to Release Information. School districts, charter schools, and the Idaho Infant Toddler program: (3-30-07)

i. Must obtain consent from the parent to release information regarding education-related services, in accordance with Federal Education Rights and Privacy Act (FERPA) regulations; (3-30-07)

ii. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services, including release of the name of the student's primary care physician. (3-30-07)

07. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. See Subsection 854.08 of this rule for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (3-30-07)

~~*a. Collateral Contact. Contact and direction must be provided by the professional who provides the treatment to the student.* (3-30-07)~~

~~*b.*~~**a.** Developmental Therapy and Evaluation. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, “Developmental Disabilities Agencies.” Certified special

education teachers are not required to take the Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental Specialist, Child. Only those school personnel who are working under a Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. (3-30-07)

~~e~~b. Medical Equipment and Supplies. See Subsection 852.03 of these rules. (3-30-07)

~~d~~c. Nursing Services. Must be provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) licensed to practice in Idaho. (3-30-07)

~~e~~d. Occupational Therapy and Evaluation. Must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (3-30-07)

~~f~~e. Personal Care Services. Must be provided by or under the direction of, a licensed professional nurse (RN) or licensed practical nurse (LPN), licensed by the State of Idaho. When services are provided by a CNA, the CNA must be supervised by an RN. Medically-oriented services having to do with the student's physical or functional requirements, such as basic personal care and grooming, assistance with bladder or bowel requirements, and assistance with eating (including feeding), must be identified on the plan of care and may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-30-07)

~~g~~f. Physical Therapy and Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (3-30-07)

~~h~~g. Psychological Evaluation. Must be provided by a: (3-30-07)

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

ii. Licensed physician; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Psychologist extender registered with the Bureau of Occupational Licenses; or (3-30-07)

v. Certified school psychologist. (3-30-07)

~~i~~h. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (3-30-07)

i. Psychiatrist, M.D.; (3-30-07)

ii. Physician, M.D.; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Licensed clinical social worker; (3-30-07)

v. Licensed clinical professional counselor; (3-30-07)

vi. Licensed marriage and family therapist; (3-30-07)

vii. Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; (3-29-10)

viii. Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (3-29-10)

ix. 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"; (3-29-10)

x. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (3-29-10)

xi. Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-29-10)

~~j~~i. Psychosocial Rehabilitation. Must be provided by a: (3-30-07)

i. Licensed physician, licensed practitioner of the healing arts, or licensed psychiatrist; (3-29-10)

ii. Licensed master's level psychiatric nurse; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Licensed clinical professional counselor or professional counselor; (3-30-07)

v. Licensed marriage and family therapist or associate marriage and family therapist; (3-29-10)

vi. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-30-07)

vii. Psychologist extender registered with the Bureau of Occupational Licenses; (3-30-07)

viii. Licensed professional nurse (RN); (3-30-07)

ix. Psychosocial rehabilitation specialist as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 131; (3-29-10)

x. Licensed occupational therapist; (3-30-07)

xi. Certified school psychologist; or (3-30-07)

xii. Certified school social worker. (3-30-07)

~~k~~j. Intensive Behavioral Intervention. Must be provided by or under the direction of a qualified professional who meets the requirements set forth in IDAPA 16.04.11 "Developmental Disabilities Agencies." (3-30-07)

~~l~~k. Speech/Audiological Therapy and Evaluation. Must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. (3-30-07)

~~m~~l. Social History and Evaluation. Must be provided by a licensed professional 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. (3-30-07)

~~n~~m. Transportation. 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. (3-30-07)

08. Paraprofessionals. The schools and Infant Toddler Program may use paraprofessionals to provide developmental therapy; 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 the appropriate licensure and certification rules. The portions of the treatment

plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP. (3-29-10)

a. Occupational Therapy. Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for supervision and service requirements. (3-29-10)

b. Physical Therapy. Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for supervision and service requirements (3-29-10)

c. Speech-Language Pathology. Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. (3-29-10)

d. Developmental Therapy. Refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," for supervision and service requirements. (3-29-10)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1103

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is July 1, 2011.

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 Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

House Bill 260 passed by the 2011 Legislature, directed the Department to limit benefits for Medicaid eligible participants' dental services. Section 56-255(5)(c), Idaho Code, provides children access to prevention, diagnosis and treatment services defined in federal law. Adult coverage is limited to medically necessary services with the exception that pregnant women have access to dental services that reflect evidence-based practice. This rulemaking reflects changes needed to meet statutory requirements.

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

These rule changes implement statutory changes adopted by the 2011 Legislature effective July 1, 2011.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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 are estimated to result in cost savings of $4,438,200 ($1,336,600 state funds, and $3,101,600 federal funds) for state fiscal year 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Arla Farmer at (208) 364-1958.

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 August 24, 2011.

DATED this 8th day of July, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0310-1103

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (5-8-09)

01. Dental Services. Dental Services are provided as described under Sections 080 through 0859 of these rules. ~~(5-8-09)~~(7-1-11)T

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

03. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (3-19-07)

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

06. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

07. Hospice. Hospice services as described in Sections 450 through 459 of these rules**.** (3-19-07)

08. Developmental Disabilities Services. (3-19-07)

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (3-19-07)

c. ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)

d. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)

09. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

10. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

076. -- 079. (RESERVED)

080. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.
All participants who are eligible for Medicaid's Enhanced Plan dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. (7-1-11)T

08~~0~~1. DENTAL SERVICES: DEFINITIONS.
~~*Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion. These services must be purchased from a licensed dentist or denturist.*~~ For the purposes of dental services covered in Sections 080 through 087 of these rules, the following definitions apply: ~~*(5-8-09)*~~(7-1-11)T

01. ~~***Children's Coverage**. Dental services for children, covered through the month of their twenty-first birthday, are listed in Sections 080 through 085 of these rules.*~~ **Adult**. A person who is past the month of his twenty-first birthday. ~~*(5-8-09)*~~(7-1-11)T

02. ~~***Adult Coverage**. Covered dental services for Medicaid eligible persons who are past the month of their twenty-first birthday who are not eligible under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Pregnant Women (PW), Qualified Medicare Beneficiary (QMB), or under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," are listed in Subsections 082.14 and 082.15 of these rules.*~~ **Child**. A person from birth through the month of his twenty-first birthday. ~~*(5-8-09)*~~(7-1-11)T

03. ~~***Limitations on Orthodontics**. Orthodontics are limited to participants from birth to twenty one (21) years of age who meet the eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. The Malocclusion Index may be found in the Appendix A of these rules. Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant.*~~ **Idaho Smiles**. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. ~~*(5-8-09)*~~(7-1-11)T

04. ~~***Participants Eligible for Other Programs**. Participants who have only Qualified Medicare Beneficiary (QMB) eligibility are not eligible for dental services.*~~ **Medicare/Medicaid Coordinated Plan (MMCP)**. Medical assistance in which Medicaid purchases services from a Medicare Advantage Organization (MAO) and provides other Medicaid-only services covered under the Medicaid Enhanced Plan in accordance with IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ~~*(5-8-09)*~~(7-1-11)T

082. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children, adults, and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria for Medicaid's Enhanced Plan are eligible for Idaho Smiles dental benefits described in Section 083 of these rules. Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles. (7-1-11)T

08~~2~~3. DENTAL SERVICES: COVERAGE AND LIMITATIONS.

Some covered dental services may require authorization from the Idaho Smiles contractor. (7-1-11)T

01. ~~Covered~~ Dental ~~Services~~ Coverage for Children. Children are covered for ~~D~~dental services ~~are covered by Medicaid as described in Section 081 of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association.~~ that include:
~~(5-8-09)~~(7-1-11)T

a. Preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, prosthodontic, and orthodontic treatments, dentures, crowns and oral surgery; (7-1-11)T

b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered. (7-1-11)T

02. ~~Non-Covered Services~~. ~~Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules.~~ **Children's Orthodontics Limitations**. Orthodontics are limited to children who meet the Enhanced Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. ~~(5-8-09)~~(7-1-11)T

~~**03. Diagnostic Dental Procedures.**~~

~~TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES~~	
~~**Dental Code**~~	~~**Description**~~
~~**a. General Oral Evaluations.**~~ ~~The following evaluations are not allowed in combination of the same day:~~	
~~D0120~~	~~Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.~~
~~D0140~~	~~Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.~~
~~D0150~~	~~Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.~~
~~D0160~~	~~Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.~~
~~D0170~~	~~Re-evaluation, limited, problem focused. Established participant, not post-operative visit.~~
~~**b. Radiographs/Diagnostic Images.**~~	
~~D0210~~	~~Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three (3) year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.~~
~~D0220~~	~~Intraoral periapical - first film.~~
~~D0230~~	~~Intraoral periapical - each additional film.~~
~~D0240~~	~~Intraoral occlusal film.~~
~~D0270~~	~~Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.~~

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. Seven (7) to eight (8) films. Allowed every six (6) months.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic type films are allowed once in a thirty six (36) month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four (4) bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve (12) month period.
c. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.
D0470	Diagnostic casts.
d. Diagnostic.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(5-8-09)

04. Dental Preventive Procedures. Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
a. Dental Prophylaxis.	
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.
b. Fluoride Treatments.	
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for participants under age twenty (21).
D1204	Topical application of fluoride - adult, twenty one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
c. Other Preventive Services.	
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants under twenty one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
d. Space Management Therapy. Space maintainers are allowed to hold space for missing teeth for participants under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1525	Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1550	Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.

(5-8-09)

05. Restorations. (5-8-09)

a. Posterior Restoration. (5-8-09)

i. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial). (5-8-09)

ii. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (5-8-09)

iii. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (5-8-09)

iv. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications. (5-8-09)

b. Anterior Proximal Restoration. (5-8-09)

i. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle. (5-8-09)

ii. A two (2) surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle. (5-8-09))

iii. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle. (5-8-09)

iv. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. (5-8-09)

c. Amalgams and Resin Restoration. (5-8-09)

i. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (5-8-09)

ii. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (5-8-09)

iii. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (5-8-09)

d. Crowns. (5-8-09)

i. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (5-8-09)

ii. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (5-8-09)

TABLE 082.05 - RESTORATIONS

Dental Code	Description
e. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent. Tooth designation required.
D2150	Amalgam - two (2) surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam - three (3) surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam - four (4) or more surfaces, primary or permanent. Tooth designation required.
f. Resin Restorations. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	
D2330	Resin - one (1) surface, anterior. Tooth designation required.
D2331	Resin - two (2) surfaces, anterior. Tooth designation required.
D2332	Resin - three (3) surfaces, anterior. Tooth designation required.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior. Tooth designation required.
D2390	Resin based composite crown, anterior, primary or permanent. Tooth designation required.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
g. Crowns.	
D2710	Crown resin indirect. Tooth designation required. Prior authorization required.
D2721	Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.

TABLE 082.05 - RESTORATIONS	
Dental Code	**Description**
D2751	Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.
D2790	Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.
D2791	Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
h. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
D2955	Post removal. Tooth designation required.
D2980	Crown repair. Tooth designation required.
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. Requires prior authorization.

(5-8-09)

06. Endodontics. Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

TABLE 082.06 - ENDODONTICS	
Dental Code	**Description**
a. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
b. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.

TABLE 082.06 - ENDODONTICS	
Dental Code	**Description**
c. Root Canal Therapy.	
Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
d. Apicoectomy/Periradicular Services.	
D3410	Apicoectomy/Periradicular surgery anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3421	Apicoectomy/Periradicular surgery bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.
D3999	Unspecified restorative procedure, by report. Narrative and tooth designation required. Requires prior authorization.

(5-8-09)

07. Periodontics.

TABLE 082.07 - PERIODONTICS	
Dental Code	**Description**
a. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.
b. Non-Surgical Periodontal Services.	
D4320	Provisional splinting - intracoronal.

TABLE 082.07 - PERIODONTICS	
Dental Code	**Description**
D4321	Provisional splinting - extracoronal.
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
c. Other Periodontal Services.	
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for participants who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the participant's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

(5-8-09)

08. Prosthodontics. (5-8-09)

a. Removable Prosthodontics. (5-8-09)

i. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. (5-8-09)

ii. If full dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. (5-8-09)

iii. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to participants age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the participant is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. (5-8-09)

b. Removable Prosthodontics by Codes.

TABLE 082.08.b. - PROSTHODONTICS	
Dental Code	**Description**
i. Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.

TABLE 082.08.b. - PROSTHODONTICS	
Dental Code	**Description**
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	
D5211	Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
iii. Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs To Complete Dentures.	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.
v. Repairs To Partial Dentures.	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).

TABLE 082.08.b. PROSTHODONTICS	
Dental Code	**Description**
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
vii. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.
D5899	Unable to deliver full or partial denture. Prior authorization required. If the participant does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(5-8-09)

09. Maxillo-Facial Prosthetics.

TABLE 082.09 MAXILLO FACIAL PROSTHETICS	
Dental Code	**Description**
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5951	Feeding aid. Narrative required when prior authorizing. Requires prior authorization.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing. Requires prior authorization.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing. Requires prior authorization.

TABLE 082.09 - MAXILLO FACIAL PROSTHETICS	
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing. Requires prior authorization.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5982	Surgical stent. Narrative required when prior authorizing. Requires prior authorization.
D5988	Surgical splint. Narrative required when prior authorizing. Requires prior authorization.
D5999	Unspecified maxillofacial prosthesis. Narrative required when prior authorizing. Requires prior authorization.

(5-8-09)

10. Fixed Prosthodontics.

TABLE 082.10 - FIXED PROSTHODONTICS	
Dental Code	**Description**
Other Fixed Prosthetic Services.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing Requires prior authorization.

(5-8-09)

11. Oral Surgery.

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
a. Simple Extraction.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
e. Other Surgical Procedures.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. Tooth designation required. Includes splinting and/or stabilization.
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
d. Alveoloplasty.	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
e. Excision of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
f. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
g. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
h. Other Repair Procedures.	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
D7999	Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.

(5-8-09)

12. Orthodontics.

TABLE 082.12 - ORTHODONTICS	
Dental Code	**Description**
a. Limited Orthodontics. Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.	
D8010	Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8020	Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8030	Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8040	Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
b. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a participant's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.	
D8070	Comprehensive orthodontic treatment of transition dentition. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.
D8080	Comprehensive orthodontic treatment of adolescent dentition, up to sixteen (16) years of age. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.
D8090	Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.
c. Minor Treatment to Control Harmful Habits.	
D8210	Removable appliance therapy. Removable indicates participant can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.

TABLE 082.12 - ORTHODONTICS	
Dental Code	**Description**
D8220	Fixed appliance therapy. Fixed indicates participant cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
d. Other Services.	
D8670	Adjustments monthly. When utilizing treatment codes D8070, D8080 or D8090 a maximum of twenty-four (24) adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.
D8680	Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to one (1) occurrence.
D8999	Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.

(5-8-09)

13. Adjunctive General Services.

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes. Provider certification required.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes. Provider certification required.
c. Professional Consultation.	

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
d. Professional Visits.	
D9410	House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per participant. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.
D9430	Office visit for observation (during regularly scheduled hours). No other services performed.
D9440	Office visit after regularly scheduled hours.
e. Miscellaneous Service.	
D9920	Behavior Management. May be reported in addition to treatment provided when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant per day.
D9930	Treatment of complication (post-surgical) - unusual circumstances.
D9940	Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
D9951	Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per visit basis. Allowed once every twelve (12) months.
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

(5-8-09)

14. Dental Codes For Adult Services. The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
a. Dental Diagnostic Procedures. The definitions for these codes are in Subsection 082.03 of theses rules.	
i. General Oral Evaluations.	
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation.
D0150	Comprehensive oral evaluation.
ii. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0270	Bitewing - single film.
D0272	Bitewings - two (2) films.
D0274	Bitewings - four (4) films.
D0277	Vertical bitewings - seven (7) to eight (8) films.
D0330	Panoramic film.
b. Dental Preventive Procedures. The definitions for these codes are in Subsection 082.04 of theses rules.	
i. Dental Prophylaxis.	
D1110	Prophylaxis - adult.
ii. Fluoride Treatments.	
D1204	Topical application of fluoride - prophylaxis not included - adult.
c. Dental Restorative Procedures. The definitions for these codes are in Subsection 082.05 of theses rules.	
i. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent.
D2150	Amalgam - two (2) surfaces, primary or permanent.
D2160	Amalgam - three (3) surfaces, primary or permanent.
D2161	Amalgam - four (4) or more surfaces, primary or permanent.
ii. Resin Restorations.	
D2330	Resin - one (1) surface, anterior.
D2331	Resin - two (2) surfaces, anterior.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D2332	Resin - three (3) surfaces, anterior.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior.
D2390	Resin based composite crown, anterior, primary or permanent.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
iii. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
d. Endodontics. The definitions for these codes are in Subsection 082.06 of theses rules.	
D3220	Therapeutic pulpotomy.
D3221	Pulpal debridement, permanent teeth.
e. Periodontics. The definitions for these codes are in Subsection 082.07 of theses rules.	
i. Non-Surgical Periodontal Service.	
D4341	Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.
D4355	Full mouth debridement.
ii. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.
f. Prosthodontics. The definitions for these codes are in Subsection 082.08.b. of theses rules.	
i. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
iii. Adjustments to Dentures.	

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.
v. Repairs to Partial Dentures.	
D5610	Repair resin denture base.
D5620	Repair cast framework.
D5630	Repair or replace broken clasp.
D5640	Replace broken teeth, per tooth.
D5650	Add tooth to existing partial denture.
D5660	Add clasp to existing partial denture.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. Oral Surgery. The definitions for these codes are in Subsection 082.11 of theses rules.	
i. Extractions.	
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
ii. Surgical Extractions	
D7210	Surgical removal of erupted tooth.
D7220	Removal of impacted tooth - soft tissue.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D7230	Removal of impacted tooth -- partially bony.
D7240	Removal of impacted tooth - completely bony.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250	Surgical removal of residual tooth roots.
iii. Other Surgical Procedures.	
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
iv. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
v. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
vi. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
h. Adjunctive General Services. The definitions for these codes are in Subsection 082.13 of theses rules.	
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
ii. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.
iii. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
iv. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(5-8-09)

15. Denturist Procedure Codes. (5-8-09)

a. The following codes are valid denturist procedure codes:

TABLE 082.15.a. DENTURIST PROCEDURE CODES	
Dental Code	Description
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the participant does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(5-8-09)

b. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. (5-8-09)

03. Dental Coverage and Limitations for Adults. Adults who are not pregnant are limited to the

dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table:

TABLE 083.03 - ADULT DENTAL SERVICES CODES

Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abcess
D7511	Incision and drainage of abcess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

(7-1-11)T

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW plans are covered for preventative and problem-focused exams, diagnostic, restorative, endontic, periodontic, and

oral surgery benefits. Specific information about pregnant women is available online at dental services. (7-1-11)T

05. Benefit Limitations. The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. (7-1-11)T

083~~3~~4. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. (7-1-11)T

01. ~~*Dental Prior Authorization*~~. ~~*All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior authorization requires a written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment.*~~ **Administer Idaho Smiles**. The contractor is responsible for administering the Idaho Smiles program, including but not limited to dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. ~~(5-8-09)~~(7-1-11)T

02. ~~*Denturist Prior*~~ Authorization. ~~*Prior authorization is not required for the dentist procedures except for dental code D5899 found in Subsection 082.15.a. of these rules.*~~ The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. ~~(5-8-09)~~(7-1-11)T

03. ~~*Crowns.*~~ Complaints and Appeals. Complaints and appeals are handled through a process between Idaho Smiles and the Department that is in compliance with state and federal requirements. ~~(5-8-09)~~(7-1-11)T

~~***a.** When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required.* (5-8-09)~~

~~***b.** Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification.* (5-8-09)~~

084~~4~~5. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
~~*All dental services must be documented in the participant's record to include: procedure, surface, and tooth number, if applicable. This record must be maintained for a period of six (6) years.*~~ Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ~~(5-8-09)~~(7-1-11)T

085~~5~~6. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
~~*Medicaid reimburses dentists and denturists for procedures on a fee-for-service basis. Usual and customary charges are paid up to the Medicaid maximum allowance. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount.*~~ The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department approved fee schedule. ~~(5-8-09)~~(7-1-11)T

087. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. (7-1-11)T

086~~6~~8. -- 089. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1104

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is July 1, 2011.

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 Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511 and 56-1601 through 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

Rule changes in this docket implement legislative intent language in House Bill 260 passed by the 2011 Legislature regarding nursing facilities and intermediate care facilities for people with intellectual disabilities. The legal authority section for repealed, amended, and new statutes is also being updated in this rulemaking. Other rule changes in this docket continue reimbursement methodologies for mental health clinics, developmental disability agencies and rehabilitative mental health service providers that were implemented in 2010.

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

These rule changes implement statutory changes adopted by the 2011 Legislature in House Bill 260, effective July 1, 2011.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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:

The fiscal impact of this docket represents $1,023,740 of the $4,700,000 general fund savings related to pricing and inflation freeze changes identified in HB 260. This savings was included in the Department's SFY 2012 appropriations.

Changes for reimbursement methodologies to mental health clinics, developmental disability agencies, and rehabilitative mental health service providers, are designed to be budget neutral and have no anticipated fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Kellerman at (208) 364-1994.

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 August 24, 2011.

DATED this 7th day of July, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0310-1104

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), and 56-264, 56-1610, Idaho Code. ~~(3-19-07)~~(7-1-11)T

02. General Administrative Authority. Title XIX and Title XXI, of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-19-07)

03. Administration of the Medical Assistance Program. (3-19-07)

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-19-07)

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-19-07)

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. ~~(3-19-07)~~(7-1-11)T

04. Fiscal Administration. (3-19-07)

a. Fiscal administration of these rules is authorized by Title XIX and Title XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated by reference in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-19-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

119. ~~(RESERVED)~~ ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Medical Assistance Upper Limit. The Department's medical assistance upper limit for reimbursement is the lower of: (7-1-11)T

a. The mental health clinic's actual charge; or (7-1-11)T

b. The allowable charge as established by the Department's medical assistance fee schedule. Mental health clinic reimbursement is subject to the provisions of 42 CFR 447.321. (7-1-11)T

02. Reimbursement. (7-1-11)T

a. For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. (7-1-11)T

b. For other health professionals authorized to administer mental health services, the statewide reimbursement rate for mental health services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 119.03 of this rule. Reimbursement rates for partial care, and social history and evaluation are set at a percentage of the statewide target reimbursement rate. (7-1-11)T

03. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER REIMBURSEMENT.
Payment for PSR agency services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (5-8-09)

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple agency staff are present. (5-8-09)

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (3-19-07)

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)

06. Evaluations and Tests. Evaluations and tests are a reimbursable service if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (5-8-09)

07. Psychiatric or Medical Inpatient Stays. Community reintegration services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those services included in the responsibilities of the inpatient facility. Treatment services are the responsibility of the facility. (5-8-09)

08. Reimbursement. (7-1-11)T

a. For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. (7-1-11)T

b. For other health professionals authorized to administer rehabilitative mental health services, the statewide target reimbursement rate for rehabilitative mental health services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 140.09 of this rule. Reimbursement rates for intake assessment, functional assessment, individual and group skill training, and community reintegration are set at a percentage of the statewide target reimbursement rate. (7-1-11)T

c. Crisis assistance for adults with serious and persistent mental illness (SPMI) will be paid based on the same reimbursement methodology as service coordination crisis intervention services defined in Subsection 736.09 of these rules. (7-1-11)T

09. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

235. NURSING FACILITY: PROVIDER REIMBURSEMENT.

01. Payment Methodology. Nursing facilities will be reimbursed in accordance with the payment methodologies as described in Sections 236 through 295 of these rules. (3-19-07)

02. Date of Discharge. Payment by the Department for the cost of long term care is to ~~*in*~~exclude the date of the participant's discharge ~~*only if the discharge occurred after 3 p.m. and is not discharged to a related ICF/ID provider*~~. If a Medicaid patient dies in a nursing home, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. ~~*(3-19-07)*~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.0~~9~~8 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. For the rate period of July 1, 2011, through June 30, 2012, rates will be calculated using cost reports ended in calendar year 2010 with no allowance for inflation to the rate period of July 1, 2011, through June 30, 2012. ~~*(5-8-09)*~~(7-1-11)T

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to

establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (3-19-07)

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free-standing and urban hospital-based nursing facility or rural hospital-based nursing facility) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (3-19-07)

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (3-19-07)

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (3-19-07)

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (3-19-07)

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities. (3-19-07)

06. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

07. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

08. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these rules. (3-19-07)

258. NURSING FACILITY: COST LIMITS BASED ON COST REPORT.
Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. For the rate period of July 1, 2011, through June 30, 2012, the direct and indirect cost limits will be fixed at the cost limits established for the rate period of July 1, 2010, through June 30, 2011. ~~(5-8-09)~~(7-1-11)T

01. Percentage Above Bed-Weighted Median. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (3-19-07)

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward. (3-29-10)

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis ~~*according to Section 39-5606, Idaho Code*~~. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. ~~*(3-19-07)*~~(7-1-11)T

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. (3-29-10)

04. Payment for Personal Assistance Agency. (3-4-11)

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR ~~*in accordance with Section 39-5606, Idaho Code*~~. For State Fiscal Year 2011, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 2010.

Personal Assistance Agencies	WAHR x supplemental component	=	$ amount/hour

~~*(3-4-11)*~~(7-1-11)T

b. Beginning with State Fiscal Year 2011, every five (5) years the Department will conduct a survey of all Personal Assistance Agencies which requests the number of hours of all Direct Care Staff and the costs involved for all travel, administration, training, and all payroll taxes and fringe benefits. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. (3-4-11)

c. Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component. (3-4-11)

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer’s disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer’s disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (3-19-07)

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR ~~*in accordance with Section 39-5606, Idaho Code*~~. Beginning with State Fiscal Year 2011, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	$ amount/week

~~*(3-4-11)*~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

622. ICF/ID: PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/ID facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/ID providers. Total payment will include the following components: Property reimbursement, capped costs, ~~*an efficiency increment,*~~ exempt costs, and excluded costs. Except as otherwise provided in this section, ~~*ICF/ID providers will be reimbursed in*~~ rates calculated for state fiscal year 201~~0~~2 (July 1, 20~~09~~11 through June 30, 201~~0~~2) ~~*at the same rate of reimbursement that was paid in state fiscal year 2009 (July 1, 2008 through June 30, 2009)*~~ will be calculated by using finalized cost reports ended in calendar year 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. ~~*(3-29-10)*~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

659. DDA SERVICES: PROVIDER REIMBURSEMENT.
~~*Payment for agency services must be in accordance with rates established by the Department.*~~ ~~*(3-19-07)*~~

01. Reimbursement. (7-1-11)T

a. For physician services where mid-levels are authorized to administer developmental disability services, the Department reimburses based on the Department's Medical Assistance fee schedule. (7-1-11)T

b. For other health professional authorized to administer developmental disability services, the statewide reimbursement rate for developmental disability services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 656.02 of this rule. (7-1-11)T

02. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (3-19-07)

04. Reimbursement. For select services, the statewide reimbursement rate for DD waiver services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 706.05 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. (7-1-11)T

05. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (5-8-09)

a. Service coordination plan development defined in Section 721 of these rules. (5-8-09)

b. Face-to-face contact required in Subsection 728.07 of these rules. (5-8-09)

c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (5-8-09)

d. Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)

e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (5-8-09)

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. (5-8-09)

a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (5-8-09)

i. During the last fourteen (14) days of an inpatient stay which is less than one hundred eighty (180) days in duration; or (5-8-09)

ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (5-8-09)

b. Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (5-8-09)

c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (5-8-09)

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (5-8-09)

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (5-8-09)

a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than 4 billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5
82	98	6
97	113	7

(5-8-09)

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (5-8-09)

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (5-8-09)

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (5-8-09)

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

07. Healthy Connections. A participant enrolled in Healthy Connection must receive a referral for assessment and provision of services from his Healthy Connections provider~~, *unless he receives personal care services or aged and disabled waiver services*~~. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. ~~*(5-8-09)*~~(7-1-11)T

08. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (3-19-07)

09. Reimbursement. The statewide reimbursement rate for a service coordinator and a paraprofessional was derived by using: (7-1-11)T

a. Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment-related expenditures; (7-1-11)T

b. Non-productive time including vacation, sick time, and holiday; and (7-1-11)T

c. An indirect general and administrative cost based on a survey as described in Subsection 736.10 of this rule. (7-1-11)T

10. Cost Survey. The Department will conduct a time study, general and administrative cost, and mileage cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain time and cost data to provide services. (7-1-11)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1105

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2011.

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 regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code, and House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

Rule changes are needed to continue cost saving measures begun during SFY 2011, as well as align the rules with House Bill 260 passed by the 2011 Legislature, and codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to comply with deadlines in amendments to governing law or federal programs, in particular, House Bill 260 (2011).

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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:

The estimated cost savings for these rule changes are as follows: $6,593,000 to continue cost saving measures begun in SFY 2011; in addition, under HB 260: $2,270,000 for reduction in adult psycho-social rehabilitation (PSR) hours, and $2,000,000 through refinements to the developmental disabilities (DD) individual budget modification process, requirements and criteria in order to respond to requests for individual budget modifications only when health and safety issues are identified for adult developmental disabilities services.

The total estimated cost savings for SFY 2012 to the state general fund for these rule changes is $10,863,000, and was included in the Department's appropriations for SFY 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Paul Leary at (208) 364-1836.

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 August 24, 2011.

DATED this 13th day of July, 2011.

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

THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0310-1105

010. DEFINITIONS: A THROUGH D.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02. Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-19-07)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

09. **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. (3-19-07)

10. **Auditor**. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-19-07)

11. **Audit Reports**. (3-19-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-19-07)

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. (3-19-07)

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. (3-19-07)

12. **Bad Debts**. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-19-07)

13. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)

14. **Capitalize**. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (3-19-07)

15. **Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)

16. **Case Mix Index (CMI)**. A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)

17. **Certified Family Home**. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)

l8. **Chain Organization**. A proprietorship, partnership, or corporation that leases, manages, or owns

two (2) or more facilities that are separately licensed. (3-19-07)

19. **Claim**. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

20. **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." (3-19-07)

~~***21.*** ***Collateral Contact****. Coordination of care communication that is initiated by a medical or qualified treatment professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. The communication is limited to interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or responsible persons or advising them how to assist the participant. Collateral contact is used to:~~ ~~(5-8-09)~~

~~***a.*** *Coordinate care between professionals who are serving the participant;* ~~(5-8-09)~~

~~***b.*** *Relay medical results and explanations to members of the participant's interdisciplinary team; or* ~~(5-8-09)~~

~~***c.*** *Conduct an intermittent treatment plan review with the participant and his interdisciplinary team.* ~~(5-8-09)~~

2~~2~~1. **Common Ownership**. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)

2~~3~~2. **Compensation**. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-19-07)

2~~4~~3. **Control**. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)

2~~5~~4. **Cost Center**. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-19-07)

2~~6~~5. **Cost Component**. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)

2~~7~~6. **Cost Reimbursement System**. A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (3-19-07)

2~~8~~7. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)

2~~9~~8. **Cost Statements**. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)

~~*30*~~29. **Costs Related to Patient Care**. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-19-07)

3~~1~~0. Costs Not Related to Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)

3~~2~~1. 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 under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

3~~3~~2. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

3~~4~~3. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-19-07)

3~~5~~4. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

3~~6~~5. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

3~~7~~6. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries: and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

3~~8~~7. Director. The Director of the Department of Health and Welfare or his designee. (3-19-07)

3~~9~~8. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics which 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 Medicaid participant. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

013. DEFINITIONS P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. For a nursing facility or an ICF/ID, a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. (3-19-07)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants.” (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility’s rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, 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. (3-19-07)

10. **Private Rate**. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. **PRM**. The Provider Reimbursement Manual. (3-19-07)

12. **Property**. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

13. **Property Costs**. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

14. **Property Rental Rate**. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

15. **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 has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. **Provider Agreement**. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

17. **Provider Reimbursement Manual (PRM)**. The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18. **Psychologist, Licensed**. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

19. **Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20. **Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. **Raw Food**. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

22. **Reasonable Property Insurance**. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

23. **Recreational Therapy (Services)**. Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (7-1-11)

24. **Regional Nurse Reviewer (RNR)**. A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

25. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

26. 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 services, facilities, or supplies for the provider. (3-19-07)

27. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

28. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

29. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

30. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

31. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

32. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

33. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

34. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

35. 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. (3-19-07)

36. 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. (3-19-07)

37. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

38. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

39. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

40. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (3-19-07)

41. Updated Assessments. Assessments are considered updated and current when a qualified professional with the same credential or the same qualifications of that professional who completed the assessment

has reviewed such assessment and verified by way of their signature and date in the participant's file that the assessment continues to reflect the participant's current status and assessed needs. (7-1-11)T

4~~1~~2. Utilities. All expenses for heat, electricity, water and sewer. (3-19-07)

4~~2~~3. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

4~~3~~4. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

4~~4~~5. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

111. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - DEFINITIONS.
These definitions apply to Sections 100 through 146 of these rules. (3-19-07)

01. Agency. A Medicaid provider who delivers either mental health clinic services or psychosocial rehabilitative services, or both. (5-8-09)

~~***02. Assessment Hours**. Time allotted for completion of intake, evaluation, and diagnostic services. (5-8-09)~~

0~~2~~3. Community Reintegration. A psychosocial rehabilitation (PSR) service that provides practical information and direct support to help the participant maintain his current skills, prevent regression, or practice newly-acquired life skills. The intention of this service is to provide the information and support needed by a participant to achieve the highest level of stability and independence that meets his ongoing recovery needs. (5-8-09)

0~~4~~3. Comprehensive Diagnostic Assessment. A thorough assessment of the participant's current condition and complete medical and psychiatric history. (5-8-09)

04. Comprehensive Diagnostic Assessment Addendum. A supplement to the comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. (7-1-11)T

05. Demographic Information. Information that identifies participants and is entered into the Department's database collection system. (3-19-07)

06. Duration of Services. Refers to length of time for a specific service to occur in a single encounter. (5-8-09)

~~***07. Functional Assessment**. In rehabilitative mental health, this assessment is used to provide supplemental information to the comprehensive diagnostic assessment that 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. (5-8-09)~~

0~~8~~7. Goal. The desired outcome related to an identified issue. (3-19-07)

0~~9~~8. Initial Contact. The date a participant, or participant's parent or legal guardian comes in to an agency and requests Enhanced Plan services. (5-8-09)

~~***10. Intake Assessment**. An agency's 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 document the indicators that mental health services are a medical necessity for the participant.* (5-8-09)~~

~~11~~09. 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. This may include professionals from several fields or professions. Team members combine their skills and resources to provide guidance and assistance in the creation of the participants treatment plan. Professionals working with the participant to fulfill the goals and objectives on the treatment plan are members of the participant's interdisciplinary team whether they attend treatment plan meetings or not. At a minimum, professional members of the team include the medical professional authorizing the treatment plan and the specific agency staff member who is working with the participant. (5-8-09)

1~~2~~0. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (3-19-07)

1~~3~~1. Level of Care. Clinical treatment decisions that determine service site, modality, urgency, and specific interventions needed to address the key presenting signs, symptoms, and environmental factors that indicate the severity of illness and the intensity of service needed by the participant. It also takes into account relevant external factors affecting clinical treatment decisions. (5-8-09)

1~~4~~2. 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 medications for psychiatric disorders. (5-8-09)

1~~5~~3. Neuropsychological Testing. Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system. The data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)

14. New Participant. A participant is considered "new" if he has not received Medicaid-reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the twelve (12) months prior to the current treatment episode. (7-1-11)T

1~~6~~5. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (3-19-07)

1~~7~~6. Occupational Therapy. For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness. (5-8-09)

1~~8~~7. Partial Care. Partial care is treatment for ~~*those children with serious emotional disturbance and adults*~~ participants with ~~*severe*~~ serious and persistent mental illness (SPMI) whose functioning is sufficiently disrupted ~~*so as*~~ to the extent that it interferes with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. ~~*(3-19-07)*~~(7-1-11)T

19~~8~~. **Pharmacological Management**. The in-depth management of medications for psychiatric disorders for relief of a participant's signs and symptoms of mental illness, provided by a licensed practitioner of the healing arts. (5-8-09)

~~20~~19. **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. (5-8-09)

2~~1~~0. **Psychosocial Rehabilitative Services (PSR)**. An array of rehabilitative services that emphasize resiliency for children with serious emotional disturbance (SED) and recovery for adults with serious and persistent mental illness (SPMI). Services target skills for children that they would have appropriately developed for their developmental stage had they not developed symptoms of SED. Services target skills for adults that have been lost due to the symptoms of their mental illness. (5-8-09)

2~~2~~1. **Psychotherapy**. A method of treating and managing psychiatric disorders through the use of evidenced-based psychological treatment modalities that match the participant's ability to benefit from the service. The focus of the service is on behavioral, emotional, and cognitive aspects of a participant's functioning. (5-8-09)

2~~3~~2. **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. (5-8-09)

2~~4~~3. **Restraints**. Restraints include the use of physical, mechanical, or chemical interventions, or other means to temporarily subdue or modify participant behavior. (5-8-09)

a. A restraint includes; (5-8-09)

i. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a participant to move his arms, legs, body, or head freely; or (5-8-09)

ii. A drug or medication when it is used as a restriction to manage the participant's behavior or restrict the participant's freedom of movement and is not a standard treatment or dosage for the participant's condition; (5-8-09)

b. A restraint does not include physical escorts or devices, such as orthopedically prescribed devices, to permit the participant to participate in activities without the risk of physical harm. (5-8-09)

2~~5~~4. **Seclusion**. Seclusion is the involuntary confinement of a participant alone in a room or area from which the participant is prevented from leaving. (5-8-09)

2~~6~~5. **Serious Emotional Disturbance (SED)**. In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is: (5-8-09)

a. An emotional or behavioral disorder, according to the DSM-IV-TR which results in a serious disability; and (5-8-09)

b. Requires sustained treatment interventions; and (5-8-09)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (5-8-09)

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. (5-8-09)

2~~7~~6. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI: (5-8-09)

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 (5-8-09)

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. 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. (5-8-09)

2~~8~~7. Serious and Persistent Mental Illness (SPMI). Participants must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-IV-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. (5-8-09)

2~~9~~8. Skill Training. The service of providing a curriculum-based method of skill building in a custom-tailored approach that meets the needs identified on the person's assessment, focuses on interventions that are necessary to maintain functioning, prevent regression, or achieve a rehabilitation goal, and promotes increased independence in thinking and behavior. Skill training may be delivered individually or in groups. (5-8-09)

~~30~~29. **Tasks**. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (3-19-07)

3~~1~~0. Treatment Plan Review. The practice of obtaining input from members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant. This review should provide feedback and suggestions intended to help team members and the participant to accomplish the participant's goals identified on the participant's individualized treatment plan. (5-8-09)

3~~2~~1. USPRA. The United States Psychiatric Rehabilitation Association is an association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. USPRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. http://www.uspra.org (5-8-09)

112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - PARTICIPANT ELIGIBILITY.
To qualify for enhanced outpatient mental health services, a participant must obtain a comprehensive diagnostic assessment as described in Section 114 of these rules. The comprehensive diagnostic assessment for enhanced outpatient mental health services must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive diagnostic assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. ~~*For PSR, the participant must also obtain a functional assessment that describes the need for skill training.*~~ Participants who receive skill training can only receive training from one (1) type of service, depending on their eligibility. ~~*(5-8-09)*~~(7-1-11)T

01. General Participant Eligibility Criteria. The medical record must have documented evidence of a history and physical examination that has been completed by a participant's primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service. Participants who are in crisis as described at Subsection 123.04 of this rule may receive mental health services prior to obtaining a history and physical examination. In order for a participant to be eligible for enhanced outpatient mental health services, the following criteria must be met and

documented in the comprehensive diagnostic assessment: (5-8-09)

a. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the participant. (5-8-09)

b. The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-2-08)

c. Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in enhanced outpatient mental health services: (4-2-08)

i. Participants at immediate risk of self-harm or harm to others who cannot be stabilized; (4-2-08)

ii. Participants needing more restrictive care or inpatient care; and (4-2-08)

iii. Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (4-2-08)

02. Eligibility Criteria for Children. To be eligible for services, a participant under the age of eighteen (18) must have a serious emotional disturbance (SED). (5-8-09)

03. Eligibility Criteria for Adults. To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI). (5-8-09)

04. Level of Care Criteria - Mental Health Clinics. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. (4-2-08)

a. Children must meet Subsections 112.01 and 112.02 of this rule. (4-2-08)

b. Adults must meet Subsections 112.01 and 112.03 of this rule. (4-2-08)

05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services ~~*and Partial Care Services*~~ for Children. To be eligible for ~~*partial care services or*~~ the PSR services of skill training and community reintegration, a child must meet the criteria of SED and Subsections 112.01 and 112.02 of this rule and must experience a substantial impairment in functioning. A child's level and type of functional impairment must be ~~*described*~~ documented in the ~~*functional assessment*~~ medical record. The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following list: ~~*(5-8-09)*~~(7-1-11)T

a. Self-harmful behavior; (4-2-08)

b. Moods/Emotions; or (4-2-08)

c. Thinking. (4-2-08)

06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Adults. To be eligible for partial care services or the PSR services of skill training and community reintegration, an adult must meet the criteria of SPMI and Subsection 112.01 of this rule. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas in Subsection 112.06.a. through 112.06.h. of this rule on either a continuous or an intermittent, at least once per year, basis. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the adult's level and type of

functional impairment must be ~~described~~ documented in the ~~functional assessment~~ medical record:~~(5-8-09)~~(7-1-11)T

a. Vocational/educational; (4-2-08)

b. Financial; (4-2-08)

c. Social relationships/support; (4-2-08)

d. Family; (4-2-08)

e. Basic living skills; (4-2-08)

f. Housing; (4-2-08)

g. Community/legal; or (4-2-08)

h. Health/medical. (4-2-08)

07. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for enhanced outpatient mental health services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed and documented in the medical record within ten (10) days of discharge. (5-8-09)

i. Up to two (2) hours of plan development hours may be used for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment in order to initiate treatment nor does the participant need to qualify as described in Section 114 of these rules. (5-8-09)

ii. Upon initiation of treatment at the agency, the treatment plan is valid for no more than one hundred twenty (120) days from the date of discharge from the hospital. A~~n intake~~ comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment~~. A comprehensive diagnostic assessment must be completed in lieu of the intake assessment~~ if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information.
~~(5-8-09)~~(7-1-11)T

b. In order for the participant to continue in the services listed on the post-hospitalization treatment plan beyond one hundred twenty (120) days, the plan must be updated and the provider must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule as applicable to the services being provided, and that enhanced outpatient mental health services are appropriate for the participant's age, circumstances, and medically necessary level of care. The PSR or mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. ~~(5-8-09)~~(7-1-11)T

113. ~~ENHANCED OUTPATIENT MENTAL HEALTH SERVICES – INTAKE ASSESSMENT~~ (RESERVED)

~~*Intake assessments may be performed by PSR agencies and Mental Health Clinics for participants who transfer to them from other agencies. Intake assessments must meet requirements listed at IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 709.03. Intake assessments must not be performed as an initial evaluation service in PSR agencies when the PSR agency is performing a comprehensive diagnostic assessment.*~~ ~~(5-8-09)~~

(BREAK IN CONTINUITY OF SECTIONS)

115. ~~*ENHANCED OUTPATIENT MENTAL HEALTH SERVICES -- FUNCTIONAL ASSESSMENT.*~~ (RESERVED)

~~*For participants seeking the PSR services of skill training and community reintegration, a functional assessment must be completed by staff who meet the requirements under Section 131 of these rules. Staff performing the CAFAS/PECFAS must be the same staff completing the functional assessment. The functional assessment must incorporate the CAFAS/PECFAS findings. A functional assessment must evaluate the participant's use of critical skills that are needed for adaptive functioning in the various environments in which he lives. The number of skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The functional assessment should include recommendations for training in skill areas from the following list in which the participant is interested in improving his skills.* (5-8-09)~~

~~***01. Health or Medical Issues**. Focus must be on participant's skills for self managing health and medical issues including ability to schedule and keep medical appointments, maximize opportunities for communicating health status to medical providers, and adherence to medical regimens prescribed by healthcare providers.* (5-8-09)~~

~~***02. Vocational And Educational Status**. Focus must be on skill development to maximize adaptive occupational functioning as applicable to work or school settings.* (5-8-09)~~

~~***03. Financial Status**. Focus must be on the participant's skills for managing personal finances.* (5-8-09)~~

~~***04. Social Relationships and Supports**. Focus must be on participant's skills for establishing and maintaining personal support systems or relationships and participant's skills for developing and participating in leisure, recreational, or social interests.* (5-8-09)~~

~~***05. Family Status**. Focus must be on participant's skills needed to carry out family roles and participate in family relationships.* (5-8-09)~~

~~***06. Basic Living Skills**. Focus must be on participant's skills needed to perform age appropriate basic living skills, including transition to adulthood.* (5-8-09)~~

~~***07. Housing**. Focus must be on participant's skills for obtaining and maintaining safe and appropriate housing.* (5-8-09)~~

~~***08. Community and Legal Status**. Focus must be on participant's skills necessary for community living including compliance with rules, laws, and informal agreements made with others.* (5-8-09)~~

116. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - WRITTEN INDIVIDUALIZED TREATMENT PLAN.

A written individualized treatment plan must be developed and implemented for each participant of enhanced outpatient mental health services as a means to address the enhanced service needs of the participant. Each individualized treatment plan must specify the individual staff person responsible for providing each service, and the amount, frequency and expected duration of treatment. The development of the initial ~~T~~treatment plan~~ning~~ is reimbursable if conducted by a professional identified in Subsections 131.01 through 131.03 of these rules. When the assessment indicates that the participant would benefit from psychotherapy or additional diagnostic services, the treatment plan must be completed by a qualified professional listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. ~~(5-8-09)~~(7-1-11)T

01. Goals. Services identified on the treatment plan must support the goals ~~*of any of the following*~~ that are applicable to the participant's identified needs. For adults, their treatment plan must incorporate the need for psychiatric services identified by the comprehensive diagnostic assessment. For children, their treatment plan must incorporate the substantial impairment areas identified by the CAFAS. Participant's goals may include any of the following: ~~(5-8-09)~~(7-1-11)T

a. Skill Training. The goal is to assist the participant in regaining skills that have been lost due to the symptoms of his mental illness or that would have been otherwise developed except for the interference of his mental health condition. Through skill training, the participant should achieve maximum reduction of symptoms of mental illness or serious emotional disturbance that will allow for the greatest adjustment to living in the community. (5-8-09)

b. Community Reintegration. The goal is to provide practical information and support for the participant to be able to be effectively involved in the rehabilitation process. (5-8-09)

c. Partial care. The goal is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment. (3-19-07)

d. Psychotherapy. The goal is to engage in active treatment that involves psychological strategies for problem resolution to promote optimal functioning and a condition of improved mental health. (5-8-09)

e. Pharmacological Management. The goal is to obtain a decrease or remission of symptoms of psychiatric illness and improve quality of life through the use of pharmacological agents without causing adverse effects. (5-8-09)

02. Plan Content. An individualized treatment plan must meet the requirements listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 710. Additionally, at least one (1) objective is required in the areas that are most likely to lead to the greatest level of stabilization. (5-8-09)

03. Plan Timeframes. An individualized treatment plan must be developed and signed by a licensed physician or other licensed practitioner of the healing arts within thirty (30) calendar days from initial contact. Intermittent treatment plan reviews must occur as needed to incorporate progress, different goals, or change in treatment focus, but must not exceed one hundred twenty (120) days between reviews. An ~~new~~ updated treatment plan must be developed for participants who will continue in treatment beyond twelve (12) months. ~~(5-8-09)~~(7-1-11)T

04. Choice of Providers. The participant or his parent or legal guardian must be allowed to choose whether or not he desires to receive enhanced outpatient mental health services and which provider agency or agencies he would like to assist him in accomplishing the objectives stated in his individualized treatment plan. Documentation must be included in the participant's medical record showing that the participant or his parent or legal guardian has been informed of his rights to refuse services and choose provider agencies. (5-8-09)

05. No Duplication of Services. The provider agency or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to enhanced outpatient mental health services participants through other Medicaid reimbursable and non-Medicaid programs. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DESCRIPTIONS.

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to twelve (12) hours per week per eligible participant. (5-8-09)

a. In order to be considered a partial care service, the service must: (3-19-07)

i. Be provided in a structured environment within the MHC setting; (3-19-07)

ii. Be identified as a service need through the participant's comprehensive diagnostic assessment and ~~the functional assessment and~~ be indicated on the individualized treatment plan with documented, concrete, and measurable objectives and outcomes; and ~~(5-8-09)~~(7-1-11)T

iii. Provide interventions for relieving symptoms, stabilizing behavior, and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (5-8-09)

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)

c. Excluded Services. Services that focus on vocation, recreation, or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. Participants who receive skill training in Partial Care can not receive skill training in psychosocial rehabilitation, developmental therapy, intensive behavioral intervention, or residential habilitation services. ~~(3-19-07)~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): COVERAGE AND LIMITATIONS. The following service limitations apply to PSR agency services, unless otherwise authorized by the Department. (5-8-09)

01. Assessment. Assessment services must not exceed ~~six~~ four (~~6~~4) hours per participant annually. The following assessments are included in this limitation: ~~(5-8-09)~~(7-1-11)T

~~**a.** Intake Assessment; (5-8-09)~~

~~**b**~~**a.** Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually; ~~(5-8-09)~~(7-1-11)T

~~**c.** Functional Assessment. (5-8-09)~~

~~**d.** Psychological and Neuropsychological Assessments. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment. (5-8-09)~~

~~**e**~~**b.** Occupational Therapy Assessment. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment. (5-8-09)

02. Psychological and Neuropsychological Testing. Testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. (7-1-11)T

0~~2~~3. **Individualized Treatment Plan**. Two (2) hours ~~per year per participant per provider agency are available for treatment plan development~~ are available for the development of the participant's initial treatment plan. Following the development of the initial treatment plan, all subsequent treatment must be based on timely updates to the initial plan. Treatment plan updates are considered part of the content of care and should occur as an integral part of the participant's treatment experience. ~~(3-19-07)~~(7-1-11)T

0~~3~~4. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. Services beyond six (6) hours weekly must be prior-authorized. (5-8-09)

0~~4~~5. Crisis Intervention Service. A maximum of ten (10) hours of crisis support in a community may be authorized per crisis per seven (7) day period. Authorization must follow procedure described above at Subsection 123.04 of these rules. This limitation is in addition to any other PSR service hours within that same time frame. (5-8-09)

0~~5~~6. Skill Training and Community Reintegration. Services are limited to five (5) hours weekly in any combination of individual or group skill training and community reintegration for eligible participants up to twenty-one (21) years of age. For participants aged twenty-one (21) years of age or older, services are limited to four (4) hours weekly in any combination of individual or group skill training and community reintegration. ~~*Up to five (5) additional weekly hours are available with prior authorization.*~~ Participants who receive skill training in psychosocial rehabilitation can not receive skill training in partial care, developmental therapy, intensive behavioral intervention, or residential habilitation services. ~~*(5-8-09)*~~(7-1-11)T

0~~6~~7. Pharmacological Management. Pharmacological management services beyond twenty-four (24) encounters per calendar year must be prior authorized by the Department. (5-8-09)

~~***07. Collateral Contact.*** *Collateral contact services beyond six (6) hours per calendar year must be prior authorized by the Department.* ***(5-8-09)***~~

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by an Occupational Therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)

09. Place of Service. PSR agency services are to be home and community-based. (5-8-09)

a. PSR agency services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is necessary to maximize the impact of the service. (5-8-09)

b. PSR agency services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (5-8-09)

125. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.
Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (3-19-07)

01. Inpatient. Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 140.0~~9~~7 of these rules. ~~*(3-19-07)*~~(7-1-11)T

02. Recreational and Social Activities. Activities which are primarily social or recreational in purpose. (3-19-07)

03. Employment. Job-specific interventions, job training and job placement services which includes helping the participant develop a resume, applying for a job, and job training or coaching. (3-19-07)

04. Household Tasks. Staff performance of household tasks and chores. (3-19-07)

05. Treatment of Other Individuals. Treatment services for persons other than the identified participant. (3-19-07)

06. Services Primarily Available Through Service Coordination Agencies. Any service that is typically addressed by Service Coordination as described in Section 727 of these rules, is not included in the program of psychosocial rehabilitation services. The PSR agency staff should refer participants to service coordination agencies for these services. (5-8-09)

07. Medication Drops. Delivery of medication only; (3-19-07)

08. Services Delivered on an Expired Individualized Treatment Plan. Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan. (3-19-07)

09. Transportation. The provision of transportation services and staff time to transport. (3-19-07)

10. Inmate of a Public Institution. Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009. (3-19-07)

11. Services Not Listed. Any other services not listed in Section 123 of these rules. (3-19-07)

126. -- 127. (RESERVED)

128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): RESPONSIBILITIES OF THE DEPARTMENT.
The Department will administer the provider agreement for the provision of PSR agency services and is responsible for the following tasks: (5-8-09)

01. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712. (3-19-07)

02. Prior Authorization Process. Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. ~~(5-8-09)~~

~~**a.** *Hours and Type of Service.* The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to *lead to achievement of the individualized treatment plan objectives*~~ address the participant's needs in relation to those services. ~~(5-8-09)~~(7-1-11)T

~~**b.** *Authorization Time Period. Prior authorizations are limited to no more than a twelve (12) month period and must be reviewed and updated to continue.* (5-8-09)~~

03. Notice of Decision. At the point the Department makes a decision that a participant is ineligible for ~~*PSR agency*~~ specific services, a notice of decision citing the reason(s) the participant is ineligible for ~~*PSR agency*~~ those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. ~~(5-8-09)~~(7-1-11)T

04. ~~*Increases in Individualized Treatment Plan Hours or Change in Service Type*~~ Responding to Requests for Services. When the Department is notified, in writing, by the provider of ~~*recommended increases in hours or change in type of*~~ service~~s~~ ~~*provided*~~ that require~~s~~ prior authorization, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. ~~*A clear rationale for the increase in hours or change in service type must be included with the request.* (5-8-09)~~(7-1-11)T

~~***05. Changes to Individualized Treatment Plan Objectives or Tasks.*** *When a provider believes that an individualized treatment plan needs to be revised without increasing hours or changing type of service, the provider should amend the individualized treatment plan at the time of the next treatment plan review or when substantial*~~

~~*changes in the participant's mental status or circumstances require immediate changes in the plan objectives. The amended individualized treatment plan must be retained in the participant's record and submitted to the Department upon request.*~~ ~~*(5-8-09)*~~

0~~6~~5. Service System. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (3-19-07)

129. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER RESPONSIBILITIES.

01. Provider Agreement. Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR agency services and also is responsible for the following tasks: (5-8-09)

~~***02. Service Provision**. Each provider must have signed additional terms to the general provider agreement with the Department.*~~ ~~*(3-19-07)*~~

0~~3~~2. Service Availability. Each provider must assure provision of PSR agency services to participants on a twenty-four (24) hour basis. (5-8-09)

0~~4~~3. Comprehensive Diagnostic Assessment and Individualized Treatment Plan Development. The provider agency is responsible to conduct a comprehensive diagnostic assessment and develop an individualized treatment plan for each new participant with input from the interdisciplinary team if these services have not already been completed by another provider. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs. ~~*(5-8-09)*~~(7-1-11)T

0~~5~~4. Individualized Treatment Plan. The provider must develop an individualized treatment plan when one (1) has not already been developed in accordance with Section 116 of these rules. Providers must update the participant's treatment plan at least every one hundred twenty (120) days, or more frequently as necessary, until the participant is discharged from services. The signature of a licensed physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the individualized treatment plan indicating the services are medically necessary at least annually. The date of the initial plan is the date it is signed by the physician. ~~*(5-8-09)*~~(7-1-11)T

0~~6~~5. Changes to Individualized Treatment Plan Objectives. When a provider believes that an individualized treatment plan needs to be revised, the provider should make those revisions in collaboration with the participant's interdisciplinary team and obtain required signatures. Amendments and modifications to the treatment plan objectives must be justified and documented in the medical record. (5-8-09)

0~~7~~6. 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 next treatment plan review. (5-8-09)

0~~8~~7. Healthy Connections Referral. Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

136. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): RECORD REQUIREMENTS FOR PROVIDERS.
In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (3-19-07)

01. Name. Name of participant. (3-19-07)

02. Provider. Name of the provider agency and the agency staff person delivering the service. (3-19-07)

03. Date, Time, Duration of Service, and Justification. Documentation of the date, time, and duration of service, and the justification for the length of time which is billed must be included in the record. (3-19-07)

04. Documentation of Progress. The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant. (3-19-07)

05. Treatment Plan Review. A documented outcome-specific review of progress toward each individualized treatment plan goal and objective must be kept in the participant's file. These reviews should occur intermittently, but not more than one hundred twenty (120) days apart on a continual basis until the participant is discharged. ~~(5-8-09)~~(7-1-11)T

a. A copy of the review must be sent to the Department upon request. Failure to do so may ~~result in the loss of a prior authorization or~~ result in a recoupment of reimbursement provided for services delivered after the intermittent staffing review date. ~~(5-8-09)~~(7-1-11)T

b. The review must also include a reassessment of the participant's continued need for services. The review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring changes in the participant's functional impairment. (5-8-09)

c. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services. (3-19-07)

06. Signature of Staff Delivering Service. The legible, dated signature, with degree credentials listed, of the staff person delivering the service. (3-19-07)

07. Choice of Provider. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (3-19-07)

08. Closure of Services. A discharge summary must be included in the participant's record and submitted to the Department identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (3-19-07)

09. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments for any purpose, transporting participants, or documenting services. For services paid at the fifteen (15) minute incremental rate, providers must comply with Medicaid billing requirements. (5-8-09)

10. 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 a minor child, informed consent must be obtained from the minor's parent or legal guardian. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

306. PERSONAL ASSISTANCE AGENCY (PAA): QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services in accordance with Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. (5-8-09)

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (3-19-07)

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-19-07)

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-19-07)

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-19-07)

d. Provision of a licensed professional nurse (RN) or, where applicable, a QIDP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-19-07)

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-19-07)

f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (3-19-07)

g. Billing Medicaid for services approved and authorized by the RMS; (3-19-07)

h. Collecting any participant contribution due; (5-8-09)

i. Conducting, at least annually, participant satisfaction or quality control reviews which are available to the Department and the general public; and (5-8-09)

~~***j.*** *Making referrals for PCS eligible participants for service coordination as described in Sections 720 through 779 of these rules when a need for the service is identified.* *(3-19-07)*~~

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-19-07)

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (3-19-07)

a. Medication management; (3-19-07)

b. Assistance with activities of daily living; (3-19-07)

c. Meals, including special diets; (3-19-07)

d. Housekeeping; (3-19-07)

e. Laundry; (3-19-07)

f. Transportation; (3-19-07)

g. Opportunities for socialization; (3-19-07)

h. Recreation; and (3-19-07)

i. Assistance with personal finances. (3-19-07)

j. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (3-19-07)

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-19-07)

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (3-19-07)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (3-19-07)

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings. (3-30-07)

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (3-19-07)

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-19-07)

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (3-19-07)

a. Intermittent Assistance may include the following. (3-19-07)

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in their home. (3-19-07)

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (3-19-07)

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-19-07)

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-19-07)

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (3-19-07)

a. Rent or own their own home; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no regular caretaker for extended periods of time; and (3-19-07)

d. Are unable to prepare a balanced meal. (3-19-07)

10. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance

with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (3-19-07)

11. Home Modifications. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (3-19-07)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-19-07)

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-19-07)

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (3-19-07)

a. Rent or own their home, or live with unpaid relatives; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no caretaker for extended periods of time; and (3-19-07)

d. Would otherwise require extensive routine supervision. (3-19-07)

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-19-07)

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-19-07)

~~***15. Service Coordination.*** *Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited.* (3-19-07)~~

~~***a.*** *All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS.* (3-19-07)~~

~~***b.*** *The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition.* (3-19-07)~~

16. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or

licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: (3-19-07)

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)

d. Injections; (3-19-07)

e. Blood glucose monitoring; and (3-19-07)

f. Blood pressure monitoring. (3-19-07)

1~~7~~6. Habilitation. Habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in alternate family homes. (3-30-07)

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-30-07)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in

which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (4-2-08)

1~~8~~7. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (3-30-07)

b. Federal Financial Participation (FFP) can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-30-07)

1~~9~~8. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

329. AGED OR DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES. Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

~~***j.*** *To make referrals for service coordination for a PCS-eligible participant when a need for such services is identified; and* *(5-8-09)*~~

~~***k.***~~ **j.** To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (3-19-07)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," including: (4-2-08)

i. Companion services; (4-2-08)

ii. Chore services; and (4-2-08)

iii. Respite care services. (4-2-08)

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D.

psychologist and have one (1) year's experience in treating severe behavior problems. (4-2-08)

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

~~*07. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules.*~~ ~~*(3-19-07)*~~

0~~8~~7. **Consultation Services**. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (3-19-07)

0~~9~~8. **Adult Residential Care Providers**. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-2-08)

~~1~~09. **Home Delivered Meals**. Providers must be a public agency or private business and must be capable of: (3-19-07)

a. Supervising the direct service; (3-19-07)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (3-19-07)

e. Being inspected and licensed as a food establishment by the district health department. (3-19-07)

1~~1~~0. **Personal Emergency Response Systems**. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (3-19-07)

1~~2~~1. **Adult Day Care**. Facilities that provide adult day care must be maintained in safe and sanitary manner. (3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-30-07)

c. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks History and Background Checks." (4-2-08)

132. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (3-19-07)

143. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (3-19-07)

154. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

165. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

176. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-19-07)

187. Residential Habilitation Supported Living Provider Qualifications. Residential habilitation supported living services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in the*ir own* home of the participant (supported living) must be *certified* employed by *the Department as a certified family home and must be affiliated with* a residential habilitation agency. *The residential habilitation agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a residential habilitation agency.* Providers of residential habilitation services must meet the following requirements: *(3-30-07)*(7-1-11)T

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (3-30-07)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable diseases; (3-30-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. (3-30-07)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services qualified by a program coordinator who *has a valid service coordination provider agreement with*

~~the Department and who has taken a traumatic brain injury training course~~ is approved by the Department. ~~(3-30-07)~~(7-1-11)T

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

e. Additional training requirements must be completed within six (6) months of employment ~~or affiliation~~ with the residential habilitation agency and include at a minimum: ~~(3-30-07)~~(7-1-11)T

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)

~~9~~**19. Residential Habilitation Program Coordination for Certified Family Home Providers**. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes" and must receive residential habilitation program coordination from a qualified program coordinator approved by the Department. Non-compliance with the certification process is cause for termination of the provider agreement or contract. ~~(3-30-07)~~(7-1-11)T

~~19~~**20. Day Rehabilitation Provider Qualifications**. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide

documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day rehabilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

2~~0~~1. **Supported Employment Service Providers**. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

2~~1~~2. **Behavior Consultation or Crisis Management Service Providers**. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

507. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION (PA).
The purpose of ~~*Behavioral Health*~~ adult developmental disability services ~~*P*~~prior ~~*A*~~authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. ~~*(3-19-07)*~~(7-1-11)T

508. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION~~*S*~~: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. ~~*(3-19-07)*~~(7-1-11)T

01. Adult. A person who is eighteen (18) years of age or older. (3-29-10)

02. Assessment. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)

03. Clinical Review. A process of professional review that validates the need for continued services. (3-19-07)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-19-07)

06. Exception Review. A clinical review of a plan that falls outside the established standards. (3-19-07)

07. Interdisciplinary Team. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

08. Level of Support. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)

09. Person-Centered Planning Process. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-19-07)

10. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

~~***13. Plan Monitor Summary.*** *A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 513.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns.* (3-19-07)~~

143. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)

154. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)

165. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

176. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)

187. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)

198. Right Price. The most integrated and least expensive services that are sufficiently intensive to

address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

*~~20~~*19. **Right Outcomes**. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

2~~1~~0. **Service Coordination**. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

2~~2~~1. **Service Coordinator**. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

2~~3~~2. **Services**. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

2~~4~~3. **SIB-R**. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

2~~5~~4. **Supports**. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

509. *~~BEHAVIORAL HEALTH~~* ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ELIGIBILITY DETERMINATION.
The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments must be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/ID level of care for waiver services in accordance with Section 584 of these rules. *~~(3-19-07)~~*(7-1-11)T

01. Initial Assessment. For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (3-19-07)

02. Annual Assessments. Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-19-07)

a. The assessment process must be completed; and (3-19-07)

b. The assessor must provide the results of the assessment to the participant. (3-19-07)

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A SIB-R will be administered by the Department for use in this determination. (3-19-07)

04. ICF/ID Level of Care Determination for Waiver Services. The assessor will determine ICF/ID level of care for adults in accordance with Section 584 of these rules. (3-19-07)

510. (RESERVED)

511. ~~INDIVIDUALS WITH~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: - COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid ~~behavioral health~~ developmental disability services for adults: ~~(3-19-07)~~(7-1-11)T

01. DD Waiver Services. DD Waiver services as described in Sections 700 through 719 of these rules; and (3-29-10)

02. Developmental Disabilities Agency Services. Developmental Disabilities Agency services as described in Sections 649 through 659 of these rules and IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; and (7-1-11)

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. ~~BEHAVIOR HEALTH~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of DDA services and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. ~~(3-19-07)~~(7-1-11)T

a. A medical, social and developmental history for each adult participant is completed by the Department or its contractor. Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. (7-1-11)T

b. A medical social and developmental history for children is required when the child is accessing DDA services for the first time, and must reflect accurate information about the participant's status. (7-1-11)T

c. After the initial medical social development history for children, additional Medical Social and Development History services for children will be reimbursed if a qualified professional determines that it no longer reflects the current status of the participant. Please refer to Subsection 655 of these rules. (7-1-11)T

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (3-19-07)

a. The SIB-R for adults is completed by the Department or its contractor. Providers must obtain and

utilize the document generated by the Department or its contractor when one is necessary for program or plan development. (7-1-11)T

b. The SIB-R for children is required for all children accessing DDA services for the first time. (7-1-11)T

c. After the initial SIB-R assessment for children, additional SIB-R assessments will be reimbursed if a qualified professional determines that the assessment no longer reflects the current status of the participant. Please refer to Subsection 655 of these rules. (7-1-11)T

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (3-19-07)

513. ~~BEHAVIOR HEALTH~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. ~~(3-19-07)~~(7-1-11)T

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services provided outside of a Development Disabilities Agency (DDA). (4-2-08)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services ~~if there are multiple plans of service~~. Duplicate services will not be authorized. ~~(3-19-07)~~(7-1-11)T

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews ~~*and complete a plan monitor summary after the six (6) month review and for annual plan development*~~. ~~*(3-19-07)*~~(7-1-11)T

e. The provider will ~~I~~immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the ~~*Regional Medicaid Services (RMS)*~~ Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. ~~*(3-19-07)*~~(7-1-11)T

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.11 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

~~***07. Plan Monitor Summary.*** *The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review.* *(3-19-07)*~~

0~~*8*~~7. **Content of the Plan of Service**. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

~~***09. Negotiation for the Plan of Service.*** *If the services requested on the plan of service fall outside the individualized budget or do not reflect the assessed needs of the participant, the plan developer and the participant will have the opportunity to negotiate the plan of service with the Department's care manager. Services will not be paid for unless they are authorized on the plan of service.* *(3-29-10)*~~

~~*1*~~0~~*8*~~. **Informed Consent**. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

~~*11*~~09. **Provider Implementation Plan**. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service.(3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

12~~.~~0. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change~~s in a participant's need or demonstrated outcomes~~ to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~(3-19-07)~~(7-1-11)T

13~~.~~1. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)

a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)

14~~.~~2. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. ~~(3-19-07)~~(7-1-11)T

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules. (3-19-07)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

1~~5~~3. ~~*Reconsiderations,*~~ Complaints~~,~~ and Administrative Appeals. ~~(3-19-07)~~(7-1-11)T

~~***a.*** *Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within twenty-eight (28) days from the date the decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request.* (3-19-07)~~

~~***b***~~**a.** ~~*Complaints.*~~ Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid~~, Bureau of Care Management~~. ~~(3-19-07)~~(7-1-11)T

~~***c***~~**b.** ~~*Administrative Appeals.*~~ A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~(3-19-07)~~(7-1-11)T

514. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. ~~(3-19-07)~~(7-1-11)T

~~***01. Methodology for Developing Participant Budget Prior to October 1, 2006.*** *The participant budget is developed using the following methodology:* (3-19-07)~~

~~***a.*** *Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services;* (3-19-07)~~

~~***b.*** *Review all assessment information identified in Section 512 of these rules;* (3-19-07)~~

~~***c.*** *Identify the level of support derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behavior as determined by the SIB-R. Six (6) broad levels of support have been identified on a scale from zero to one hundred (0 - 100) (see Table 514.01.c.). There are six (6) levels of support, each corresponding to a support score range.*~~

TABLE 514.01.c. - LEVEL OF SUPPORT	
Support Score Range	Level of Support
1-24	Pervasive
25-39	Extensive
40-54	Frequent
55-69	Limited
70-84	Intermittent
85-100	Infrequent

(3-19-07)

d. Correlate the level of support identified by the SIB-R to a budget range derived from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service; (3-19-07)

02. Negotiating an Appropriate Participant Budget Prior to October 1, 2006. The assessor, the participant, and the plan developer must use all the information from Subsections 514.01.a. through 514.01.d. of these rules to negotiate an appropriate budget that will support the participant's identified needs. (3-19-07)

03**1**. **Individualized Budget Beginning on October 1, 2006**. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, and other individual factors related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-29-10)(7-1-11)T

a. During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the previous year's budget amount. The Department will collect information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology. (3-19-07)

b**a**. The Department notifies each participant of his set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may request reconsideration of appeal the set budget amount. (3-19-07)(7-1-11)T

c**b**. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-19-07)(7-1-11)T

04**3**. **Residential Habilitation - Supported Living Acuity-Based Levels of Support**. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision and have an SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-19-07)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

515. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may terminate authorization of service for providers who do not comply with the corrective action plan. (3-19-07)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (3-19-07)

03. Exception Review. In order to assure health and safety of the participant, ~~T~~the Department will complete an ~~clinical~~ exception review of plans of service ~~that~~ requesting residential habilitation High or Intense Supported Living when the request exceeds the assigned budget authorized by the assessor, ~~or are inconsistent with the participant's assessed needs~~ and when the services requested on the plan are required, based on medical necessity in accordance with Subsection 012.14 of these rules. ~~The supporting documentation must demonstrate the medical necessity of services in the plan of service.~~ ~~(3-19-07)~~(7-1-11)T

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (3-19-07)

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

581. ICF/ID: ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the ~~Regional Nurse Reviewer (RNR)~~ Department has determined that the individual meets the criteria for ICF/ID services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. ~~(3-19-07)~~(7-1-11)T

582. ICF/ID: DETERMINATION OF ENTITLEMENT FOR MEDICAID PAYMENT.
Applications for Medicaid payment of an individual with an intellectual disability or related condition, in an ICF/ID will be through the Department~~'s RMS staff~~. All required information necessary for a medical entitlement determination must be submitted to the ~~Regional Medicaid Services~~ Department before a determination and approval for payment is made. The effective date of Medicaid payment will be no earlier than the physician's signed and dated certification for ICF/ID level of care. ~~(3-19-07)~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

651. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts. The following therapy services are reimbursable when provided in accordance with these rules. (7-1-11)

01. Required DDA Services. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided by qualified employees of the agency or through a formal written agreement. (7-1-11)

a. Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (7-1-11)

b. When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one. (7-1-11)

02. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on a comprehensive developmental assessment completed prior to the delivery of developmental therapy. Developmental therapy will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. ~~(7-1-11)~~(7-1-11)T

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-11)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-11)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-11)

03. Psychotherapy Services. The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to deliver the service: (7-1-11)

a. Individual psychotherapy; (7-1-11)

b. Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and (7-1-11)

c. Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. (7-1-11)

d. Psychotherapy services~~, *alone or in combination with supportive counseling,*~~ are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered. ~~(7-1-11)~~(7-1-11)T

e. Psychotherapy services must be provided by one (1) of the following qualified professionals: (7-1-11)

i. Licensed Psychiatrist; (7-1-11)

ii. Licensed Physician; (7-1-11)

iii Licensed Psychologist; (7-1-11)

iv. Licensed Clinical Social Worker; (7-1-11)

v. Licensed Clinical Professional Counselor; (7-1-11)

vi. Licensed Marriage and Family Therapist; (7-1-11)

vii. Certified Psychiatric Nurse (RN), 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; (7-1-11)

viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.e.i. through 651.03.e.vii. of this rule; (7-1-11)

ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

x. 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 (7-1-11)

xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-11)

04. Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

05. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

06. Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Speech-language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules. (7-1-11)

07. Optional Services. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, ~~*collateral contact,*~~ Intensive Behavioral Intervention (IBI)~~*, and supportive counseling*~~. All services must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. ~~*(7-1-11)*~~(7-1-11)T

08. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency, and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (7-1-11)

09. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the

participant's plan of service with the type, amount, frequency, and duration of service specified. (7-1-11)

a. Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. (7-1-11)

b. On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. (7-1-11)

c. Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: (7-1-11)

i. Psychiatrist; (7-1-11)

ii. Physician or other practitioner of the healing arts; (7-1-11)

iii. Psychologist; (7-1-11)

iv. Clinical social worker; or (7-1-11)

v. Clinical professional counselor. (7-1-11)

10. Community Crisis Supports. Community crisis supports are interventions for adult participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. (7-1-11)

~~***11. Collateral Contact**. Collateral contact is consultation with or treatment direction given to a person with a primary relationship to a participant for the purpose of assisting the participant to live in the community. Collateral contact must be: (7-1-11)~~

~~***a.** Conducted by Agency Professionals. Be conducted by agency professionals qualified to deliver services and be necessary to gather and exchange information with individuals having a primary relationship to the participant. (7-1-11)~~

~~***b.** Face to Face or by Telephone. Be conducted either face to face or by telephone when telephone contact is the most expeditious and effective way to exchange information. Collateral contact does not include general staff training, general staffings, regularly scheduled parent-teacher conferences, general parent education, or treatment team meetings, even when the parent is present. (7-1-11)~~

~~***c.** On the Plan of Service. Have a goal and objective stated on the plan of service that identifies the purpose and outcome of the service and is conducted only with individuals specifically identified on the plan of service. Program Implementation Plans are not required for collateral contact objectives. (7-1-11)~~

1~~2~~1. Intensive Behavioral Intervention. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. (7-1-11)

a. IBI is limited to a lifetime limit of thirty-six (36) months. (7-1-11)

b. The DDA must receive prior authorization from the Department prior to delivering IBI services. (7-1-11)

c. IBI must only be delivered on an individualized, one-to-one (1 to 1) basis. (7-1-11)

d. Intensive behavioral intervention services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. (7-1-11)T

~~d~~e. ~~*Established Developmental Therapy Program.*~~ After July 1, 2006, agencies must have provided

developmental therapy for at least one (1) year and not be operating under a provisional certification prior to providing IBI services. ~~(7-1-11)~~(7-1-11)T

~~e~~**f.** ~~Exception.~~ Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of this rule. ~~(7-1-11)~~(7-1-11)T

~~f~~**g.** ~~IBI Consultation.~~ IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. ~~(7-1-11)~~(7-1-11)T

~~**13. Supportive Counseling**. Supportive counseling must only be delivered on an individualized, one to one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. (7-1-11)~~

~~**a.** Psychological Assessment. The initial and ongoing need for the service of supportive counseling must be recommended in a current psychological assessment. (7-1-11)~~

~~**b.** On Plan of Service. Supportive counseling must be provided in accordance with the requirements for the plan of service. The type, amount, frequency, and duration of this service must be specified on the plan of service. (7-1-11)~~

~~**c.** Staff Qualifications. Supportive counseling must be provided by a professional listed under Subsection 651.03.c. of these rules or by a licensed social worker (LSW). (7-1-11)~~

1~~4~~2. **Excluded Services**. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

1~~5~~3. **Limitations on DDA Services**. DDA ~~T~~therapy services may not exceed the limitations as specified below. ~~(7-1-11)~~(7-1-11)T

a. The combination of therapy services listed in Subsections 651.02 through 651.06, and 651.1~~2~~1~~, and 651.13~~ of this rule must not exceed twenty-two (22) hours per week. ~~(7-1-11)~~(7-1-11)T

b. Therapy services listed in Subsections 651.02 through 651.06, and 651.1~~2~~1~~, and 651.13~~ of this rule, provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. ~~(7-1-11)~~(7-1-11)T

c. When an HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (7-1-11)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

655. DDA SERVICES: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. ~~*Twelve*~~ Four (~~*12*~~4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. Psychological assessment benefits are separately limited to four (4) hours annually. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: ~~*(7-1-11)*~~(7-1-11)T

a. Comprehensive Developmental Assessment; (7-1-11)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the ~~*twelve*~~ four (~~*12*~~4) hour limitation described in Subsection 655.01 of this rule; ~~*(7-1-11)*~~(7-1-11)T

c. Occupational Therapy Assessment; (7-1-11)

d. Physical Therapy Assessment; (7-1-11)

e. Speech and Language Assessment; (7-1-11)

f. Medical/Social History; and (7-1-11)

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (7-1-11)

02. Comprehensive Assessments Conducted by the DDA. Assessments must be conducted by qualified professionals defined under Section 657 of these rules for the respective discipline or areas of service. (7-1-11)

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

iii. Guide treatment; (7-1-11)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)

v. For medical or psychiatric assessments, formulate a diagnosis. For psychological assessments, formulate a diagnosis and recommend the type of therapy necessary to address the participant's needs. For other types of assessments, recommend the type and amount of therapy necessary to address the participant's needs. (7-1-11)

b. Current Assessments Required. When the DDA determines developmental disabilities eligibility, current assessments must be completed or obtained as necessary. (7-1-11)

c. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)

d. Assessment must be completed within forty-five (45) days. (7-1-11)

i. With the exception noted under Subsection 655.02.d.ii. of this rule, each assessment must be completed within forty-five (45) calendar days of the date it was recommended by the physician or other practitioner of the healing arts. If the assessment is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. (7-1-11)

ii. This forty-five (45) day requirement does not apply to participant plans of service authorized under Sections 507 through 515 of these rules. (7-1-11)

03. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. (7-1-11)

a. ~~*Current Assessments for Ongoing Services.*~~ To be considered current, assessments must be completed or updated at least ~~*annually*~~ every two (2) years for service areas in which the participant is receiving services on an ongoing basis. ~~*(7-1-11)*~~(7-1-11)T

b. ~~*Updated Assessments.*~~ Assessments or updates are required in disciplines in which services are being delivered and when recommended by a professional. At the time of the required review of the assessment(s), the qualified professional in the respective discipline must determine whether a full assessment or an updated assessment is required for the purpose of reflecting the participant's current status in that service area. If, during the required review of the assessment(s), the latest assessment accurately represents the status of the participant, the file must contain documentation from the professional stating so. ~~*(7-1-11)*~~(7-1-11)T

c. ~~*Medical/Social Histories and Medical Assessments.*~~ Medical/social histories and medical assessments must be completed at a frequency determined by the recommendation of a professional qualified to conduct those assessments. ~~*(7-1-11)*~~(7-1-11)T

d. ~~*Intelligence Quotient (IQ) Tests.*~~ Once initial eligibility has been established, annual assessment of IQ is not required for persons whose categorical eligibility for DDA services is based on a diagnosis of mental retardation. IQ testing must be reconducted on a frequency determined and documented by the agency psychologist or at the request of the Department. ~~*(7-1-11)*~~(7-1-11)T

e. ~~*Completion of Assessments.*~~ Assessments must be completed or obtained prior to the delivery of therapy in each type of service. ~~*(7-1-11)*~~(7-1-11)T

f. ~~*Psychological Assessment.*~~ A current psychological assessment must be ~~*completed or obtained*~~ updated in accordance with Subsection 655.03.f. of these rules: ~~*(7-1-11)*~~(7-1-11)T

~~*i. When the participant is receiving a behavior modifying drug(s); (7-1-11)*~~

i~~*i*~~. Prior to the initiation of restrictive interventions to modify inappropriate behavior(s); (7-1-11)

~~*iii. Prior to the initiation of supportive counseling; (7-1-11)*~~

i~~*v*~~i. When it is necessary to determine eligibility for services or establish a diagnosis; (7-1-11)

~~*v*~~iii. When a participant has been diagnosed with mental illness; or (7-1-11)

~~*v*~~iv. When a child has been identified to have a severe emotional disturbance. (7-1-11)

04. Assessments for Adults. DDAs must obtain assessments required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515 of these rules. All specific skill assessments must be conducted in accordance with Subsection 655.06 of these rules. (7-1-11)

05. Types of Comprehensive Assessments. (7-1-11)

a. Comprehensive Developmental Assessment. A comprehensive developmental assessment must be conducted by a qualified Development Specialist and reflect a person's developmental status in the following areas: (7-1-11)

i. Self-care; (7-1-11)

ii. Receptive and expressive language; (7-1-11)

iii. Learning; (7-1-11)

iv. Gross and fine motor development; (7-1-11)

v. Self-direction; (7-1-11)

vi. Capacity for independent living; and (7-1-11)

vii. Economic self-sufficiency. (7-1-11)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. The requirements for the comprehensive IBI assessment are found under Subsection 656.03 of these rules. (7-1-11)

c. Occupational Therapy Assessment. Occupational therapy assessments must be conducted by an occupational therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. (7-1-11)

d. Physical Therapy Assessment. Physical therapy assessments must be conducted by a physical therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. (7-1-11)

e. Speech and Language Assessment. Speech and language assessments must be conducted by a Speech-Language Pathologist who is qualified under Section 657 of these rules. (7-1-11)

f. Medical Assessments. Medical assessments must be completed by a physician or other practitioner of the healing arts who is qualified in accordance with Section 657 of these rules and accurately reflects the current status and needs of the person. (7-1-11)

g. Medical/Social History. Medical/social histories must be completed by a licensed social worker or other qualified professional working within the scope of his license. The medical/social history is a narrative report that must include: (7-1-11)

i. Medical history including age of onset of disability, prenatal and postnatal birth issues, other major medical issues, surgeries, and general current health information; (7-1-11)

ii. Developmental history including developmental milestones and developmental treatment interventions; (7-1-11)

iii. Personal history including social functioning/social relationships, recreational activities, hobbies, any legal and criminal history, and any history of abuse; (7-1-11)

iv. Family history including information about living or deceased parents and siblings, family medical history, relevant family cultural background, resources in the family for the participant; (7-1-11)

v. Educational history including any participation in special education; (7-1-11)

vi. Prevocational or vocational paid and unpaid work experiences; (7-1-11)

vii. Financial resources; and (7-1-11)

viii. Recommendation of services necessary to address the participant's needs. (7-1-11)

h. Hearing Assessment. A hearing assessment must be conducted by an audiologist who is qualified under Section 657 of these rules. (7-1-11)

i. Psychological Assessment. A psychological assessment includes psychological testing for diagnosis and assessment of personality, psychopathology, emotionality, or intellectual abilities (IQ test). The assessment must include a narrative report. Psychological assessment encompasses psychological testing and the psychiatric diagnostic interview. (7-1-11)

j. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of a person'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. (7-1-11)

i. Psychological testing may be provided when in direct response to a specific assessment question. (7-1-11)

ii. The psychological report must contain the reason for the performance of this service. (7-1-11)

iii. Agency staff may deliver this service if they meet one (1) of the following qualifications: (7-1-11)

(1) Licensed Psychologist; (7-1-11)

(2) Psychologist Extender; or (7-1-11)

(3) A qualified therapist listed in Subsection 651.03.e. 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. (7-1-11)

k. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must be conducted in accordance with Subsection 651.09 of these rules. (7-1-11)

06. Requirements for Specific Skill Assessments. Specific skill assessments must: (7-1-11)

a. Further Assessment. Further assess an area of limitation or deficit identified on a comprehensive assessment. (7-1-11)

b. Related to a Goal. Be related to a goal on the IPP, ISP, or IFSP. (7-1-11)

c. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective disciplines as defined in this chapter. (7-1-11)

d. Determine a Participant's Skill Level. Be conducted for the purposes of determining a participant's skill level within a specific domain. (7-1-11)

e. Determine Baselines. Be used to determine baselines and develop the program implementation plan. (7-1-11)

07. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. When a participant receives developmental therapy, documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. (7-1-11)

b. Additional Requirements for Participants Eighteen Years or Older. For participant's eighteen (18) years of age or older, DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-11)

c. Additional Requirements for Participants Seven Through Sixteen. For participants ages seven (7) through sixteen (16), the DDA must also document that the child has been referred to the local school district in accordance with the collaboration requirements in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

d. Additional Requirements for Participants Birth to Three Years of Age. For participants birth to age three (3), the following are required in addition to those requirements in Subsection 654.01 of these rules: (7-1-11)

i. Documentation of the six (6) month and annual reviews; (7-1-11)

ii. Documentation of participation in transition planning at the IFSP developed closest to the child's second birthday to ensure service continuity and access to community services as early intervention services end at age three (3); (7-1-11)

iii. Documentation that participant rights have been met in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

iv. Documentation of participation in the transition meeting with the school district; and (7-1-11)

v. Documentation of consultation with other service providers who are identified on the IFSP. (7-1-11)

08. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The Program Implementation Plan must include the following requirements: (7-1-11)

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

658. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.

01. Standards for Paraprofessionals Providing Developmental Therapy and IBI. When a paraprofessional provides either developmental therapy or IBI, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 657 of these rules. A paraprofessional providing IBI must be supervised by an IBI professional; a paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. Paraprofessionals providing developmental therapy to children birth to three (3) years of age must work under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. For paraprofessionals to provide developmental therapy or IBI in a DDA, the agency must adhere to the following standards: (7-1-11)

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service, develop a Program Implementation Plan, or conduct ~~collateral contact or~~ IBI consultation. These activities must be conducted by a professional qualified to provide the service. ~~(7-1-11)~~(7-1-11)T

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or more often if necessary: (7-1-11)

i. Give instructions; (7-1-11)

ii. Review progress; and (7-1-11)

iii. Provide training on the program(s) and procedures to be followed. (7-1-11)

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under his supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (7-1-11)

d. Limitations to Service Provision by an IBI Paraprofessional. IBI provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time, per individual participant. The remaining ten percent (10%) of the direct intervention time must be provided by the professional qualified to provide and direct the provision of IBI. (7-1-11)

e. Additional Training Requirements for IBI Professionals and IBI Paraprofessionals. Qualified IBI professionals and IBI paraprofessionals must complete and pass a Department-approved training course and examination for certification. The training must include a curriculum that addresses standards of competence for the provision of IBI and ethical standards. Specifically, the curriculum must include: (7-1-11)

i. Assessment of individuals; (7-1-11)

ii. Behavioral management; (7-1-11)

iii. Services or treatment of individuals; (7-1-11)

iv. Supervised practical experience; and (7-1-11)

v. Successful completion of a student project that includes an observation of demonstrated competencies for all individuals applying for initial certification or recertification after July 1, 2003. (7-1-11)

f. Continuing Training Requirements for IBI Professionals and IBI Paraprofessionals. Each IBI professional and IBI paraprofessional, in order to maintain certification, must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. (7-1-11)

i. The initial IBI certification training meets the yearly training requirement for the calendar year in which the IBI professional or paraprofessional was first certified. (7-1-11)

ii. If the individual has not completed the required training during any yearly training period, he may not provide IBI services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

iii. An individual may remain IBI certified, despite being unable to bill for services, through two (2) consecutive annual training periods during which that individual has deficient training hours. A DDA may begin billing for the certified IBI Professional or Paraprofessional again after the required training hours are accumulated. (7-1-11)

iv. If an individual completes three (3) consecutive annual training periods without having accumulated sufficient training to satisfy the training requirement for the first of those periods, that individual's IBI certification is automatically rescinded and will no longer be recognized. To be recertified, the individual must retake the state IBI exam and complete the IBI Student Project, if not previously completed. (7-1-11)

02. General Staffing Requirements for Agencies. (7-1-11)

a. Administrative Staffing. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (7-1-11)

i. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and (7-1-11)

ii. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. (7-1-11)

b. Other required staffing. The agency must have available, at a minimum, the following personnel, qualified in accordance with Section 657 of these rules, as employees of the agency or through formal written agreement: (7-1-11)

i. Speech-language pathologist or audiologist; (7-1-11)

ii. Developmental Specialist; (7-1-11)

iii. Occupational therapist; (7-1-11)

iv. Physical therapist; (7-1-11)

v. Psychologist; and (7-1-11)

vi. Social worker, or other professional qualified to provide the required services under the scope of his license. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a

participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

d. Residential Habilitation services will not be reimbursed if a participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. (7-1-11)T

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-19-07)

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by

the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

13. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation -- Supported Living. When ~~R~~residential habilitation services ~~must be~~ are provided by an agency, ~~that is~~ the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and ~~is~~ must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the~~ir own~~ home of the participant (supported living) must be ~~certified~~ employed by ~~the Department as a certified family home and must be affiliated with~~ a Residential Habilitation Agency. ~~The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency.~~ Providers of residential habilitation services must meet the following requirements: ~~(3-19-07)~~(7-1-11)T

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs.
~~(3-19-07)~~(7-1-11)T

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: ~~(3-19-07)~~(7-1-11)T

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

d. Additional training requirements must be completed within six (6) months of employment ~~*or affiliation*~~ with the residential habilitation agency and include at a minimum: ~~(3-19-07)~~(7-1-11)T

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

~~***f.*** *When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider's provider agreement.* (3-19-07)~~

02. Residential Habilitation -- Certified Family Home (CFH). (7-1-11)T

a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides. (7-1-11)T

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (7-1-11)T

i. Be at least eighteen (18) years of age; (7-1-11)T

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (7-1-11)T

iii. Have current CPR and First Aid certifications; (7-1-11)T

iv. Be free from communicable diseases; (7-1-11)T

v. Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training. (7-1-11)T

vi. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" and (7-1-11)T

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (7-1-11)T

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (7-1-11)T

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: (7-1-11)T

i. Purpose and philosophy of services; (7-1-11)T

ii. Service rules; (7-1-11)T

iii. Policies and procedures; (7-1-11)T

iv. Proper conduct in relating to waiver participants; (7-1-11)T

v. Handling of confidential and emergency situation that involve the waiver participant; (7-1-11)T

vi. Participant rights; (7-1-11)T

vii. Methods of supervising participants; (7-1-11)T

viii. Working with individuals with developmental disabilities; and (7-1-11)T

ix. Training specific to the needs of the participant. (7-1-11)T

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (7-1-11)T

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (7-1-11)T

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (7-1-11)T

iii. Feeding; (7-1-11)T

iv. Communication; (7-1-11)T

v. Mobility; (7-1-11)T

vi. Activities of daily living; (7-1-11)T

vii. Body mechanics and lifting techniques; (7-1-11)T

viii. Housekeeping techniques; and (7-1-11)T

ix. Maintenance of a clean, safe, and healthy environment. (7-1-11)T

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (7-1-11)T

0~~2~~3. **Chore Services**. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

0~~3~~4. **Respite**. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

0~~4~~5. **Supported Employment**. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background

check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05~~5~~6. **Transportation**. Providers of transportation services must: (3-19-07)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

06~~6~~7. **Environmental Accessibility Adaptations**. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

07~~7~~8. **Specialized Equipment and Supplies**. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)

08~~8~~9. **Personal Emergency Response System**. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)

***09~~9~~*10.** **Home Delivered Meals**. Services of Home Delivered Meals under this Subsection may only be provided by an agency capable of supervising the direct service and must: (7-1-11)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

10~~*0*~~1. **Skilled Nursing**. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

11~~*1*~~2. **Behavior Consultation or Crisis Management**. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

1~~2~~3. Adult Day Care. Providers of adult day care services must ~~*be employed by or be affiliated with the residential habilitation agency that provides*~~ notify the Department or its contractor for residential habilitation program coordination, ~~*for*~~ on behalf of the participant, if the ~~*service*~~ adult day care is provided in a certified family home other than the participant's primary residence~~.~~. The adult day care provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: ~~*(3-19-07)*~~(7-1-11)T

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (4-2-08)

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

1~~3~~4. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

724. ~~*SERVICE COORDINATION -- ELIGIBILITY: INDIVIDUALS ELIGIBLE FOR PERSONAL ASSISTANCE SERVICES.*~~ (RESERVED)

~~*An individual is eligible to receive service coordination if he meets the following requirements in Subsections 724.01 and 724.02 of this rule.*~~ ~~*(5-8-09)*~~

~~***01. Personal Care and Waiver Services.*** *Adults age eighteen (18) and older, who is eligible to receive state plan personal care services, or Aged and Disabled Home and Community Based Waiver Services.*~~ ~~*(5-8-09)*~~

~~***02. Need Assistance.*** *Requires and chooses assistance to access services and supports necessary to maintain his independence in the community.*~~ ~~*(5-8-09)*~~

(BREAK IN CONTINUITY OF SECTIONS)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed medical, psychiatric, social, early intervention, educational, and other services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (5-8-09)

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

a. Taking a participant's history; (5-8-09)

b. Identifying the participant's needs and completing related documentation; and (5-8-09)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions to address medical, psychiatric, social, early intervention, educational, and other services needed by the participant. The plan must be updated at least annually and as needed to meet the needs of the participant. (5-8-09)

03. Referral and Related Activities. Activities that help link the participant with medical, psychiatric, social, early intervention, educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (5-8-09)

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met: (5-8-09)

a. Services are being provided according to the participant's plan; (5-8-09)

b. Services in the plan are adequate; and (5-8-09)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 507 through 515 of these rules. (5-8-09)

c. Crisis Assistance for Adults with Serious and Persistent Mental Illness. Initial crisis assistance is limited to a total of three (3) hours per calendar month. Additional crisis service coordination services must be

authorized by the Department and may be requested when the participant is at imminent risk of reinstitutionalization within fourteen (14) days following discharge from a hospital, institution, jail or nursing home, or meets the criteria listed in Subsection 727.05.c.i. through 727.05.c.iii. of this rule; (5-8-09)

i. The participant is experiencing symptoms of psychiatric decompensation that interferes or prohibits the participant from gaining or coordinating necessary services; (5-8-09)

ii. The participant has already received the maximum number of monthly hours of ongoing service coordination and crisis service coordination hours; and (5-8-09)

iii. No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR). (5-8-09)

~~*d. Crisis Assistance for Individuals Eligible for Personal Assistance Services. Crisis hours are not available until eight (8) hours of service coordination have already been provided in the month. Crisis hours must be authorized by the Department.* (5-8-09)~~

~~e~~**d.** Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. (5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving either children's service coordination or service coordination for adults with mental illness.The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (5-8-09)

09. Limitations on Service Coordination. Service coordination is limited to the following: (5-8-09)

a. Service Coordination for Persons with Mental Illness. Up to five (5) hours per month of ongoing service coordination for participants with mental illness. (5-8-09)

~~*b. Service Coordination for Personal Assistance Services. Up to eight (8) hours per month for participants who are eligible to receive personal assistance services.* (5-8-09)~~

~~c~~**b.** Service Coordination for Children. Up to four and a half (4.5) hours per month for participants who meet the eligibility qualifications for Children's Service Coordination. (5-8-09)

~~d~~**c.** Service Coordination for Adults with a Developmental Disability. Up to four and a half (4.5) hours per month for participants with developmental disabilities. (5-8-09)

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours annually for children, adult participants with mental illness, or adult ~~*personal assistance*~~ participants diagnosed with developmental disabilities. ~~*Plan development for adult participants with developmental disabilities cannot exceed twelve (12) hours annually.*~~

~~*(5-8-09)*~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (5-8-09)

a. Service coordination plan development defined in Section 721 of these rules. (5-8-09)

b. Face-to-face contact required in Subsection 728.07 of these rules. (5-8-09)

c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (5-8-09)

d. Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)

e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (5-8-09)

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. (5-8-09)

a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (5-8-09)

i. During the last fourteen (14) days of an inpatient stay which is less than one hundred eighty (180) days in duration; or (5-8-09)

ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (5-8-09)

b. Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (5-8-09)

c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (5-8-09)

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (5-8-09)

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (5-8-09)

a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5
82	98	6
97	113	7

(5-8-09)

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (5-8-09)

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (5-8-09)

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (5-8-09)

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

07. Healthy Connections. A participant enrolled in Healthy Connection must receive a referral for assessment and provision of services from his Healthy Connections provider~~, *unless he receives personal care services or aged and disabled waiver services*~~. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. ~~*(5-8-09)*~~(7-1-11)T

08. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.13 - CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-1101

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2011.

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 regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, and, 56-250 through 56-257, Idaho Code; also House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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 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:

Rule changes are being made to align the rules with House Bill 260 passed by the 2011 Legislature. In Section 56-255(3)(f), Idaho Code, as amended, the Department is directed to respond to requests for budget modifications only when health and safety issues are identified and meet the criteria as defined in rule.

The Department is refining the developmental disabilities individual budget modification process, and related requirements and criteria. This will enable the Department to respond to requests for individual developmental disabilities budget modifications only when health and safety issues are identified.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to comply with deadlines in amendments to governing law or federal programs, in particular, House Bill 260 (2011).

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

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:

Self-Directed Services come under Developmental Disabilities Waiver Services found in IDAPA 16.03.10. The total estimated cost savings to the state general fund for these rule changes for SFY 2012 has already been included in the fiscal impact statement and the Department's appropriations for SFY 2012 in the PARF under Docket No. 16-0310-1105. (Specifically, it is included in the $2,000,000 portion related to the budget for developmental disabilities services.)

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Paige Grooms at (208) 947-3364.

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 August 24, 2011.

DATED this 13th day of July, 2011.

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

THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0313-1101

000. LEGAL AUTHORITY.
In accordance with Sections 56-202, 56-203, ~~*and*~~ Sections 56-250 through 257, and Sections 56-260 through 56-266, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the provision of consumer-directed services. ~~*(3-30-07)*~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. Circle of Supports. People who encourage and care about the participant and provide unpaid supports. (3-30-07)

02. Community Support Worker. An individual, agency, or vendor selected and paid by the participant to provide community support worker services. (3-30-07)

03. Community Support Worker Services. Community support worker services are those identified supports listed in Section 110 of these rules. (3-30-07)

04. Consumer-Directed Community Supports (CDCS). For the purposes of this chapter, consumer-directed supports include Self-Directed Community Supports (SDCS) and Family-Directed Community Supports (FDCS). (7-1-11)

05. Family-Directed Community Supports (FDCS). A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

06. Financial Management Services (FMS). Services provided by a fiscal employer agent that include: (3-29-10)

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; (3-30-07)

b. Performing payroll services; and (3-30-07)

c. Handling billing and employment related documentation responsibilities. (3-30-07)

07. Fiscal Employer Agent (FEA). An agency that provides financial management services to participants who have chosen the CDCS option. The fiscal employer agent (FEA) is selected by the participant. The duties of the FEA are defined under Section 3504 of the Internal Revenue Code (26 USC 3504). (7-1-11)

08. Goods. Tangible products or merchandise that are authorized on the support and spending plan. (3-30-07)

09. Guiding Principles for the CDCS Option. Consumer-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: (7-1-11)

a. Freedom for the participant to make choices and plan his own life; (3-30-07)

b. Authority for the participant to control resources allocated to him to acquire needed supports; (3-30-07)

c. Opportunity for the participant to choose his own supports; (3-30-07)

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (3-30-07)

e. Shared responsibility between the participant and his community to help the participant become an involved and contributing member of that community. (3-30-07)

10. Participant. A person eligible for and enrolled in the Consumer-Directed Services Programs. (7-1-11)

11. Readiness Review. A review conducted by the Department to ensure that each fiscal employer agent is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. (3-29-10)

12. Self-Directed Community Supports (SDCS). A program option for adults eligible for the Adult Developmental Disabilities (DD) Waiver described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

13. Support and Spending Plan. A support and spending plan is a document that functions as a participant's plan of care when the participant is eligible for and has chosen a consumer-directed service option. This document identifies the goods or services, or both, selected by a participant, including those goods, services, and supports available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each of the identified goods and services. The participant uses this document to manage his individualized budget. ~~(7-1-11)~~(7-1-11)T

14. Supports. Services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a community support worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. (3-30-07)

15. Support Broker. An individual who advocates on behalf of the participant and who is hired by the participant to provide support broker Services. (3-30-07)

16. Support Broker Services. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. (3-30-07)

17. Traditional Adult DD Waiver Services. A program option for participants eligible for the Adult Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in

IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

18. Traditional Children's DD Waiver Services. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

19. Traditional Children's HCBS State Plan Option Services. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

20. Waiver Services. A collective term that refers to services provided under a Medicaid Waiver program. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

111. UNPAID COMMUNITY SUPPORTS AND SERVICES.
The Department requires that participants and their support broker identify and prioritize the use of any goods, services and supports available through an unpaid volunteer support or service, or those goods, services, and supports that can be provided by a natural support such as a family member, a friend, a neighbor or other volunteer. (7-1-11)T

11~~1~~2. -- 119. (RESERVED)

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following: (3-30-07)

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option found in Section 010 of these rules. (7-1-11)

02. Person-Centered Planning. Participating in the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. ~~(3-30-07)~~(7-1-11)T

03. Rates. Negotiating payment rates for all paid community supports he wants to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and that are cost-effective when comparing them to reasonable alternatives, and including the details in the employment agreements. ~~(3-30-07)~~(7-1-11)T

04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms. (3-30-07)

05. Agreement Detail. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; and no employer-related claims will be filed against the Department. (3-30-07)

06. Plan. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning. (3-30-07)

07. Time Sheets and Invoices. Reviewing and verifying that supports being billed were provided and

indicating that he approves of the bill by signing the timesheet or invoice. (3-29-10)

08. Quality Assurance and Improvement. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

136. SUPPORT BROKER DUTIES AND RESPONSIBILITIES.

01. Support Broker Initial Documentation. Prior to beginning employment for the participant, the support broker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. This packet must include documentation of: (3-30-07)

a. Support broker application approval by the Department; (3-30-07)

b. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-30-07)

c. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the support broker. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The negotiated rate must not exceed the maximum hourly rate for support broker services established by the Department. (3-30-07)

02. Required Support Broker Duties. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must: (3-30-07)

a. Participate in the person-centered planning process; (3-30-07)

b. Develop a written support and spending plan with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; ~~(3-30-07)~~(7-1-11)T

c. Assist the participant to monitor and review his budget; (3-30-07)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-30-07)

e. Participate with Department quality assurance measures, as requested; (3-30-07)

f. Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization; (3-30-07)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect his own health and safety; (7-1-11)

h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and his circle of support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected; and (7-1-11)

i. Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they

transition to adult DD services. (7-1-11)

03. Additional Support Broker Duties. In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: (3-30-07)

a. Assist the participant to develop and maintain a circle of support; (3-30-07)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-30-07)

c. Assist the participant to negotiate rates for paid community support workers; (3-30-07)

d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; (3-30-07)

e. Assist the participant to monitor community supports; (3-30-07)

f. Assist the participant to resolve employment-related problems; and (3-30-07)

g. Assist the participant to identify and develop community resources to meet specific needs. (3-30-07)

04. Termination of Support Broker Services. If a support broker decides to end services with a participant, he must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

160. SUPPORT AND SPENDING PLAN DEVELOPMENT.

01. Support and Spending Plan Requirements. The participant, with the help of his support broker, must develop a comprehensive support and spending plan based on the information gathered during the person-centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: (3-30-07)

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community. (3-30-07)

b. Paid or non-paid consumer-directed community supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-11)

i. Personal health and safety including quality of life preferences; (3-30-07)

ii. Securing and maintaining employment; (3-30-07)

iii. Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; (3-30-07)

iv. Learning and practicing ways to recognize and minimize interfering behaviors; and (3-30-07)

v. Learning new skills or improving existing ones to accomplish set goals. (3-30-07)

c. Support needs such as: (3-30-07)

i. Medical care and medicine; (3-30-07)

ii. Skilled care including therapies or nursing needs; (3-30-07)

iii. Community involvement; (3-30-07)

iv. Preferred living arrangements including possible roommate(s); and (3-30-07)

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. (3-30-07)

d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (3-30-07)

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; and (3-30-07)

f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment. (3-30-07)

02. Support and Spending Plan Limitations. Support and spending plan limitations include: (3-30-07)

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and consumer-directed services at the same time, the participant, the support broker, and the Department must all work together to assure that there is no interruption of required services when moving between traditional services and the CDCS option; (7-1-11)

b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the consumer-directed option from choosing to live with recipients of traditional Medicaid services; (7-1-11)

c. All paid community supports must fit into one (1) or more types of community supports described in Section 110 of these rules. ~~*Community supports that are not medically necessary or that do not minimize the participant's need for institutionalization must only be listed as non paid supports. Additionally, t*~~The support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; ~~*(3-30-07)*~~(7-1-11)T

d. Support and spending plans that exceed the approved budget amount will not be authorized; and (3-30-07)

e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized support and spending plan amount will not be paid by the fiscal employer agent. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

190. INDIVIDUALIZED BUDGET.

The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that he understands the budget figure is a fixed amount. (3-29-10)

01. Budget Amount Notification. The Department notifies each participant of his set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount. ~~*The notification will include how the participant may request to appeal the set budget amount determined by the Department.*~~ ~~*(7-1-11)*~~(7-1-11)T

02. Annual Re-Evaluation of Adult Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's ~~*individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget*~~ condition that results in a need for services that meet medical necessity criteria, and that is not reflected on the current inventory of individual needs. ~~*(3-30-07)*~~(7-1-11)T

03. Annual Re-Evaluation of Children's Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs diagnosis, or a change in the specific need is not reflected in the assessment. (7-1-11)T