Dear Senators HEIDER, Nuxoll, Bock, and
Representatives WOOD, Perry, Rusche:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Health and Welfare:
IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Docket No. 16-0309-1301);
IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1301).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 10/03/2013. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 11/01/2013.

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 on the memorandum attached below.

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

Jeff Youtz
Director

MEMORANDUM

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

FROM: Senior Legislative Research Analyst - Ryan Bush

DATE: September 16, 2013

SUBJECT: Department of Health and Welfare - Medicaid Basic Plan Benefits & Medicaid Enhanced Plan Benefits

IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Docket No. 16-0309-1301)

IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1301)

(1) IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Docket No. 16-0309-1301)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits. The Department states that pursuant to Section 56-261, Idaho Code, passed by the Idaho Legislature in House Bill 260 (2011), it is incorporating managed care waiver changes for behavioral health. The Department further states the following:

(1) Its submission for a 1915(b) waiver was approved by CMS;

(2) Rules relating to behavioral health services are being removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and incorporated into these rules;

(3) This rulemaking will integrate mental health clinic services, psychosocial rehabilitative services, service coordination for adults with severe and persistent mental illness, service coordination for children with severe emotional disturbance and substance use disorder services into behavioral health services;

(4) Specific service limitations are being removed from these rules to allow for behavioral health services to be delivered in an individualized and evidence-based manner under a managed care structure; and

(5) Requirements are being added to describe the responsibilities of the Department and the managed care contractor in administering the behavioral health managed care delivery system.

Additionally, this rulemaking accomplishes the following:

(a) Defines the Idaho Behavioral Health Plan (IBHP) and the Prepaid Ambulatory Health Plan (PAHP);

(b) Limits service selection for those with a PAHP;

(c) Redesignates "mental health clinic services" as "outpatient behavioral health services" and states that such services shall be contained in the IBHP;

(d) Provides that all participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services are automatically enrolled in the IBHP and may access behavioral health services determined to be medically necessary;

(e) Removes rules formerly relating to mental health clinic services;

(f) Provides for community-based outpatient behavioral health services under the IBHP;

(g) Provides for provider qualifications and procedural requirements for outpatient behavioral health services;

(h) Provides for eligibility for school-based service for psychosocial rehabilitation, behavioral intervention and behavioral consultation, and personal care services; and

(i) Defines a psychosocial rehabilitation specialist in school-based service.

The Department states that negotiated rulemaking was not conducted because this is a temporary rule being done to comply with Section 56-261, Idaho Code, and that a temporary rule is appropriate because this rulemaking confers a benefit. Public hearings were held in Coeur d'Alene on August 20 and in Boise and Idaho Falls on August 21. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, is being incorporated by reference into these rules. The Department states that there will be no fiscal impact to the state general fund associated with this rulemaking.

The proposed rule appears to be consistent with the intent of Section 56-261, Idaho Code, and within the statutory authority granted to the Department in Section 56-202(b), Idaho Code.

(2) IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1301)

The Department of Health and Welfare submits notice of temporary proposed rulemaking at IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits. The Department states that all rules related to behavioral health services are being removed from these rules and moved into IDAPA 16.03.09 - Medicaid Basic Plan Benefits.

The Department states that negotiated rulemaking was not conducted because this is a temporary rule being done to comply with Section 56-261, Idaho Code, and that a temporary rule is appropriate because this rulemaking confers a benefit. Public hearings were held in Coeur d'Alene on August 20 and in Boise and Idaho Falls on August 21. The Department states that there will be no fiscal impact to the state general fund associated with this rulemaking.

The proposed rule appears to be consistent with the intent of Section 56-261, Idaho Code, and within the statutory authority granted to the Department in Section 56-202(b), Idaho Code.

cc: Department of Health and Welfare - Medicaid Basic Plan Benefits & Medicaid Enhanced Plan Benefits
Tamara Prisock
Carolyn Burt

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2013.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Tuesday, August 20, 2013 6:00 p.m. P.D.T.	Wednesday, August 21, 2013 1:00 p.m. M.D.T.	Wednesday, August 21, 2013 6:00 p.m. M.D.T.
IDHW Region I Office (lrg. conf. room, lower level) 1120 Ironwood Dr., Suite 102 Coeur d'Alene, ID 83814	Medicaid Central Office (conf. rooms D-East & West) 3232 Elder Street Boise, ID 83705	IDHW Region VII Office (2nd flr., large conf. room) 150 Shoup Ave. Idaho Falls, ID 83402

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:

Section 56-261, Idaho Code, directs the Department to implement managed care tools to develop an accountable care system to improve health outcomes. In order to comply, the State will implement a 1915(b) Waiver that will require Medicaid participants to enroll in a statewide prepaid ambulatory health plan (PAHP). Rule changes are being made to incorporate the managed care waiver changes into these rules.

Rule changes will integrate mental health clinic services, psychosocial rehabilitative services, service coordination for adults with severe and persistent mental illness (SPMI), service coordination for children with severe emotional disturbance (SED), and substance use disorder services into behavioral health services.

All rules related to behavioral health services are being removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and moved into these rules. In addition, specific service limitations are being removed from the rule to allow for behavioral health services to be delivered individualized and evidence-based under a managed care structure, and requirements are being added to describe the responsibilities of the Department and the Department's designee (a managed care contractor) to administer the behavioral health managed care delivery system.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit. In compliance with Section 56-261, Idaho Code, that requires the Department to implement managed care systems whenever possible, these rule changes are necessary in order for the Department to confer the Idaho Medicaid Behavioral Health benefits under the applicable authority.

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: NA

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

There is no anticipated fiscal impact to the state general fund. The consolidation of mental health clinic services, psychosocial rehabilitative services, mental health service coordination, and substance use disorder service benefits into one program of behavioral health services provided through a managed care delivery system will be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this is a temporary rule being done to comply with the requirements in Section 56-261, Idaho Code.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V) is being incorporated by reference into these rules to give it the force and effect of law. The document is not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Carolyn Burt at (208) 364-1844.

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 28, 2013.

DATED this 9th day of July, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
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 AND THE TEXT OF THE PROPOSED RULE FOR DOCKET NO. 16-0309-1301

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (3-30-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at http://practice.aap.org/content.aspx?aid=1599. (3-30-07)

02. American Academy of Pediatrics (AAP) Periodicity Schedule. This document is available on the internet at http://practice.aap.org/content.aspx?aid=1599. The schedule is also available at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (3-30-07)

03. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: http://www.asha.org/docs/html/TR2004-00142.html. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-29-10)

04. CDC Child and Teen BMI Calculator. The Centers for Disease Control (CDC) Child and Teen Body Mass Index (BMI) Calculator is available on the internet at http://www.cdc.gov/nccdphp/dnpa/bmi/index.htm. The Calculator is also available through the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (3-30-07)

05. DSM-~~I~~IV-~~TR~~. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, ~~*Fourth*~~ Fifth Edition, ~~*Text Revision*~~ (DSM-~~I~~IV-~~TR~~) ~~*Washington*~~ Arlington, ~~*DC*~~ VA, American Psychiatric Association, 20~~00~~13. ~~*Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005.*~~ A copy of the manual is ~~*also*~~ available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ~~*(3-30-07)*~~(9-1-13)T

06. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-30-07)

07. Idaho Infant Toddler Program Implementation Manual (Revised September 1999). The full text of the "Idaho Infant Toddler Program Implementation Manual," revised September 1999, is available at http://www.infanttoddler.idaho.gov. (7-1-13)

08. Idaho Special Education Manual, September 2001. The full text of the "Idaho Special Education Manual, September 2001" is available on the Internet at http://www.sde.idaho.gov/site/special_edu/. A copy is also available at the Idaho Department of Education, 650 West State Street, P.O. Box 83720, Boise, Idaho 83720-0027. (3-30-07)

09. Medicare Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D Supplier Manual 2007, As Amended. Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the Medicare. DME MAC Jurisdiction D Supplier Manual is available via the Internet at https://www.noridianmedicare.com/dme/news/manual/index.html%3f. (3-30-07)

10. Physician's Current Procedural Terminology (CPT® Manual). This document may be obtained from the American Medical Association, P.O. Box 10950, Chicago, Illinois 60610, or online at http://www.ama-assn.org/ama/pub/category/3113.html. (3-30-07)

11. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at http://www.cms.gov/Manuals/PBM/list.asp. (3-30-07)

12. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702. (3-30-07)

13. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." (3-30-07)

02. Availability to Work or Provide Service. (3-30-07)

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. (3-30-07)

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-30-07)

03. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-30-07)

04. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: (3-30-07)

~~*a. Mental Health Clinics. The criminal history check requirements applicable to mental health clinic staff are found in Subsection 714.05 of these rules.* (3-30-07)~~

~~*b.*~~**a.** Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of individual contracted transportation providers defined in Subsection 870.05 of these rules. (4-7-11)

~~*c. Substance Abuse Treatment Providers. The criminal history check requirements applicable to substance abuse treatment providers are found in Section 694 of these rules.* (5-8-09)~~

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules must consent to comply with criminal background checks, including fingerprinting, in accordance with 42 CFR 455.434. (9-1-13)T

(BREAK IN CONTINUITY OF SECTIONS)

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

01. ICF/ID. Intermediate Care Facility for People with Intellectual Disabilities. An ICF/ID is an entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-30-07)

02. Idaho Behavioral Health Plan (IBHP). The Idaho Behavioral Health Plan is a prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment as well as case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. (9-1-13)T

0~~2~~3. Idaho Infant Toddler Program. The Idaho Infant Toddler Program serves children from birth up to three (3) years of age (36 months), and must meet the requirements and provisions of the Individuals with

Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. (7-1-13)

a. These requirements for the Idaho Infant Toddler Program include: (7-1-13)

i. Adherence to procedural safeguards and time lines; (7-1-13)

ii. Use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs); (7-1-13)

iii. Provision of early intervention services in the natural environment; (7-1-13)

iv. Transition planning; and (7-1-13)

v. Program enrollment and reporting requirements. (7-1-13)

b. The Idaho Infant Toddler Program may provide the following services for Medicaid reimbursement: (7-1-13)

i. Occupational therapy; (7-1-13)

ii. Physical therapy; (7-1-13)

iii. Speech-language pathology; (7-1-13)

iv. Audiology; and (7-1-13)

v. Children's developmental disabilities services defined under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)

0~~3~~4. **In-Patient Hospital Services**. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-30-07)

0~~4~~5. **Intermediary**. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-30-07)

0~~5~~6. **Intermediate Care Facility Services**. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-07)

0~~6~~7. **Legal Representative**. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-07)

0~~7~~8. **Legend Drug**. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-30-07)

0~~8~~9. **Level of Care**. The classification in which a participant is placed, based on severity of need for institutional care. (3-30-07)

1~~0~~9. **Licensed, Qualified Professionals**. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-30-07)

1~~0~~1. **Lock-In Program**. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-07)

1~~1~~2. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-30-07)

1~~2~~3. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

1~~3~~4. Medicaid. Idaho's Medical Assistance Program. (3-30-07)

1~~4~~5. Medicaid-Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (3-30-07)

1~~5~~6. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-30-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-30-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-30-07)

c. Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-30-07)

1~~6~~7. Medical Supplies. Items excluding drugs, biologicals, and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-30-07)

1~~7~~8. Midwife. An individual qualified as one of the following: (3-29-12)

a. Licensed Midwife. A person who is licensed by the Idaho Board of Midwifery under Title 54, Chapter 55, Idaho Code, and IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-29-12)

b. Nurse Midwife (NM). An advanced practice professional nurse who is licensed by the Idaho Board of nursing and who meets all the applicable requirements to practice as a nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-29-12)

1~~8~~9. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)

~~19~~20. Nonambulatory. Unable to walk without assistance. (3-30-07)

2~~0~~1. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

2~~1~~2. Nurse Practitioner (NP). A registered nurse or licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-13)

2~~2~~3. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-30-07)

2~~3~~4. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-30-07)

2~~4~~5. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-30-07)

2~~5~~6. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-30-07)

2~~6~~7. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (3-30-07)

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

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-30-07)

02. Patient. The person undergoing treatment or receiving services from a provider. (3-30-07)

03. 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. (3-30-07)

04. Physician Assistant (PA). 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." (3-30-07)

05. 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. (3-30-07)

06. Prepaid Ambulatory Health Plan (PAHP). As defined in 42 CFR 438.2, a PAHP is an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. (9-1-13)T

0~~6~~7. Private Rate. Rate most frequently charged to private patients for a service or item. (3-30-07)

0~~7~~8. PRM. Provider Reimbursement Manual. (3-30-07)

0~~8~~9. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-30-07)

1~~0~~9. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (3-30-07)

a. Artificially replace a missing portion of the body; or (3-30-07)

b. Prevent or correct physical deformities or malfunctions; or (3-30-07)

c. Support a weak or deformed portion of the body. (3-30-07)

d. Computerized communication devices are not included in this definition of a prosthetic device. (3-30-07)

10~~1~~. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department in accordance with Section 205 of these rules. (3-30-07)

11~~2~~. Provider Agreement. A written agreement between the provider and the Department, entered into in accordance with Section 205 of these rules. (3-30-07)

12~~3~~. Provider Reimbursement Manual (PRM). A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. (3-30-07)

13~~4~~. Prudent Layperson. A person who possesses an average knowledge of health and medicine. (3-30-07)

14~~5~~. 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." (3-30-07)

15~~6~~. 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. (3-30-07)

16~~7~~. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

17~~8~~. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). (3-30-07)

18~~9~~. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (3-30-07)

~~19~~20. R.N. Registered Nurse, which in the State of Idaho is known as a Licensed Professional Nurse. (3-30-07)

20~~1~~. Rural Health Clinic (RHC). An outpatient entity that meets the requirements of 42 USC Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally-defined, medically underserved areas, or designated health professional shortage areas. (3-30-07)

21~~2~~. Rural Hospital-Based Nursing Facilities. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (3-30-07)

22~~3~~. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-30-07)

2~~3~~4. **State Plan**. The contract between the state and federal government under 42 USC Section 1396a(a). (3-30-07)

2~~4~~5. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-30-07)

2~~5~~6. **Title XVIII**. Title XVIII of the Social Security Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (3-30-07)

2~~6~~7. **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. (3-30-07)

2~~7~~8. **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. (3-30-07)

2~~8~~9. **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 medical assistance participant. (3-30-07)

~~29~~30. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

150. CHOICE OF PROVIDERS.

01. **Service Selection**. Each participant may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in Healthy Connections or a Prepaid Ambulatory Health Plan (PAHP) that limits provider choice. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the Medical Assistance Program, or from setting standards relating to the qualifications of providers of such care. ~~(3-30-07)~~(9-1-13)T

02. **Lock-In Option**. (3-30-07)

a. The Department may implement a total or partial lock-in program for any participant found to be misusing the Medical Assistance Program according to provisions in Sections 910 through 918 of these rules. (3-30-07)

b. In situations where the participant has been restricted to a participant lock-in program, that participant may choose the physician and pharmacy of his choice. The providers chosen by the lock-in participant will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

230. GENERAL PAYMENT PROCEDURES.

01. **Provided Services**. (3-30-07)

a. Each participant may consult a participating physician or provider of his choice for care and receive covered services by presenting his identification card to the provider, subject to restrictions imposed by ~~a~~

participation in Healthy Connections or enrollment in a Prepaid Ambulatory Health Plan (PAHP).
~~(3-30-07)~~(9-1-13)T

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System and transfer the required information onto the appropriate claim form. Where the Electronic Verification System (EVS) indicates that a participant is enrolled in Healthy Connections, the provider must obtain a referral from the primary care provider. Claims for services provided to participant designated as participating in Healthy Connections by other than the primary care provider, without proper referral, will not be paid. (3-30-07)

c. Upon providing the care and services to a participant, the provider or his agent must submit a properly completed claim to the Department. (3-30-07)

d. The Department is to process each claim received and make payment directly to the provider. (3-30-07)

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in Appendix D of the Idaho Medicaid Provider Handbook. (3-30-07)

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (3-30-07)

a. The provider's actual charge for service; or (3-30-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-30-07)

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-30-07)

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (3-30-07)

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325. (3-30-07)

05. Review of Records. (3-30-07)

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Bureau of Audits and Investigations have the right to review pertinent records of providers receiving Medicaid reimbursement for covered services. (3-30-07)

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (3-30-07)

i. The necessity for the care; or (3-30-07)

ii. That treatment was rendered in accordance with accepted medical standards of practice; or (3-30-07)

iii. That charges were not in excess of the provider's usual and customary rates; or (3-30-07)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (3-30-07)

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (3-30-07)

i. Withholding payments to the provider until access to the requested information is granted; or (3-30-07)

ii. Suspending the provider's number. (3-30-07)

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge or at a nominal charge are reimbursed fair compensation which is the same as reasonable cost. (3-30-07)

07. Procedures for Medicare Cross-Over Claims. (3-30-07)

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (3-30-07)

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (3-30-07)

c. If a provider does not accept a Medicare assignment, a MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

d. For all other services, a MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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 545. (3-29-12)

d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)

e. Optometrist services are described in Sections 553 through 556. (3-29-12)

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 579 of these rules**.** (5-8-09)

a. Healthy Connections services are described in Sections 560 through 566. (4-4-13)

b. Health Home services are described in Sections 570 through 576. (4-4-13)

06. Prevention Services. The range of prevention services covered is described in Sections 580 through 649 of these rules. (4-4-13)

a. Child Wellness Services are described in Sections 580 through 586. (3-30-07)

b. Adult Physical Services are described in Sections 590 through 596. (3-30-07)

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

d. Diagnostic Screening Clinic services are described in Sections 610 through 614. (4-4-13)

e. Additional Assessment and Evaluation services are described in Section 615. (4-4-13)

f. Health Questionnaire Assessment is described in Section 618. (4-4-13)

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

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

i. 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.*~~ **Outpatient Behavioral Health Services**. Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. ~~*(5-8-09)*~~(9-1-13)T

~~***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*~~**11.** **Inpatient Psychiatric Hospital Services**. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. ~~*(3-30-07)*~~(9-1-13)T

~~***b.** Mental Health Clinic services are described in Sections 707 through 719. (4-4-13)*~~

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. (3-29-12)

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 85~~6~~7. ~~*(3-30-07)*~~(9-1-13)T

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 medical transportation services are described in Sections 870 through 876. (4-4-13)

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)

500. PHYSICIAN SERVICES: DEFINITIONS.

01. Physician Services. Physician services include the treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and Subsection 502.01 of these rules. Physician services as defined in Subsection 500.01 of this rule will be reimbursed by the Department. (5-8-09)

02. Psychiatric Telehealth. Psychiatric Telehealth is an electronic real time synchronous audio-visual contact between a physician and participant related to the treatment of the participant. The participant is in one (1) location, called the hub site, with specialized equipment including a video camera and monitor, and with the hosting provider. The physician is at another location, called the spoke site, with specialized equipment. The physician and participant interact as if they were having a face-to-face service. This rule does not apply to outpatient behavioral health services provided through the Idaho Behavioral Health Plan (IBHP) that are delivered via telehealth methods. ~~(5-8-09)~~(9-1-13)T

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. Outpatient Psychiatric Mental Health Services. Physician services not provided through the IBHP as ~~O~~outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. ~~(3-30-07)~~(9-1-13)T

02. Sterilization Procedures. Particular restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (3-30-07)

03. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)

04. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (3-30-07)

05. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis. (3-30-07)

06. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-30-07)

07. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)

08. Psychiatric Telehealth. Payment for psychiatric telehealth services not provided through the IBHP is limited to psychiatric services for diagnostic assessments, pharmacological management, and psychotherapy with evaluation and management services twenty (20) to thirty (30) minutes in duration. Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. Service will not be reimbursed when provided via a videophone or webcam. ~~(5-8-09)~~(9-1-13)T

(BREAK IN CONTINUITY OF SECTIONS)

611. -- 614. (RESERVED)

~~***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 114, and provider qualifications under Section 715 of these rules and under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 130 and 131.* (3-29-12)~~

~~***02. 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)

686. -- ~~689.~~ ~~(RESERVED)~~

~~***SUB AREA: SUBSTANCE ABUSE TREATMENT SERVICES***~~
~~***(Sections 690 Through 699)***~~

~~***690. SUBSTANCE ABUSE TREATMENT SERVICES: DEFINITIONS.***~~
~~*The following definitions apply to Sections 690 through 696 of these rules.* (5-8-09)~~

~~***01. Assessment Services**. Assessment services include annual assessment, interviewing, and treatment plan building.* (5-8-09)~~

~~***02. Case Management Services**. Case management services consist of the following:* (5-8-09)~~

~~***a.** Finding, arranging, and assisting the participant to gain access to and maintain appropriate services, supports, and community resources.* (5-8-09)~~

~~***b.** Monitoring participant's progress to verify that services are received and are satisfactory to the participant, ascertaining that services meet the participant's needs, documenting progress and any revisions in services needed, and making alternative arrangements if services become unavailable to the participant.* (5-8-09)~~

~~c. Planning services with the participant that include both community reintegration planning and exit planning. (5-8-09)~~

~~03. Drug Testing. A urinalysis test used to detect the presence of alcohol or drugs. (5-8-09)~~

~~04. Family Therapy. Service provided jointly to a participant and the participant's family. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. Family therapy sessions are for the exclusive benefit of the participant. (5-8-09)~~

~~05. Group Counseling. Service provided to participants in a peer group setting. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. (5-8-09)~~

~~06. Individual Counseling. Service provided to a participant in a one-on-one setting with one (1) participant and one (1) counselor. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. (5-8-09)~~

~~07. Qualified Substance Abuse Treatment Professional. A person who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the criteria listed in Subsection 690.07.a. through 690.07.g. of this rule. (5-8-09)~~

~~a. Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC); (5-8-09)~~

~~b. Licensed professional counselor or licensed clinical professional counselor; (5-8-09)~~

~~c. Licensed physician; (5-8-09)~~

~~d. Licensed psychologist; (5-8-09)~~

~~e. Mid-level practitioner including licensed physician assistant, nurse practitioner or clinical nurse specialist; (5-8-09)~~

~~f. Licensed clinical social worker or licensed master social worker; (5-8-09)~~

~~g. Licensed marriage and family therapist; or (5-8-09)~~

~~h. Qualified substance abuse treatment professional. (5-8-09)~~

~~08. Unit. An increment of fifteen (15) minutes of time. (5-8-09)~~

~~691. SUBSTANCE ABUSE TREATMENT SERVICES: PARTICIPANT ELIGIBILITY.~~
~~Each participant must meet the intake eligibility screening criteria described in IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services." (5-8-09)~~

~~692. SUBSTANCE ABUSE TREATMENT SERVICES: COVERAGE AND LIMITATIONS.~~

~~01. Included Services. The services listed in Subsections 692.01.a. through 692.01.f. of this rule are covered including any limitation on the service for substance abuse treatment. (5-8-09)~~

~~a. Assessment services are limited to thirty-two (32) units annually. Each assessment is valid for six (6) months and must meet the requirements in IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services." (5-8-09)~~

~~b. Case management services are limited to two hundred and twenty (220) units annually and must~~

not exceed sixteen (16) units per week. Case management services for substance abuse treatment are not covered when the participant is enrolled in any service coordination services described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." Case management is only provided on an outpatient basis to participants who are at risk of being institutionalized. (5-8-09)

c. Drug testing is limited to three (3) tests per week. (5-8-09)

d. Family therapy services are limited to eight (8) units per week. (5-8-09)

e. Group counseling services are limited to forty-eight (48) units per week. (5-8-09)

f. Individual counseling services are limited to forty-eight (48) units per week. (5-8-09)

02. Lifetime Cap. Substance abuse treatment services provided under this chapter of rules are limited to a lifetime cap of five (5) years. The five-year period begins on the date of the initial assessment, regardless of the source of payment for that assessment. This lifetime cap applies only to participants twenty-two (22) years of age or older. (5-8-09)

03. Excluded Services. Services specifically excluded are described in IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services," residential services, and life skills training services. (5-8-09)

693. SUBSTANCE ABUSE TREATMENT SERVICES: PROCEDURAL REQUIREMENTS.

01. Assessment. Each participant must receive a biopsychosocial assessment of the participant's alcohol or substance abuse treatment needs. This assessment must meet the requirements in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs," and IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services," and utilize a Department approved standardized assessment tool. (5-8-09)

02. Treatment Plan. The assessment must be used to develop an individualized treatment plan for each participant. The development and content of the treatment plan must meet the requirements in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs," and IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services." (5-8-09)

03. Treatment Services. Substance abuse treatment services necessary to meet participant needs must be identified in the individualized treatment plan. The treatment services must meet the requirements in IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services." (5-8-09)

04. Records. Each treatment provider must maintain a written record for each participant. The record must meet the standards required for client records in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." (5-8-09)

05. Prior Authorization. Substance abuse treatment services must be prior authorized by the Department or its designee as required in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." (5-8-09)

06. Healthy Connections Referral. A referral from the participant's Healthy Connections provider is required for substance abuse treatment services when the participant is enrolled in Healthy Connections. (5-8-09)

694. SUBSTANCE ABUSE TREATMENT SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Network. Each provider of substance abuse treatment services must maintain a network of approved programs and treatment facilities that meet the requirements in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." (5-8-09)

02. Certificate of Approval for Programs and Facilities. Each program and facility providing substance abuse treatment services must meet the applicable approval and certification requirements described in

~~*IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." An agency must have a certificate of approval issued by the Department prior to staff providing substance abuse treatment services.* (5-8-09)~~

~~***03. Criminal History Check.*** *Agency staff providing services to participants must have a criminal history check as provided in Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks."* (5-8-09)~~

~~***04. Assessment.*** *Assessment must be conducted by a qualified substance abuse treatment professional who is certified to administer the standardized assessment tool being used.* (5-8-09)~~

~~***05. Therapy and Counseling Services.*** *Therapy and counseling services must be provided by a qualified substance abuse treatment professional.* (5-8-09)~~

~~***06. Case Management.*** *Case management services must be provided by a qualified substance abuse treatment professional.* (5-8-09)~~

~~***695. SUBSTANCE ABUSE TREATMENT SERVICES: PROVIDER REIMBURSEMENT.***~~
~~*Each covered substance abuse treatment service, except drug testing, is reimbursed by units. Each unit is equal to fifteen (15) minutes of service provided.* (5-8-09)~~

~~***696. SUBSTANCE ABUSE TREATMENT SERVICES: QUALITY ASSURANCE.***~~

~~***01. Quality Assurance.*** *Alcohol and drug programs are subject to the quality assurance provisions described in IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs."* (5-8-09)~~

~~***02. Department Performance Measurements.*** *The Department will establish performance measurements to evaluate the effectiveness of substance abuse treatment services. The measurements will be reviewed at least annually and adjusted as necessary to provide effective outcomes and quality services.* (5-8-09)~~

~~***697.*** ~~699. (RESERVED)~~

SUB AREA: ~~*MENTAL*~~ BEHAVIORAL HEALTH SERVICES
(Sections 700 -- 719)

(BREAK IN CONTINUITY OF SECTIONS)

707. ~~*MENTAL HEALTH CLINIC SERVICES: DEFINITIONS*~~ OUTPATIENT BEHAVIORAL HEALTH SERVICES.
Outpatient behavioral health services are contained in the "Idaho Behavioral Health Plan" (IBHP) that is authorized by a 1915(b) waiver authority and delivered under a PAHP contract. The IBHP allows for the contractor to provide the administration of community-based outpatient behavioral health services for individuals, based on medical necessity, that include therapeutic and rehabilitative treatment intended to minimize symptoms of mental illness, emotional disturbance, and substance use disorders. These services also help restore independent functioning to the greatest extent possible. For more information, please visit the IBHP website at: http://www.optumidaho.com/.
(9-1-13)T

~~***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. 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. (3-29-12)~~

~~04. 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)~~

~~05. 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)~~

~~06. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing 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. (3-29-12)~~

~~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*~~ OUTPATIENT BEHAVIORAL 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.~~ All participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services, except for participants enrolled in the Idaho Medicare-Medicaid Coordinated Plan (MMCP), are automatically enrolled in the Idaho Behavioral Health Plan and may access behavioral health services that are determined to be medically necessary.
~~(5-8-09)~~(9-1-13)T

~~***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 Assessment and Individualized Treatment Plan**. If an individual who is not eligible for Medicaid receives 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 comprehensive diagnostic assessment and individualized treatment plan are required, which must be developed by a professional listed under Subsection 715.03 of these rules.* (3-29-12)~~

709. ~~*MENTAL*~~ OUTPATIENT BEHAVIORAL 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 a comprehensive diagnostic assessment as the initial evaluation in mental health clinics.* (3-29-12)~~

~~***a.** 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:~~ ~~(3-29-12)~~

~~i. A comprehensive diagnostic assessment is medically necessary in order to provide Basic Plan mental health services;~~ ~~(3-29-12)~~

~~ii. The participant is seeking Enhanced Plan services; and~~ ~~(3-29-12)~~

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

~~**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)~~

~~**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)~~

~~**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 the completion of a comprehensive diagnostic assessment must be fully documented in the participant's medical record; and (3-29-12)

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. 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)

***08. 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)

***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 four (4) hours per year is the maximum time allowed for diagnostic assessment services. 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. (3-29-12)*

***10. 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)

01. Community-Based Outpatient Behavioral Health Services. The Community-Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include: (9-1-13)T

a. Assessments and Planning; (9-1-13)T

b. Psychological and Neurological Testing; (9-1-13)T

c. Psychotherapy (Individual, Group, and Family); (9-1-13)T

d. Pharmacologic Management; (9-1-13)T

e. Partial Care Treatment; (9-1-13)T

f. Behavioral Health Nursing; (9-1-13)T

g. Drug Screening; (9-1-13)T

h. Community-Based Rehabilitation; (9-1-13)T

i. Substance Use Disorder Treatment Services; and (9-1-13)T

j. Case Management. (9-1-13)T

02. Prior Authorization. Some behavioral health services may require prior authorization from the IBHP contractor. (9-1-13)T

710. ~~*MENTAL*~~ OUTPATIENT BEHAVIORAL HEALTH ~~*CLINIC*~~ SERVICES: ~~*WRITTEN INDIVIDUALIZED TREATMENT PLAN*~~ PROVIDER QUALIFICATIONS.

~~*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. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules.*~~ The IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All community-based outpatient behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. These agreements will include the reimbursement methodology agreed upon by the contractor and Department. ~~*(3-29-12)*~~(9-1-13)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 assessment process.~~ ~~(3-29-12)~~

~~**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, 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 revision of the individualized treatment plan must be recorded on the treatment plan.~~ ~~(3-29-12)~~

~~**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)~~

711. ~~MENTAL~~ OUTPATIENT BEHAVIORAL HEALTH ~~CLINIC~~ SERVICES: ~~EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID~~ PROCEDURAL REQUIREMENTS.

Providers must enroll in the IBHP with the contractor and meet both the credentialling and quality assurance guidelines of the contractor. (9-1-13)T

~~**01. Inpatient Medical Facilities**. Medicaid will not pay for mental health clinic services rendered to participants residing in inpatient medical facilities, including nursing homes, hospitals, or public institutions defined in 42 CFR 435.1009; or (5-8-09)~~

~~**02. Non-Reimbursable**. The Department will not reimburse a service unless the participant's medical record includes the signature and credential of the professional staff providing the therapy or participant contact, the length of the session, and the date of the contact. (5-8-09)~~

~~**03. Non-Eligible Staff**. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 715.03 of these rules is not eligible for reimbursement by the Department. (5-8-09)~~

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

01. Administer IBHP. The contractor is responsible for administering the IBHP, including: eligibility verification, management of behavioral health service provision, behavioral health claims processing, payments to providers, data reporting, utilization management, and customer service. (9-1-13)T

02. Authorization. The contractor is responsible for authorization of covered behavioral health services that require authorization prior to claim payment. (9-1-13)T

03. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled through a process between the contractor and Department that is in compliance with state and federal requirements. Participants must utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. (9-1-13)T

~~**712. MENTAL HEALTH CLINIC SERVICES: CREDENTIALING RESPONSIBILITIES OF THE DEPARTMENT.**~~

~~**01. Reimbursement**. A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to achieve or maintain credentialed status will have its Medicaid provider agreement terminated. (5-8-09)~~

~~**02. Application**. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department. All initial applications will be responded to within thirty (30) calendar days. If the application is incomplete or is not in substantial compliance with these rules, the applicant must submit the additional information within ten (10) business days of receipt of notice for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal, then the application will be denied and the application will not be considered again for twelve (12) months. (5-8-09)~~

~~**03. Temporary Credentialed Status**. In order for existing providers to be able to continue to provide services during initial development, the Department will grant a one-time temporary credential to all existing providers. (5-8-09)~~

~~**04. New Providers**. New provider applicants will be required to submit a credentialing application and successfully complete the credentialing application process as a condition for Department approval as a Medicaid provider. If the new provider applicant successfully passes the application portion of credentialing, then a temporary credential will be issued to the provider for up to one hundred eighty (180) days. Within the one hundred eighty (180)~~

days, an on-site review will be conducted. If the provider applicant is deemed to be in substantial compliance with these rules, then the temporary credential will be converted to a full credential. If the provider fails to be in substantial compliance, then the temporary credential will expire, credentialed status will be denied, and the provider applicant will not be considered for credentialing again for twelve (12) months. (5-8-09)

05. Elements of Credentialing. The initial credentialing process consists of the application, self-study, and an on-site review for compliance with the requirements of these rules. (5-8-09)

a. The application provides documentation the agency has met the criteria set forth in these rules. Elements contained in the application include: (5-8-09)

i. Ownership and governance; (5-8-09)

ii. Physician contract for medical and clinical oversight and supervision; (5-8-09)

iii. Proof of appropriate insurance; (5-8-09)

iv. Appropriate employment and contract documentation; and (5-8-09)

v. Copies of relevant licenses and transcripts. (5-8-09)

b. The self-study provides the agency the opportunity to formally document policies and procedures that demonstrate compliance with Sections 713 and 714 of these rules. (5-8-09)

c. The on-site review provides the Department the opportunity to observe service delivery and ensure the agency actually implements and complies with their policies and procedures. (5-8-09)

06. Deemed Status. Providers accredited by private accreditation agencies, (i.e., the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or Commission on the Accreditation of Rehabilitation Facilities (CARF)), will be exempt from credentialing processes. Other accrediting agencies may be determined acceptable upon review by the Department. Providers must submit to the Department appropriate documentation of their private accreditation status. (5-8-09)

07. Expiration and Renewal of Credentialed Status. Credentials issued under these rules will be issued for a period up to three (3) years. Unless denied or revoked, the agency's credential will expire on the date designated by the Department. No later than ninety (90) days before expiration, an agency must apply for renewal of credentials. A site review may be conducted by the Department for renewal applications. (5-8-09)

08. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred eighty (180) days. During that time, the Department will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (3-30-07)

09. Denial or Revocation of Credentialed Status. The Department may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial or revocation of credentials include the following: (5-8-09)

a. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (3-30-07)

b. The provider agency or provider agency applicant has been convicted of fraud, gross negligence, abuse, assault, battery or exploitation; (5-8-09)

c. The provider agency or provider agency applicant has been convicted of a criminal offense within

the past five (5) years other than a minor traffic violation or similar minor offense; (3-30-07)

d. The provider agency or provider agency applicant has been denied or has had revoked any health facility license or certificate; (3-30-07)

e. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (3-30-07)

f. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (3-30-07)

g. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 712.09.a. through 712.09.f. of this rule. (3-30-07)

10. Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon denial or revocation of credentials, the Department will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

713. 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: (3-29-12)

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. (3-29-12)

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. (3-29-12)

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. (3-29-12)

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

01. Healthy Connections Referral. Provider agencies must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program and document the referral in the participant's medical record. Provider agencies must document compliance with the requirements under Subsection 708.01 of these rules. (5-8-09)

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

~~the participant's treatment plan review.~~ ~~(5-8-09)~~

~~**03. Staff-to-Participant Ratio**. The following treatment staff-to-participant ratios for group treatment services must be observed:~~ ~~(5-8-09)~~

~~**a.** For children under four (4) years of age, the ratio must be 1:1. No group work is allowed.~~ ~~(5-8-09)~~

~~**b.** For children four (4) to twelve (12) years of age, the ratio must be 1:6 for groups. Group size must not exceed twelve (12) participants.~~ ~~(5-8-09)~~

~~**c.** For children over twelve (12) years of age, the ratio must be 1:10 for groups. Group size must not exceed twelve (12) participants.~~ ~~(5-8-09)~~

~~**04. Family Participation Requirement**. The following standards must be observed for services provided to children:~~ ~~(5-8-09)~~

~~**a.** For a child under four (4) years of age, the child's parent or legal guardian should be actively involved by being present on the premises and available for consultation with the staff during the delivery of mental health services. The child's parent or legal guardian does not have to participate in the treatment session or be present in the room in which the service is being conducted;~~ ~~(5-8-09)~~

~~**b.** For a child four (4) to twelve (12) years of age, the child's parent or legal guardian should be actively involved. The child's parent or legal guardian does not have to participate in the treatment session but must be available for consultation with the staff providing the service;~~ ~~(5-8-09)~~

~~**c.** For a child over twelve (12) years of age, the child's parent or legal guardian should be involved, as appropriate. If the interdisciplinary team recommends that the child's parent or legal guardian not be involved in any aspect of the treatment, then the reasons for excluding the child's parent or legal guardian must be documented in the medical record.~~ ~~(5-8-09)~~

~~**d.** For a child whose parent or legal guardian does not participate in the services, the provider must document efforts made to involve the parent or legal guardian and must make appropriate adjustments to the treatment plan to address the parent or legal guardian's lack of involvement.~~ ~~(5-8-09)~~

~~**e.** Nothing in these rules may interfere with compliance to provisions of Section 16-2428, Idaho Code, regarding confidentiality and disclosure of children's mental health information.~~ ~~(5-8-09)~~

~~**05. Mental Health Clinic**. Each location of the agency must meet the requirements under this rule.~~ ~~(3-30-07)~~

~~**06. Physician Requirement for Clinic Supervision**. In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician.~~ ~~(3-30-07)~~

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

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

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

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

~~**b.** The physician must see the participant at least once annually to determine the medical necessity and appropriateness of clinic services; (5-8-09)~~

~~**c.** The physician must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed; and (5-8-09)~~

~~**d.** The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services and must sign all intermittent treatment plan reviews that represent substantial changes in the goals, objectives, or services. (5-8-09)~~

~~**08. Assessment**. All treatment in mental health clinics must be based on one (1) or more assessments of the participant's needs, required under Section 709.03 of these rules and provided under the direction of a licensed physician. (5-8-09)~~

~~**09. Criminal History Checks**. (3-30-07)~~

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

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

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

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

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

~~**a.** Standards and requirements for supervision under the rules of the Idaho Bureau of Occupational Licenses and the Idaho State Board of Medicine must be met; (5-8-09)~~

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

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

~~**12. Restraints and Seclusion**. (5-8-09)~~

~~**a.** Restraints and seclusion must not be employed under any circumstances except when an agency staff person employs physical holds as an emergency response to assault or aggression or other immediate safety risks in accordance with the following requirements in Subsections 714.12.a.i. through 714.12.a.iii.: (5-8-09)~~

~~i. The agency must have an accompanying policy and procedure that addresses the use of the such holds. (5-8-09)~~

~~ii. The physical holds employed must be a part of a nationally recognized non violent crisis intervention model. (5-8-09)~~

~~iii. The staff person who employs the hold technique(s) must have evidence in his personnel record of current certification in the method. (5-8-09)~~

~~**b.** Provider agencies must develop policies that address the agency's response by staff to emergencies involving assault or aggression or other immediate safety risks. All policies and procedures must be consistent with licensure requirements, federal, state, and local laws, and be in accordance with accepted standards of healthcare practice. (5-8-09)~~

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

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

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

~~i. US Psychiatric Rehabilitation Association Code of Ethics found at https://usprа.ipower.com/Certification/Practitioner_Code_of_Ethics.pdf; (3-30-07)~~

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

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

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

~~v. Marriage and Family Therapists Code of Ethics found at http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx. (3-30-07)~~

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

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

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

~~**15. Building Standards For Mental Health Clinics**. (3-30-07)~~

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

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

~~**c.** Capacity. Clinics must provide qualified staff as listed in Subsection 715.01 of these rules to meet a staff to participant ratio required under Subsection 714.03 of this rule that ensures safe, effective and clinically~~

~~appropriate interventions.~~ ~~(5-8-09)~~

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

~~i. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority and successfully pass the inspection. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and~~ ~~(5-8-09)~~

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

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

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

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

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

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

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

~~ix. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 714.15.d. of this rule; and~~ ~~(5-8-09)~~

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

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

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

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

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

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

~~iii. All employees must participate in fire and safety training upon employment and at least annually thereafter; and~~ ~~(3-30-07)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~**715. MENTAL HEALTH CLINIC SERVICES: AGENCY STAFF QUALIFICATIONS.**~~

~~**01. Staff Qualifications.** The mental health clinic must assure that each agency staff person delivering treatment services to Medicaid participants works within the scope of his license and has, at a minimum, one (1) or more of the following credentials: (5-8-09)~~

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

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

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

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

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

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

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

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

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

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

~~**k.** Licensed Associate Marriage and Family Therapist; (5-8-09)~~

~~**l.** Certified Psychiatric Nurse, (RN), as described in Subsection 707.13 of these rules; (5-8-09)~~

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

~~**n.** Licensed Occupational Therapist. (5-8-09)~~

~~**02. Staff Qualified to Deliver a Comprehensive Diagnostic Assessment.** A comprehensive diagnostic assessment is a reimbursable service when delivered by one (1) of the following licensed professionals: (5-8-09)~~

~~**a.** Psychiatrist; (5-8-09)~~

~~**b.** Physician; (5-8-09)~~

~~**c.** Practitioner of the healing arts; (5-8-09)~~

~~**d.** Psychologist; (5-8-09)~~

~~**e.** Clinical Social Worker; (5-8-09)~~

~~**f.** Clinical Professional Counselor; (5-8-09)~~

~~**g.** Licensed Marriage and Family Therapist; (5-8-09)~~

~~**h.** Certified Psychiatric Nurse, (RN), as described in Subsection 707.13 of these rules; (5-8-09)~~

~~**i.** Licensed Professional Counselor whose provision of diagnostic services is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (5-8-09)~~

~~**j.** Licensed Masters Social Worker whose provision of diagnostic services is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (5-8-09)~~

~~k. Licensed Associate Marriage and Family Therapist whose provision of diagnostic services is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (5-8-09)~~

~~l. Psychologist Extender, registered with the Bureau of Occupational Licenses whose provision of diagnostic services is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (5-8-09)~~

~~03. Qualified Interdisciplinary Treatment Planning Staff. The individualized treatment plan development is reimbursable if conducted by a qualified staff person who, at a minimum, has one (1) or more of the following qualifications: (5-8-09)~~

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

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

~~c. Licensed Masters Social Worker; (5-8-09)~~

~~d. Licensed Clinical Social Worker; (5-8-09)~~

~~e. Certified Psychiatric Nurse, (RN); (3-30-07)~~

~~f. Licensed Clinical Professional Counselor; (5-8-09)~~

~~g. Licensed Professional Counselor; (5-8-09)~~

~~h. Licensed Physician or other licensed practitioner of the healing arts; (5-8-09)~~

~~i. Licensed Psychiatrist; (5-8-09)~~

~~j. Licensed Marriage and Family Therapist; (5-8-09)~~

~~k. Licensed Associate Marriage and Family Therapist; or (5-8-09)~~

~~l. Licensed Professional Nurse, RN. (5-8-09)~~

~~04. Non-Qualified Staff. Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Sections 709 or 715 of these rules, is not eligible for reimbursement under the Medicaid. (5-8-09)~~

~~05. Staff Qualifications for Psychotherapy Services. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 709.04 through 709.06 of these rules must have, at a minimum, one (1) or more of the following credentials: (5-8-09)~~

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

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

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

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

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

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

~~g. Certified Psychiatric Nurse (RN), as described in Subsection 707.09 of these rules; (5-8-09)~~

~~h. 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"; (5-8-09)~~

~~i. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (5-8-09)~~

~~j. Licensed Associate Marriage and Family Therapist whose provision of psychotherapy is supervised as described in IDAPA 25.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (5-8-09)~~

~~k. A 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." (5-8-09)~~

~~06. Support Staff. For the purposes of this rule, support staff is any person who is not a professional listed in Subsection 715.01 of this rule. The agency may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid. (5-8-09)~~

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

~~01. Assessments. A comprehensive diagnostic assessment must be contained in all participant medical records. (3-29-12)~~

~~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 assessments and testing 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. (3-29-12)~~

~~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)~~

~~***717. MENTAL HEALTH CLINIC SERVICES: PROVIDER REIMBURSEMENT.***~~

~~***01. Services**. Payment for clinic services will be made directly to the clinic and will be in accordance with rates established by the Department for the specific services.* (3-30-07)~~

~~***02. Payment in Full**. Each provider of clinic services must accept the Department's payment for such services as payment in full and must not bill the medical assistance participant for any portion of any charges incurred for the cost of his care.* (3-30-07)~~

~~***03. Third Party**. All available third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible participant. Proof of billing other third party payers will be required by the Department.* (3-30-07)~~

~~***04. Injections**. Payment for the administration of injections must be in accordance with rates established by the Department.* (3-30-07)~~

~~***718. MENTAL HEALTH CLINIC SERVICES: QUALITY OF SERVICES.***~~
~~*The Department must monitor the quality and outcomes of mental health clinic services provided to participants, in coordination with the Divisions of Medicaid, Management Services, Family and Community Services (FACS), and Behavioral Health.* (3-30-07)~~

712 -- **719. (RESERVED)**

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting 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. (3-30-07)

02. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or as educational facilities, which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students, and which are included in the individual educational plan for the participant. (3-29-10)

03. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (7-1-13)

04. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. https://netforum.avectra.com/eWeb/StartPage.aspx?Site=USPRA. (9-1-13)T

0~~4~~5. **Practitioner of the Healing Arts**. A physician's assistant, nurse practitioner, or clinical nurse specialist who is licensed and approved by the state of Idaho to make such recommendations or referrals for Medicaid

services. (7-1-13)

06. **Serious Mental Illness (SMI)**. In accordance with 42 CFR 483.102(b)(1), a person with SMI: (9-1-13)T

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-V; and (9-1-13)T

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (9-1-13)T

07. **Serious and Persistent Mental Illness (SPMI)**. A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-V 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. (9-1-13)T

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts and charter schools must ensure the student is: (7-1-13)

01. **Medicaid Eligible**. Eligible for Medicaid and the service for which the school district or charter school is seeking reimbursement; (7-1-13)

02. **School Enrollment**. Enrolled in an Idaho school district or charter school; (7-1-13)

03. **Age**. Twenty-one (21) years of age or younger and the semester in which his twenty-first birthday falls is not finished; (3-30-07)

04. **Educational Disability**. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness." (7-1-13)

05. **Inpatients in Hospitals or Nursing Homes**. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. Health-related services for students residing in an ICF/ID are eligible for reimbursement. (7-1-13)

~~***06.*** ***Service Specific Eligibility****. Psychosocial Rehabilitation (PSR), Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements.* ***(7-1-13)***~~

~~***a.*** ***Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student must meet the PSR eligibility criteria for children in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 112, or the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at the Idaho Department of Education website, http://www.sde.idaho.gov/site/special_edu/. Districts are to coordinate the delivery of services if the student is receiving PSR services authorized by the Department.*** ***(7-1-13)***~~

~~***b.*** ***Behavioral Intervention and Behavioral Consultation. To be eligible for behavioral intervention and behavioral consultation services, the student must:*** ***(7-1-13)***~~

~~***i.*** ***Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501; and*** ***(7-1-13)***~~

~~*ii. Exhibit maladaptive behaviors that include frequent disruptive behaviors, aggression, self injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by at least two (2) raters familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by at least two (2) raters familiar with the student, on a standardized behavioral assessment approved by the Department; and (7-1-13)*~~

~~*iii. Have maladaptive behaviors that interfere with the student's ability to access an education. (7-1-13)*~~

~~*c. Personal Care Services. To be eligible for personal care services (PCS) the student must have a completed children's PCS assessment approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. (7-1-13)*~~

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.
Psychosocial Rehabilitation (PSR), Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. (9-1-13)T

01. Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student participant must meet one (1) of the following: (9-1-13)T

a. A student who is a child under eighteen (18) years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, and have documented evidence of a history and physical examination that has been completed within the last twelve (12) months prior to the initiation of mental health services. A child who meets the criteria for SED must experience a substantial impairment in functioning. The child's level and type of functional impairment must be documented in the 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: Self-harmful Behavior, Moods/Emotions, or Thinking. In addition, the child must have obtained a comprehensive diagnostic assessment that indicates: (9-1-13)T

i. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the child; (9-1-13)T

ii. The service can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced; and (9-1-13)T

iii. Verification that the child is not at immediate risk of self-harm or harm to others who cannot be stabilized, not in need of more restrictive care or inpatient care, and not over the age of eighteen (18). (9-1-13)T

b. A student who is eighteen (18) years old or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, 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. 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 listed below on either a continuous or intermittent basis, at least once per year. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training

services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: (9-1-13)T

i. Vocational/educational; (9-1-13)T

ii Financial; (9-1-13)T

iii. Social relationships/support; (9-1-13)T

iv. Family; (9-1-13)T

v. Basic living skills; (9-1-13)T

vi. Housing; (9-1-13)T

vii. Community/legal; or (9-1-13)T

viii. Health/medical. (9-1-13)T

c. A student must meet the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at the Idaho Department of Education website, http://www.sde.idaho.gov/site/special_edu/. (9-1-13)T

02. Behavioral Intervention and Behavioral Consultation. To be eligible for behavioral intervention and behavioral consultation services, the student must: (9-1-13)T

a. Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501; and (9-1-13)T

b. Exhibit maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by at least two (2) raters familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by at least two (2) raters familiar with the student, on a standardized behavioral assessment approved by the Department; and (9-1-13)T

c. Have maladaptive behaviors that interfere with the student's ability to access an education. (9-1-13)T

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. (9-1-13)T

852~~2~~3. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (7-1-13)

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. Be recommended or referred by a physician or other practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral; (7-1-13)

b. Be conducted by qualified professionals for the respective discipline as defined in Section 85~~4~~5 of these rules; ~~(7-1-13)~~(9-1-13)T

c. Be directed toward a diagnosis; and (7-1-13)

d. Include recommended interventions to address each need. (7-1-13)

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral. (7-1-13)

a. Behavioral Intervention. Behavioral Intervention is used to promote the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. The following staff-to-participant ratios apply: (7-1-13)

i. There must be at least one (1) qualified staff providing direct services for every three (3) students, unless the student has an assessment score of at least two (2) standard deviations from the mean in one (1) composite score. (7-1-13)

ii. When intervention is provided by a professional for students with an assessment score of at least two (2) standard deviations from the mean in one (1) composite score, there must be at least one (1) qualified staff for every two (2) students. (7-1-13)

iii. When intervention is provided by a paraprofessional for students with an assessment score of at least two (2) standard deviations from the mean in one (1) composite score, group intervention is not allowable. (7-1-13)

iv. As the number and severity of the students with behavioral issues increases, the staff participant ratio must be adjusted accordingly. (7-1-13)

v. Group services should only be delivered when the child's goals relate to benefiting from group interaction. (7-1-13)

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. (7-1-13)

i. Behavioral consultation cannot be provided as a direct intervention service. (7-1-13)

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. (7-1-13)

c. 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 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 by the student. (7-1-13)

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

f. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements. The provider must deliver at least one (1) of the following services: (7-1-13)

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (7-1-13)

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bedpan routines; (7-1-13)

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-13)

iv. The continuation of developmental disabilities programs to address the activities of daily living needs in the school setting as identified on the child's PCS assessment, in order to increase or maintain independence for the student with developmental disabilities as determined by the nurse or qualified intellectual disabilities professional (QIDP); (7-1-13)

v. Assisting the student with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; (7-1-13)

vi. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and the requirements are met in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. (7-1-13)

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

h. Psychological Evaluation. (3-30-07)

i. Psychotherapy. (3-30-07)

j. 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)*~~(9-1-13)T

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

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

m. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: (7-1-13)

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 85~~4~~5 of these rules for documentation requirements. ~~(3-30-07)~~(9-1-13)T

n. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-13)

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)

85~~3~~4. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.
The following documentation must be maintained by the provider and retained for a period of six (6) years: (7-1-13)

01. Individualized Education Program (IEP) and Other Service Plans. School districts and charter schools may bill for Medicaid services covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP) when the child turns three (3) years old, or Services Plan (SP) defined in the Idaho Special Education Manual on the State Department of Education website for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically-necessary health-related service, and lists all the Medicaid reimbursable services for which the school district or charter school is requesting reimbursement. The IEP and transitional IFSP must include: (7-1-13)

i. Type, frequency, and duration of the service(s) provided; (7-1-13)

ii. Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; (7-1-13)

iii. Measurable goals, when goals are required for the service; and (7-1-13)

iv. Specific place of service. (7-1-13)

02. Evaluations and Assessments. Evaluations and assessments must support services billed to

Medicaid, and must accurately reflect the student's current status. Evaluations and assessments must be completed at least every (3) years. (7-1-13)

03. Service Detail Reports. A service detail report that includes: (7-1-13)

a. Name of student; (7-1-13)

b. Name and title of the person providing the service; (7-1-13)

c. Date, time, and duration of service; (7-1-13)

d. Place of service, if provided in a location other than school; (7-1-13)

e. Category of service and brief description of the specific areas addressed; and (7-1-13)

f. Student's response to the service when required for the service. (7-1-13)

04. 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. (7-1-13)

05. Documentation of Qualifications of Providers. (7-1-13)

06. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (7-1-13)

a. School-based services must be recommended or referred by a physician or other practitioner of the healing arts for all Medicaid services for which the school district or charter school is receiving reimbursement. (7-1-13)

b. A recommendation or referral must be obtained prior to the provision of services for which the school district or charter school is seeking reimbursement. (7-1-13)

07. Parental Notification. School districts and charter schools 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 8534.08 of this rule. ~~(7-1-13)~~(9-1-13)T

08. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district or charter school 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. (7-1-13)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools 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 of 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 (7-1-13)

b. Notification to Primary Care Physician. School districts and charter schools 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: (7-1-13)

i. Results of evaluations within sixty (60) days of completion; (7-1-13)

ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (7-1-13)

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

(7-1-13)

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district or charter school 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. (7-1-13)

85~~4~~5. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (7-1-13)

01. Behavioral Intervention. Behavioral intervention must be provided by or under the supervision of a professional. (7-1-13)

a. A behavioral intervention professional must meet the following: (7-1-13)

i. An individual with an Exceptional Child Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 028; or (7-1-13)

ii. An individual with an Early Childhood/Early Childhood Special Education Blended Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 019; or (7-1-13)

iii. A Special Education Consulting Teacher who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 029; or (7-1-13)

iv. Habilitative intervention professional who meets the requirements defined in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits," Section 685; or (7-1-13)

v. Individuals employed by a school as certified Intensive Behavioral Intervention (IBI) professionals prior to July 1, 2013, are qualified to provide behavioral intervention; and (7-1-13)

vi. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. This can be achieved by previous work experience gained through paid employment, university practicum experience, or internship. It can also be achieved by increased on-the-job supervision experience gained during employment at a school district or charter school. (7-1-13)

b. A paraprofessional under the direction of a qualified behavioral intervention professional, must meet the following: (7-1-13)

i. Must be at least eighteen (18) years of age; (7-1-13)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned, and meet the requirements under the "Standards for Paraprofessionals Supporting Students with Special Needs," available online at the State Department of Education website; and (7-1-13)

iii. Must meet the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title 1, Part A, Section 1119. (7-1-13)

c. A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider. The professional must observe and review the direct services performed by the paraprofessional on a monthly basis, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the behavioral intervention service. (7-1-13)

02. Behavioral Consultation. Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child

development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: (7-1-13)

a. An individual with an Exceptional Child Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 028. (7-1-13)

b. An individual with an Early Childhood/Early Childhood Special Education Blended Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 019. (7-1-13)

c. A Special Education Consulting Teacher who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity" Section 029. (7-1-13)

d. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," Section 027, excluding a registered nurse or audiologist. (7-1-13)

e. An occupational therapist who is qualified and registered to practice in Idaho. (7-1-13)

f. Therapeutic consultation professional who meets the requirements defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 685. (7-1-13)

03. Medical Equipment and Supplies. See Subsection 85~~2~~3.03 of these rules. ~~(7-1-13)~~(9-1-13)T

04. Nursing Services. Nursing services must be provided by a registered nurse or licensed professional nurse (RN), or by a licensed practical nurse (LPN) licensed to practice in Idaho. (7-1-13)

05. Occupational Therapy and Evaluation. Occupation therapy and evaluation must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (7-1-13)

06. Personal Care Services. Personal care services must be provided by or under the direction of a registered nurse licensed by the State of Idaho. (7-1-13)

a. Providers of PCS must have at least one (1) of the following qualifications: (7-1-13)

i. Registered Nurse or Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a registered nurse or licensed professional nurse; (7-1-13)

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-1-13)

iii. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. Medically-oriented services may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." The professional nurse may require a certified nursing assistant (CNA) if, in their professional judgment, the student's medical condition warrants a CNA. (7-1-13)

b. The registered nurse (RN) must complete the PCS assessment and develop the written plan of care annually. Oversight provided by the RN must include all of the following: (7-1-13)

i. Development of the written PCS plan of care; (7-1-13)

ii. Review of the treatment given by the personal assistant through a review of the student's PCS record as maintained by the provider; and (7-1-13)

iii. Reevaluation of the plan of care as necessary, but at least annually. (7-1-13)

c. In addition to the RN oversight, the Qualified Intellectual Disabilities Professional (QIDP) as defined in 42 CFR 483.430 provides oversight for students with developmental disabilities when identified as a need

on the PCS assessment. Oversight must include: (7-1-13)

i. Assistance in the development of the PCS plan of care for those aspects of developmental disabilities programs that address the student's activities of daily living needs provided in the school by the personal assistant; (7-1-13)

ii. Review of the developmental disabilities programs given by the personal assistant through a review of the student's PCS record as maintained by the provider and through on-site observation of the student; and (7-1-13)

iii. Reevaluation of the PCS plan of care as necessary, but at least annually. (7-1-13)

d. The RN, QIDP, or a combination of both, must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (7-1-13)

07. Physical Therapy and Evaluation. Physical therapy and evaluation must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (7-1-13)

08. Psychological Evaluation. A psychological evaluation must be provided by a: (7-1-13)

a. Licensed psychiatrist; (7-1-13)

b. Licensed physician; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Psychologist extender registered with the Bureau of Occupational Licenses; or (7-1-13)

e. Certified school psychologist. (7-1-13)

09. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (7-1-13)

a. Psychiatrist, M.D.; (7-1-13)

b. Physician, M.D.; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Licensed clinical social worker; (7-1-13)

e. Licensed clinical professional counselor; (7-1-13)

f. Licensed marriage and family therapist; (7-1-13)

g. Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; (7-1-13)

h. 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"; (7-1-13)

i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (7-1-13)

j. 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 (7-1-13)

k. 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." (7-1-13)

10. Psychosocial Rehabilitation (PSR). Psychosocial rehabilitation must be provided by a: (7-1-13)

a. Licensed physician, licensed practitioner of the healing arts, or licensed psychiatrist; (7-1-13)

b. Licensed master's level psychiatric nurse; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Licensed clinical professional counselor or professional counselor; (7-1-13)

e. Licensed marriage and family therapist or associate marriage and family therapist; (7-1-13)

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (7-1-13)

g. Psychologist extender registered with the Bureau of Occupational Licenses; (7-1-13)

h. Licensed professional or registered nurse (RN); (7-1-13)

~~***i.*** *Psychosocial rehabilitation specialist as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 131;*~~ ~~*(7-1-13)*~~

j~~***j.***~~ Licensed occupational therapist; (7-1-13)

k~~***k.***~~ Certified school psychologist; ~~*or*~~ ~~*(7-1-13)*~~(9-1-13)T

l~~***l.***~~ Certified school social worker~~.~~; or ~~*(7-1-13)*~~(9-1-13)T

l. Psychosocial rehabilitation (PSR) specialist. A PSR specialist is: (9-1-13)T

i. An individual who has a Bachelor's degree and holds a current PRA credential; or (9-1-13)T

ii. An individual who has a Bachelor's degree or higher and was hired on or after November 1, 2010, to work as a PSR specialist to deliver Medicaid-reimbursable mental health services. This individual may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. In order to continue as a PSR specialist beyond a total period of thirty (30) months from the date of hire, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the PRA. (9-1-13)T

iii. Credential required for PSR specialists working primarily with adults. (9-1-13)T

(1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the PRA requirements. (9-1-13)T

(2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. (9-1-13)T

iv. Credential required for PSR specialists working primarily with children. (9-1-13)T

(1) Applicants who intend to work primarily with children under the age of eighteen (18) must obtain a certificate in children's psychiatric rehabilitation in accordance with the PRA requirements. (9-1-13)T

(2) Applicants who primarily work with children, but who also intend to work with participants eighteen (18) years of age or older, must have training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The worker's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the worker's caseload. (9-1-13)T

v. An individual who is qualified to apply for licensure to the Idaho Bureau of Occupational Licenses, in any of the professions listed above in Subsections 855.10.a. through 855.10.i., who has failed his licensing exam or has been otherwise denied licensure is not eligible to provide services under the designation of PSR Specialist unless this individual has obtained one (1) of the PRA credentials. (9-1-13)T

11. Speech/Audiological Therapy and Evaluation. 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. (7-1-13)

12. Social History and Evaluation. Social history and evaluation must be provided by a registered nurse or 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. (7-1-13)

13. Transportation. 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. (7-1-13)

14. Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. (7-1-13)

a. Occupational Therapy. Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (7-1-13)

b. Physical Therapy. Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision and service requirements. (7-1-13)

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 qualifications, supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. (7-1-13)

855~~5~~6. SCHOOL-BASED SERVICE: PROVIDER REIMBURSEMENT.
Payment for health-related services provided by school districts and charter schools must be in accordance with rates established by the Department. (7-1-13)

01. Payment in Full. Providers of services must accept as payment in full the school district or charter school payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. (7-1-13)

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. (3-30-07)

03. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (3-30-07)

04. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service

reimbursement. School districts and charter schools must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (3-30-07)

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (3-30-07)

b. School districts and charter schools will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (3-30-07)

c. The Department will hold matching funds in an interest bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (3-30-07)

d. The payments to the districts will include both the federal and non-federal share (matching funds). (3-30-07)

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (3-30-07)

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. (3-30-07)

g. The Department will provide the school districts a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (3-30-07)

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. (3-30-07)

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (3-30-07)

856~~6~~7. SCHOOL-BASED SERVICE: QUALITY ASSURANCE.
The provider will grant the Department immediate access to all information required to review compliance with these rules. (3-30-07)

857~~7~~8. -- 859. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2013.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Tuesday, August 20, 2013 6:00 p.m. P.D.T.	Wednesday, August 21, 2013 1:00 p.m. M.D.T.	Wednesday, August 21, 2013 6:00 p.m. M.D.T.
IDHW Region I Office (lrg. conf. room, lower level) 1120 Ironwood Dr., Suite 102 Coeur d'Alene, ID 83814	Medicaid Central Office (conf. rooms D-East & West) 3232 Elder Street Boise, ID 83705	IDHW Region VII Office (2nd flr., large conf. room) 150 Shoup Ave. Idaho Falls, ID 83402

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:

Section 56-261, Idaho Code, directs the Department to implement managed care tools to develop an accountable care system to improve health outcomes. In order to comply, the State will implement a 1915(b) Waiver that will require Medicaid participants to enroll in a statewide prepaid ambulatory health plan (PAHP). Rule changes are being made to incorporate the managed care waiver changes into these rules.

All rules related to behavioral health services are being removed from these rules and moved into IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit. In compliance with Section 56-261, Idaho Code, that requires the Department to implement managed care systems whenever possible, these rule changes are necessary in order for the Department to confer the Idaho Medicaid Behavioral Health benefits under the applicable authority.

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:

There is no anticipated fiscal impact to the state general fund. The consolidation of mental health clinic services, psychosocial rehabilitative services, mental health service coordination, and substance use disorder service benefits into one program of behavioral health services provided through a managed care delivery system will be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this is a temporary rule being done to comply with the requirements in Section 56-261, Idaho Code.

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 Carolyn Burt at (208) 364-1844.

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 28, 2013.

DATED this 9th day of July, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
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 AND THE TEXT OF THE PROPOSED RULE FOR DOCKET NO. 16-0310-1301

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-19-07)

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. Dental services for the Medicaid Enhanced Plan are covered under Sections 080 through 085 of these rules. Outpatient behavioral health benefits are contained in IDAPA 16.03.09. "Medicaid Basic Plan Benefits." ~~(5-8-09)~~(9-1-13)T

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers' claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (3-19-07)

a. Cost verification of actual costs for providing goods and services; (3-19-07)

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-19-07)

c. Effectiveness of the service to achieve desired results or benefits; and (3-19-07)

d. Reimbursement rates or settlement calculated under this chapter. (3-19-07)

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following document: (3-19-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at http://www.access.gpo.gov/nara/cfr/cfr-table-search.html. (3-19-07)

02. CDT - 2007/2008 (Current Dental Terminology, Sixth Edition). Current Dental Terminology, Sixth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60601-9985, or may be ordered online at http://www.adacatalog.org. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (5-8-09)

~~*03. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702.* (3-19-07)~~

0~~4~~3. **Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives.** This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)

0~~5~~4. **Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor**. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-19-07)

0~~6~~5. **Provider Reimbursement Manual (PRM)**. The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at http://www.cms.gov/Manuals/PBM/list.asp. (3-19-07)

0~~7~~6. **Resource Utilization Groups (RUG) Grouper**. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-19-07)

0~~8~~7. **SIB-R Comprehensive Manual**. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. (3-19-07)

0~~9~~8. **Travel Policies and Procedures of the Idaho State Board of Examiners**. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov/. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Subsection 009.03 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks."(3-19-07)

02. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

03. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Health Providers. The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules. (4-4-13)

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (4-2-08)

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (4-2-08)

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules. (4-4-13)

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-2-08)

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (4-2-08)

g. Crisis Intervention Providers. The criminal history and background check requirements applicable to crisis intervention providers as provided in Section 685 of these rules. (7-1-11)

h. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (4-2-08)

i. Day Habilitation Providers. The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules. (4-4-13)

j. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 009. (7-1-11)

k. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (4-2-08)

~~***l.*** *Mental Health Clinics. The criminal history and background check requirements applicable to mental health clinic staff as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 714.* *(3-19-07)*~~

~~***m***~~**l.** Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (3-19-07)

~~***n***~~**m.** Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

~~***o.*** *Psychosocial Rehabilitation Agencies. The criminal history and background check requirements applicable to psychosocial rehabilitation agency employees as provided in Subsection 130.02 of these rules.* *(3-19-07)*~~

~~p~~n. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (4-2-08)

~~q~~o. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. (7-1-11)

~~r~~p. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (3-19-07)

~~s~~q. Skilled Nursing Providers. The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules. (4-4-13)

~~t~~r. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (4-2-08)

~~u~~s. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

038. GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT SERVICES.
The following types of services are reimbursed as provided in Section 037 of these rules. (4-4-13)

~~*01. Payment for Enhanced Outpatient Mental Health Services. The fees for outpatient mental health services described in Section 110 of these rules. (4-4-13)*~~

~~*02. Psychosocial Rehabilitative Services (PSR). The fees for psychosocial rehabilitative services (PSR) described in Section 120 of these rules. (4-4-13)*~~

0~~3~~1. **Personal Care Services**. The fees for personal Care Services (PCS) described in Section 300 of these rules. (4-4-13)

0~~4~~2. **Aged and Disabled Waiver Services**. The fees for personal care services (PCS) described in Section 320 of these rules. (4-4-13)

0~~5~~3. **Children's Waiver Services**. The fees for children's waiver services described in Section 680 of these rules. (4-4-13)

0~~6~~4. **Adults with Developmental Disabilities Waiver Services**. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. (4-4-13)

0~~7~~5. **Service Coordination**. The fees for service coordination described in Section 720 of these rules. (4-4-13)

0~~8~~6. **Therapy Services**. The fees for physical therapy, occupational therapy, and speech-language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

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 089 of these rules. (3-29-12)

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*~~ Outpatient Behavioral Health Benefits. Enhanced ~~*Mental*~~ Outpatient Behavioral Health services are ~~*provided under Sections 100 through 147 of these rules.*~~ described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~*(3-19-07)*~~(9-1-13)T

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. Children's Developmental Disability Services as described in Sections 520 through 528, 660 through 666, and 680 through 686 of these rules. (7-1-13)

c. Adult Developmental Disabilities Services as described in Sections 507 through 520, and 649 through 657 of these rules. (7-1-13)

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

e. 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)

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: ENHANCED ~~MENTAL HEALTH~~ INPATIENT PSYCHIATRIC HOSPITAL SERVICES
(Sections 100 Through 199)

(BREAK IN CONTINUITY OF SECTIONS)

103. --~~109.~~ ~~(RESERVED)~~

~~110. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES.~~
~~In addition to mental health services covered under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 709 through 718, the Medicaid Enhanced Plan Benefits include the following enhanced outpatient mental health benefits. (5-8-09)~~

~~**01. Community Reintegration**. The enhanced services include community reintegration as described in Sections 111 through 146 of these rules. (5-8-09)~~

~~**02. Partial Care Services**. The enhanced services include partial care services in a Mental Health Clinic as described in Subsection 116.01 of these rules. (5-8-09)~~

~~**03. Psychotherapy**. The enhanced services include additional psychotherapy in a Mental Health Clinic as described in Subsection 118.01 of these rules. (5-8-09)~~

~~**04. Skill Training**. The enhanced services include skill training as described in Sections 111 through 146 of these rules. (5-8-09)~~

~~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. 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)~~

~~**03. 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. (3-29-12)~~

~~**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. Goal**. The desired outcome related to an identified issue. (3-19-07)~~

~~**08. 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)~~

~~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)~~

~~10. **Issue**. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (3-19-07)~~

~~11. **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)~~

~~12. **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)~~

~~13. **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. (3-29-12)~~

~~15. **Objective**. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (3-19-07)~~

~~16. **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)~~

~~17. **Partial Care**. Partial care is treatment for participants with serious and persistent mental illness (SPMI) whose functioning is sufficiently disrupted 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. (3-29-12)~~

~~18. **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)~~

~~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)~~

~~20. **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)~~

~~**21. 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)~~

~~**22. 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)~~

~~**23. 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)~~

~~**24. 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)~~

~~**25. 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)~~

~~**26. 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)~~

~~**27. 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)~~

~~**28. 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)~~

~~**29. Tasks**. Specific, time limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (3-19-07)~~

~~**30. 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)~~

~~**31. 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. (4-4-13)~~

~~**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 for Children. (4-4-13)~~

~~a. To be eligible for 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. (4-4-13)~~

~~b. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services. (4-4-13)~~

~~c. A child's level and type of functional impairment must be documented in the 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. (4-4-13)~~

~~d. 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: self harmful behavior, moods/emotions, or thinking. (4-4-13)~~

~~06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Adults. (4-4-13)~~

~~a. 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.c.i. through 112.06.c.viii. of this rule on either a continuous or an intermittent, at least once per year, basis. (4-4-13)~~

~~b. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services. (4-4-13)~~

~~c. 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 documented in the medical record in the following areas: (4-4-13)~~

~~i. Vocational/educational; (4-2-08)~~

ii. Financial; (4-2-08)

iii. Social relationships/support; (4-2-08)

iv. Family; (4-2-08)

v. Basic living skills; (4-2-08)

vi. Housing; (4-2-08)

vii. Community/legal; or (4-2-08)

viii. 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 comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. (3-29-12)

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. (3-29-12)

113. (RESERVED)

114. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: COMPREHENSIVE DIAGNOSTIC ASSESSMENT.

In order to determine eligibility for enhanced outpatient mental health services, a comprehensive diagnostic assessment must first be completed by one (1) of the licensed professionals listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.02. For participants seeking services beyond twelve (12) months, a review of the existing assessment is required to determine whether a full comprehensive diagnostic assessment or an updated assessment is needed to reflect the participant's current status on an annual basis. The treatment staff's determination that the latest assessment accurately represents the status of the participant must be documented in the medical record. In such cases, only an updated assessment that includes a new mental status examination is required. The assessment must be directed toward formulation of a diagnosis and a written individualized treatment plan. The

participant, and the participant's parent or guardian when appropriate, must take part in the assessment to the fullest extent possible. The comprehensive diagnostic assessment must include a five (5) axes diagnosis under DSM-IV-TR documented in a face-to-face evaluation, a complete psychiatric and medical history, 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, treatment recommendations including level of care, and any other information that contributes to the assessment of the participant's current psychiatric status and need for services. (5-8-09)

115. (RESERVED)

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 treatment plan 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. (3-29-12)

01. Goals. Services identified on the treatment plan must support the goals 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: (3-29-12)

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 updated treatment plan must be developed for participants who will continue in treatment beyond twelve (12) months. (3-29-12)

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)

117. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: MENTAL HEALTH CLINICS (MHC). All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718 apply to Mental Health Clinic services in this chapter with the enhancements described under Section 118 of these rules. (5-8-09)

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 be indicated on the individualized treatment plan with documented, concrete, and measurable objectives and outcomes; and (3-29-12)

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 cannot receive skill training in psychosocial rehabilitation services. (4-4-13)

119. 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: (3-21-12)

a. The mental health clinic's actual charge; or (3-21-12)

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. (3-21-12)

02. Reimbursement. 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. (3-21-12)

~~120. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).~~
~~Under 42 CFR 440.130(d) and in accordance with Section 39-3124, Idaho Code, the Department in each region will cover psychosocial rehabilitative services (PSR) for maximum reduction of mental disability. For PSR provided by a school district under an individualized education plan (IEP), refer to IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 850.~~ ~~(3-19-07)~~

~~121. -- 122. (RESERVED)~~

~~123. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): DESCRIPTIONS.~~
~~All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achievable objectives in accordance with the treatment plan. In addition to the services described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 709, the PSR program consists of the following services described in Subsections 123.01 through 123.04 of this rule.~~ ~~(5-8-09)~~

~~01. Skill Training. The service of skill training must be provided in accordance with the objectives specified in the individualized treatment plan. Skill training is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications, in accordance with Section 131 of these rules. Skill training includes one (1) or more of the following:~~ ~~(5-8-09)~~

~~a. Assistance in gaining and utilizing skills necessary to function adaptively in home and community settings and attain or retain capability for independence. This includes helping the participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, and other self-care skills needed for community integration. This service cannot be duplicative of other services the participant may be receiving from other programs.~~ ~~(5-8-09)~~

~~b. Assistance in gaining and utilizing skills necessary for managing personal finances, living arrangements, and daily home care duties.~~ ~~(5-8-09)~~

~~c. Individual interventions in social skill training directly related to the participant's mental illness to improve community functioning and to facilitate appropriate interpersonal behavior.~~ ~~(5-8-09)~~

~~d. Assistance in gaining and utilizing cognitive skills for problem solving everyday dilemmas, listening, symptom management, and self-regulation.~~ ~~(5-8-09)~~

~~e. Assistance for gaining and utilizing communications skills for the participant to be able to express himself coherently to others including other service providers.~~ ~~(5-8-09)~~

~~i. For participants receiving skill training for communication issues who cannot express necessary information to his healthcare providers or understand instructions given to him by healthcare providers, the PSR agency staff person may accompany the participant to medical appointments as a part of the communication skill training service.~~ ~~(5-8-09)~~

~~ii. For reimbursement purposes, the PSR agency staff person must deliver a skill training service that is identified on the treatment plan during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable.~~ ~~(5-8-09)~~

~~iii. The individualized treatment plan must identify how the issue is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child.~~ ~~(5-8-09)~~

~~f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness, symptom management, and adherence to the treatment regimen.~~ ~~(5-8-09)~~

~~g. Assistance for gaining and utilizing skills needed by the participant to arrange for his transportation, or to access and utilize the public transportation system.~~ ~~(5-8-09)~~

~~02. Community Reintegration. The service of community reintegration must be provided in accordance with the objectives specified in the individualized treatment plan. The service may include: (5-8-09)~~

~~a. Assisting the participant with self administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. (5-8-09)~~

~~b. Assisting the participant with maintaining or obtaining services that the participant usually takes care of for himself but is temporarily unable to do so because of an exacerbation of his symptoms. The targeted skills must be necessary to maintain his status in the home or community. (5-8-09)~~

~~c. Working with the participant's legal guardian immediately following the delivery of a mental health service in order to provide follow-up and support actions that facilitate the participant's positive response to the services. (5-8-09)~~

~~03. Group Skill Training. Group skill training must be provided in accordance with the objectives specified in the individualized treatment plan. Group skill training is a service provided to two (2) or more individuals concurrently. Group skill training is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 131 of these rules. This service includes one (1) or more of the following: (5-8-09)~~

~~a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness, symptom management, and skills for adhering to their medical regimen. These groups must not be used solely for the purpose of group prescription writing; (5-8-09)~~

~~b. Community Living skills groups that focus on occupation-related symptom management, symptom reduction, and skills related to appropriate job or school-related behaviors; (5-8-09)~~

~~c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (3-19-07)~~

~~d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and (3-19-07)~~

~~e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management. (3-19-07)~~

~~04. Crisis Intervention Service. Crisis support includes intervention for a participant in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under Section 131 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or refer the participant to community resources to resolve the crisis or both. Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. (5-8-09)~~

~~a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules. (3-19-07)~~

~~**b.** *Crisis Support in an Emergency Department.* (3-19-07)~~

~~i. *A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment.* (3-19-07)~~

~~ii. *The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant.* (3-19-07)~~

~~**c.** *Crisis Support Limitations. Crisis support services are available up to a total of ten (10) hours per week. This limitation is in addition to any other PSR service hours within that same time frame. Crisis support hours must be authorized by the Department.* (5-8-09)~~

~~**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 four (4) hours per participant annually. The following assessments are included in this limitation:* (3-29-12)~~

~~**a.** *Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually;* (3-29-12)~~

~~**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.* (3-29-12)~~

~~**03. Individualized Treatment Plan**. *Two (2) hours 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.* (3-29-12)~~

~~**04. 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)~~

~~**05. 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)~~

~~**06. 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. Participants who receive skill training in psychosocial rehabilitation cannot receive skill training in partial care. Participants with both a developmental disability diagnosis and a qualifying mental health diagnosis, who want to receive skill training services from a PSR agency provider in addition to a developmental disability service provider, must obtain authorization from the Department prior to service implementation.* (4-4-13)~~

~~**07. Pharmacological Management**. *Pharmacological management services beyond twenty-four (24) encounters 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 140.07 of these rules. (3-29-12)

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. 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.~~ ~~(3-29-12)~~

~~**03. 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.~~ ~~(3-29-12)~~

~~**04. Responding to Requests for Services**. When the Department is notified, in writing, by the provider of services that require prior authorization, the Department must review the request and either approve or deny the request within ten (10) working days of receipt.~~ ~~(3-29-12)~~

~~**05. 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 Availability**. Each provider must assure provision of PSR agency services to participants on a twenty-four (24) hour basis.~~ ~~(5-8-09)~~

~~**03. 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.~~ ~~(3-29-12)~~

~~**04. 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.~~ ~~(3-29-12)~~

~~**05. 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)~~

~~**06. 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)*

07. Healthy Connections Referral. *Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program.* *(3-19-07)*

130. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER AGENCY REQUIREMENTS. *Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements:* *(3-19-07)*

01. Agency. *A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 131 of these rules, and offering both direct and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll.* *(5-8-09)*

02. Criminal History Checks. *(3-19-07)*

a. *The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Criminal History and Background Checks."* *(3-19-07)*

b. *Once an employee, subcontractor, or agent of the agency has completed a self declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check.* *(3-19-07)*

c. *Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction.* *(3-19-07)*

03. PSR Agency Staff Qualifications. *The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 131 of these rules and maintains ongoing compliance with the education requirements defined in Subsection 130.09 or Subsection 131.03.c.iii. of this rule.* *(3-29-12)*

04. Additional Terms. *The agency must have signed additional terms to the general provider agreement with the Department. The additional terms must specify what direct services must be provided by the agency. The agency's additional terms may be revised or cancelled at any time.* *(5-8-09)*

05. Agency Employees and Subcontractors. *Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency.* *(3-19-07)*

06. Supervision. *The agency must provide staff with adequate case-specific supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. An agency staff person without a Master's degree must be supervised by a licensed master's level professional, as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. PSR agency staff must be supervised in accordance with their applicable status as follows:* *(3-29-12)*

a. *Certified Psychiatric Rehabilitation Practitioners (CPRP) may provide case specific supervision to other CPRP applicants when the supervising CPRP is directly supervised by a Master's level professional defined in Subsection 715.03.* *(3-29-12)*

b. *PSR Specialist applicants who are working toward, or have achieved, the USPRA Certificate in Children's Psychiatric Rehabilitation must be supervised by a licensed master's level professional, as defined in Subsection 715.03.* *(3-29-12)*

c. *The supervisors must ensure that the individual staff members demonstrate adequate competency to work with all populations assigned to them.* *(3-29-12)*

~~**d.** Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-19-07)~~

~~**e.** An agency must assure that clinical supervision, as required in the rules of the Idaho Bureau of Occupational Licenses and the Idaho State Board of Medicine, is available to all staff who provide psychotherapy. The amount of supervision should be adequate to ensure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department. (5-8-09)~~

~~**f.** The licensed physician or other licensed practitioner of the healing arts must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed. (5-8-09)~~

~~**07. Staff-to-Participant Ratio**. The following treatment staff-to-participant ratios for group treatment services must be observed: (5-8-09)~~

~~**a.** For children under four (4) years of age, the ratio must be 1:1. No group work is allowed. (5-8-09)~~

~~**b.** For children four (4) to twelve (12) years of age, the ratio must be 1:6 for groups. Group size must not exceed twelve (12) participants. (5-8-09)~~

~~**c.** For children over twelve (12) years of age, the ratio must be 1:10 for groups. Group size must not exceed twelve (12) participants. (5-8-09)~~

~~**08. Family Participation Requirement**. The following standards must be observed for services provided to children: (5-8-09)~~

~~**a.** For a child under four (4) years of age, the child's parent or legal guardian should be actively involved by being present on the premises and available for consultation with the staff during the delivery of mental health services. The child's parent or legal guardian does not have to participate in the treatment session or be present in the room in which the service is being conducted; (5-8-09)~~

~~**b.** For a child four (4) to twelve (12) years of age, the child's parent or legal guardian should be actively involved. The child's parent or legal guardian does not have to participate in the treatment session, but must be available for consultation with the staff providing the service; (5-8-09)~~

~~**c.** For a child over twelve (12) years of age, the child's parent or legal guardian should be involved, as appropriate. If the interdisciplinary team recommends that the child's parent or legal guardian not be involved in any aspect of the treatment, then the reasons for excluding the child's parent or legal guardian must be documented in the medical record. (5-8-09)~~

~~**d.** For a child whose parent or legal guardian does not participate in the services, the provider must document efforts made to involve the parent or legal guardian and must make appropriate adjustments to the treatment plan to address the parent or legal guardian's lack of involvement. (5-8-09)~~

~~**e.** Nothing in these rules may interfere with compliance to provisions of Section 16-2428, Idaho Code, regarding confidentiality and disclosure of children's mental health information. (5-8-09)~~

~~**09. Continuing Education**. The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (3-19-07)~~

~~**10. Crisis Service Availability**. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (3-19-07)~~

~~**11. Restraints and Seclusion.** (5-8-09)~~

~~**a.** Restraints and seclusion must not be employed under any circumstances except when an agency staff person employs physical holds as an emergency response to assault or aggression or other immediate safety risks in accordance with the following requirements in Subsections 130.11.a.i. through 130.11.a.iii.: (5-8-09)~~

~~i. The agency must have an accompanying policy and procedure that addresses the use of the such holds. (5-8-09)~~

~~ii. The physical holds employed must be a part of a nationally recognized non-violent crisis intervention model. (5-8-09)~~

~~iii. The staff person who employs the hold technique(s) must have evidence in his personnel record of current certification in the method. (5-8-09)~~

~~**b.** Provider agencies must develop policies that address the agency's response by staff to emergencies involving assault or aggression or other immediate safety risks. All policies and procedures must be consistent with licensure requirements, federal, state, and local laws, and be in accordance with accepted standards of healthcare practice. (5-8-09)~~

~~**12. Building Standards, Credentialing and Ethics.** All PSR agencies must comply with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712 and Subsection 714.14. PSR agencies whose participants are in the agency building for treatment purposes must follow the rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 714.15. (5-8-09)~~

~~**131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): AGENCY STAFF QUALIFICATIONS.** All agency staff delivering direct services must have at least one (1) of the following credentials: (5-8-09)~~

~~**01. Any of the Professions Listed Under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01.** (5-8-09)~~

~~**02. Clinician.** A clinician must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources. (5-8-09)~~

~~**03. Psychosocial Rehabilitation (PSR) Specialist.** (5-8-09)~~

~~**a.** Individuals hired as of June 30, 2009, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so until January 1, 2012. In order to continue working as a PSR specialist beyond this date, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. (3-29-12)~~

~~**b.** Individuals hired between July 1, 2009, and October 31, 2010, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so for a period not to exceed thirty (30) months from their initial date of hire. In order to continue as a PSR Specialist beyond a total period of thirty (30) months, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. (3-29-12)~~

~~**c.** Individuals hired as of November 1, 2010, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. In order to continue as a PSR Specialist beyond a total period of thirty (30) months, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. Such workers must have a bachelor's degree or higher in any field. (3-29-12)~~

i. Credential Required for PSR Specialists Working Primarily with Adults. (3-29-12)

(1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the USPRA requirements. (3-29-12)

(2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. (3-29-12)

ii. Credential Required for PSR Specialists Working Primarily with Children. (3-29-12)

(1) Applicants who intend to work primarily with children under the age of eighteen (18) must obtain a certificate in children's psychiatric rehabilitation in accordance with the USPRA requirements. (3-29-12)

(2) Applicants who primarily work with children, but who also intend to work with participants eighteen (18) years of age or older, must have training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The worker's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the worker's caseload. (3-29-12)

iii. Classroom Hours. Classroom hours completed for a USPRA credential may be used toward a PSR specialist applicant's continuing education requirements as described in Subsection 130.09 of these rules. The completion of required classroom hours must be documented in the agency's personnel records. (3-29-12)

d. An individual who is qualified to apply for licensure to the Idaho Bureau of Occupational Licenses, in the professions identified under Subsections 131.01 through 131.03 of this rule, who has failed his licensing exam or has been otherwise denied licensure is not eligible to provide services under the designation of PSR Specialist unless this individual has obtained one (1) of the USPRA credentials. (3-29-12)

132. -- 135. (RESERVED)

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. (3-29-12)

a. A copy of the review must be sent to the Department upon request. Failure to do so may result in a recoupment of reimbursement provided for services delivered after the intermittent staffing review date. (3-29-12)

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)

137. -- 139. (RESERVED)

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.***~~ ~~*(3-21-12)*~~

~~***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.*~~ ~~*(3-21-12)*~~

~~***b.*** *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.*~~ ~~*(3-21-12)*~~

~~***141. 145. (RESERVED)***~~

~~***146. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): QUALITY OF SERVICES.***~~
~~*The Department must monitor the quality and outcomes of PSR agency services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Behavioral Health.*~~ ~~*(5-8-09)*~~

~~***147.*** ~~**199. (RESERVED)**

(BREAK IN CONTINUITY OF SECTIONS)

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-13)

03. Requirements for Collaboration with Other Providers. ~~*(4-4-13)*~~

~~***a.*** When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain

documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the ~~*Psychosocial Rehabilitation (PSR)*~~ outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. ~~*(4-4-13)*~~(9-1-13)T

~~***b.*** *A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition.* *(4-4-13)*~~

(BREAK IN CONTINUITY OF SECTIONS)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

d. Practitioner of the healing arts; (7-1-11)

e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)

f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of habilitative intervention must meet the following minimum qualifications: (7-1-13)

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college; (7-1-11)

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)

d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the

Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-13)

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic 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." (7-1-11)

d. Therapeutic consultation providers employed by a DDA or the Infant Toddler Program must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-13)

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of crisis intervention must meet the following minimum qualifications: (7-1-13)

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.05 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention 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." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services 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. If the individual has not completed the required training during any yearly training period, he may not provide waiver 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)

08. Requirements for Clinical Supervision. All DD services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA or the Infant Toddler Program on a continuous and regularly scheduled basis. (7-1-13)

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the

necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA and the Infant Toddler Program must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-13)

09. Requirements for Collaboration with Other Providers. ~~(4-4-13)~~

~~**a.**~~ Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. 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 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. ~~(7-1-13)~~(9-1-13)T

~~**b.** *A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition.* (4-4-13)~~

10. Requirements for Quality Assurance. Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

720. SERVICE COORDINATION.
The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. These rules are not applicable to behavioral health service coordination, also known as case management services, provided under the Idaho Behavioral Health Plan (IBHP) included in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~(3-19-07)~~(9-1-13)T

721. SERVICE COORDINATION: DEFINITIONS.
The following definitions apply for Sections 721 through 736 of these rules. (5-8-09)

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. (5-8-09)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-19-07)

03. Conflict of Interest. A situation in which an agency or person directly or indirectly influences. or appears to influence the direction of a participant to other services for financial gain. (5-8-09)

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-19-07)

a. Hospitalization; (3-19-07)

b. Loss of housing; (3-19-07)

c. Loss of employment or major source of income; (3-19-07)

d. Incarceration; or (3-19-07)

e. Physical harm to self or others, including family altercation or psychiatric relapse. (3-19-07)

~~***05. High Cost Services**. As used in Subsection 725.01 of these rules, high cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include:* *(3-19-07)*~~

~~***a.** Emergency room visits or procedures;* *(3-19-07)*~~

~~***b.** Inpatient medical and psychiatric services;* *(3-19-07)*~~

~~***c.** Nursing home admission and treatment;* *(3-19-07)*~~

~~***d.** Institutional care in jail or prison;* *(3-19-07)*~~

~~***e.** State, local, or county hospital treatment for acute or chronic illness; and* *(3-19-07)*~~

~~***f.** Outpatient hospital services.* *(3-19-07)*~~

0~~6~~5. **Human Services Field**. A particular area of academic study in health care, social services, education, behavioral science or counseling. (5-8-09)

0~~7~~6. **Paraprofessional**. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. (5-8-09)

0~~8~~7. **Person-Centered Planning**. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. (5-8-09)

0~~9~~8. **Practitioner of the Healing Arts**. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-19-07)

~~1~~09. **Service Coordination**. Service coordination is a case management activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. (5-8-09)

~~1~~10. **Service Coordination Plan**. The service coordination plan, also known in these rules as the "plan," includes two components: (5-8-09)

a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and (5-8-09)

b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. (5-8-09)

1~~2~~1. **Service Coordination Plan Development**. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. (5-8-09)

1~~3~~2. **Service Coordinator**. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (5-8-09)

143. **Supports**. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

724. -- 725. (RESERVED)

~~***725. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.***~~

~~*An adult is eligible for service coordination if he meets the following requirements in Subsections 725.01 through 725.03 of this rule.* (5-8-09)~~

~~***01. Uses High Cost Services**. Is eighteen (18) years of age or older and uses, or has a history of using, high cost medical services associated with periods of increased severity of mental illness.* (5-8-09)~~

~~***02. Diagnosis of Mental Illness**.* (3-19-07)~~

~~***a.** The participant must have undergone a comprehensive diagnostic assessment that meets the definition in Section 111 of these rules. This assessment must be completed by one (1) of the licensed professionals listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.02, and the participant must meet the criteria for:* (5-8-09)~~

~~*i. Serious and Persistent Mental Illness (SPMI) that meets the definition in Section 111 of these rules;* (5-8-09)~~

~~*ii. Delirium dementia, and amnestic disorders; other cognitive disorders; and mental disorders due to a general medical condition; or* (5-8-09)~~

~~*iii. Schizoid, schizotypal, paranoid personality disorders.* (5-8-09)~~

~~***b.** If the only diagnosis is an intellectual disability or is a substance use related disorder, then the person is not included in the target population for mental health service coordination.* (5-8-09)~~

~~***03. Need Assistance**. Have mental illness of sufficient severity to cause a disturbance in their performance or coping skills in at least two (2) of the following areas, on either a continuous (more than one (1) year) or an intermittent (at least once per year) basis:* (5-8-09)~~

~~***a.** Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history.* (3-19-07)~~

~~***b.** Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support himself or manage his finances without assistance.* (3-19-07)~~

~~***c.** Social and interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests.* (3-19-07)~~

~~***d.** Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family.* (3-19-07)~~

~~***e.** Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements.* (3-19-07)~~

~~***f.** Housing: Has lost or is at risk of losing his current residence.* (3-19-07)~~

~~g. Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior, which may result in intervention by law enforcement, the judicial system, or both.~~ ~~(3-19-07)~~

~~h. Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens.~~ ~~(3-19-07)~~

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.
To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.0~~5~~3. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination must be made by the Department prior to the initiation of initial and ongoing plan development and services. ~~(7-1-13)~~(9-1-13)T

01. Age. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. (5-8-09)

02. Diagnosis. Must ~~be~~ have special health care needs requiring medical and multidisciplinary rehabilitation services identified by a physician or other practitioner of the healing arts ~~as having one (1) of the diagnoses found in Subsections 726.03 through 726.04 of this rule~~ to prevent or minimize a disability.
~~(7-1-13)~~(9-1-13)T

~~03. Special Health Care Needs. Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability.~~ ~~(3-19-07)~~

~~04. Serious Emotional Disturbance (SED). Have a serious emotional disturbance (SED) with an expected duration of at least one (1) year. The following definition of the SED target populations is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code.~~ ~~(3-19-07)~~

~~a. Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and~~ ~~(3-19-07)~~

~~b. Requires sustained treatment interventions; and~~ ~~(3-19-07)~~

~~c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior.~~ ~~(3-19-07)~~

~~d. The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires that the child scores in the "moderate" impairment range in at least two (2) of the subscales. One (1) of the two (2) must be from the following:~~ ~~(5-8-09)~~

~~i. Self-Harmful Behavior;~~ ~~(3-19-07)~~

~~ii. Moods/Emotions; or~~ ~~(3-19-07)~~

~~iii. Thinking.~~ ~~(3-19-07)~~

~~e. 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.~~ ~~(3-19-07)~~

0~~5~~3. Need Assistance. ~~Have one (1) or more of the following problems in Subsection726.05.a. through 726.06.e. of this rule associated with their diagnosis~~ Medicaid-reimbursed service coordination services are not

available for participants whose needs can be met by other service coordination or case management resources, including paid and non-paid sources. The participant must have needs for service coordination for one (1) or more of the following problems: ~~(7-1-13)~~(9-1-13)T

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; (5-8-09)

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; (5-8-09)

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; (5-8-09)

d. Further complications may occur as a result of the condition without provision of service coordination services; or (3-19-07)

e. The child requires multiple service providers and treatments. (3-19-07)

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)~~(9-1-13)T

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)~~(9-1-13)T

03. Referral and Related Activities. Activities that help link the participant with ~~*medical, psychiatric, social, early intervention, educational providers or other programs and*~~ service~~s~~ providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. ~~(5-8-09)~~(9-1-13)T

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.*~~ c. 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)*~~(9-1-13)T

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 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)~~

~~*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)~~(9-1-13)T

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 participants diagnosed with developmental disabilities*~~ per year. ~~(3-29-12)~~(9-1-13)T

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. ~~*All service coordination s*~~Services must be prior authorized by the Department~~*, except the following:*~~ according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com. ~~(5-8-09)~~(9-1-13)T

~~*a. Adult mental health service coordination services: service coordination plan development and five (5) hours of ongoing service coordination per month; and the first three (3) hours of crisis service coordination per month. For adults with mental illness, crisis service coordination over three (3) hours per month must be prior authorized.* (5-8-09)~~

~~*b. Children's service coordination services: four and a half (4.5) hours of ongoing service coordination per month.* (5-8-09)~~

02. Service Coordination Plan Development. (5-8-09)

a. A written plan, described in Section 731 of these rules, must be developed and implemented within sixty (60) days after the participant chooses a service coordinator ~~*except in the case of adults with serious and persistent mental illness; in which case the time limit is thirty (30) days*~~. ~~(5-8-09)~~(9-1-13)T

b. The plan must be updated at least annually and amended as necessary. (5-8-09)

c. The plan must address the service coordination needs of the participant as identified in the assessment described in Section 730 of these rules. (5-8-09)

d. The plan must be developed prior to ongoing service coordination being provided. (5-8-09)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: (3-19-07)

a. The name of the eligible participant. (5-8-09)

b. The name of the provider agency and the person providing the services. (5-8-09)

c. The date, time, duration, and place the service was provided. (5-8-09)

d. The nature, content, units of the service coordination received and whether goals specified in the plan have been achieved. (5-8-09)

e. Whether the participant declined any services in the plan. (5-8-09)

f. The need for and occurrences of coordination with any non-Medicaid case managers. (5-8-09)

g. The timeline for obtaining needed services. (5-8-09)

h. The timeline for re-evaluation of the plan. (5-8-09)

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (5-8-09)

j. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (5-8-09)

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (5-8-09)

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (5-8-09)

m. A copy of the informed consent form signed by the participant, parent, or legal guardian which documents that the participant has been informed of the purposes of service coordination, his rights to refuse service coordination, and his right to choose his service coordinator and other service providers. (5-8-09)

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. ~~*Mental health service coordination plans must also be signed by a physician or other practitioner of the healing arts.*~~ The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or his legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan. ~~*(5-8-09)*~~(9-1-13)T

~~***04. Documentation of Crisis Assistance for Adults With Serious and Persistent Mental Illness.***~~ ~~*Documentation to support authorization of crisis assistance beyond the monthly limitation must be submitted to the Department before such authorization may be granted. The crisis situation and the crisis service coordination services must be documented in the progress notes of the participant's medical record. Documentation to support delivery of crisis assistance must also be maintained in the participant's agency record and must include:*~~ ~~*(5-8-09)*~~

~~***a.*** *A description of the crisis, including identification of unanticipated events that precipitate the need for crisis service coordination services;*~~ ~~*(5-8-09)*~~

~~***b.*** *A brief review of service coordination and other services or supports available to, or already provided to, the participant to resolve the crisis;*~~ ~~*(5-8-09)*~~

~~***c.*** *A crisis resolution plan; and*~~ ~~*(3-19-07)*~~

~~***d.*** *Outcomes of crisis assistance service provision.*~~ ~~*(3-19-07)*~~

0~~5~~4. **Documentation Completed by a Paraprofessional**. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (5-8-09)

0~~6~~5. **Participant Freedom of Choice**. A participant must have freedom of choice when selecting from the service coordinators available to him. The service coordinator cannot restrict the participant's choice of other health care providers. (5-8-09)

0~~7~~6. **Service Coordinator Contact and Availability**. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and must meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At

least every ninety (90) days, ~~the~~ service coordinators must have ~~a~~ face-to-face contact with ~~the~~ each participant ~~except as described in Subsection 728.07.a. of this rule~~. ~~(5-8-09)~~(9-1-13)T

~~a. Mental health service coordinators must have face-to-face contact every month with each participant.~~ ~~(5-8-09)~~

~~b~~a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. (5-8-09)

~~c~~b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. (5-8-09)

0~~8~~7. **Service Coordinator Responsibility Related to Conflict of Interest**. Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must: (5-8-09)

a. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (5-8-09)

b. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. (5-8-09)

0~~9~~8. **Agency Responsibility Related to Conflict of Interest**. To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information: (5-8-09)

a. The definition of conflict of interest as defined in Section 721 of these rules; (5-8-09)

b. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant parent, or legal guardian; and (5-8-09)

c. The participant's, parent's, or legal guardian's signature on the document. (5-8-09)

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. (5-8-09)

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-19-07)

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: (5-8-09)

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and (5-8-09)

b. That a paraprofessional is not a supervisor. (5-8-09)

03. Agency Supervisor Required Education and Experience. (5-8-09)

a. Master's Degree in a a human services field from a nationally accredited university or college, and

have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

c. Be a licensed professional nurse (RN), and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

~~***d.*** *For mental health service coordination, the supervisor must have obtained the required supervised work experience in a mental health treatment setting with the serious and persistent mentally ill population.* *(5-8-09)*~~

04. Service Coordinator Education and Experience. (5-8-09)

a. Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Be a licensed professional nurse (RN); and have twelve (12) months work experience with the population being served. (5-8-09)

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience. (5-8-09)

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: (5-8-09)

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; (5-8-09)

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and (5-8-09)

c. Have twelve (12) months supervised work experience with the population being served. (5-8-09)

06. Limitations on Services Delivered by Paraprofessionals. ~~*(5-8-09)*~~

~~***a.***~~ Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.0~~7~~6 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. ~~*(5-8-09)*~~(9-1-13)T

~~***b.*** *Mental Health Service Coordination does not allow for service provision by paraprofessionals.* *(5-8-09)*~~

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, "Criminal History and Background Checks." (5-8-09)

08. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (3-19-07)

09. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (5-8-09)

730. SERVICE COORDINATION: PLAN DEVELOPMENT -- ASSESSMENT.

01. Assessment Process. The service coordination assessment must be completed by a service coordinator as part of the person-centered planning process. The focus of the assessment is to identify the participant's need for assistance in gaining and coordinating access to care and services. The participant must be included in the assessment process. The parent or legal guardian, when appropriate, and pertinent service providers as identified by the participant must also be included during the assessment process. The assessment component is used to determine the prioritized needs and services of the participant and must be documented in the plan. When the participant is a child, the assessment must include identification of the family's needs to ensure the child's needs are met. (5-8-09)

02. Components of an Assessment. The components in the assessment of a participant's service coordination needs must document the following information; (5-8-09)

a. Basic needs; (5-8-09)

b. Medical needs; (5-8-09)

c. Health and safety needs; (5-8-09)

d. Therapy needs; (5-8-09)

e. Educational needs; (5-8-09)

f. Social and integration needs; (5-8-09)

g. Personal needs; (5-8-09)

h. Family needs and supports; (5-8-09)

i. Long range planning; (5-8-09)

j. Legal needs; and ~~(5-8-09)~~(9-1-13)T

k. Financial needs~~; and~~. ~~(5-8-09)~~(9-1-13)T

~~***l.*** *For adults with mental illness the comprehensive diagnostic assessment used to establish service coordination eligibility described in Section 725 of these rules* *(5-8-09)*~~

~~***03. Assessment for Mental Health Service Coordination****. The assessment for mental health service coordination must not duplicate the comprehensive diagnostic assessment.* *(5-8-09)*~~

(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 728.0~~7~~6 of these rules. ~~(5-8-09)~~(9-1-13)T

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

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
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. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. (3-21-12)

08. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (3-19-07)