



Eric Milstead
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Legislative Services Office Idaho State Legislature

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MEMORANDUM

TO: Senators MARTIN, Souza, Jordan and,
Representatives WOOD, Wagoner, Chew

FROM: Elizabeth Bowen - Principal Legislative Drafting Attorney

DATE: April 02, 2020

SUBJECT: Temporary Rule

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Adoption of Temporary Rule - Docket No.
16-0309-2002

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Adoption of Temporary Rule - Docket No.
16-0309-2003

We are forwarding this temporary rule to you for your information only. No analysis was done by LSO. This rule is posted on our web site. If you have any questions, please call Elizabeth Bowen at the Legislative Services Office at (208) 334-4845. Thank you.

Attachment: Temporary Rule

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IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2002

NOTICE OF RULEMAKING – ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 20, 2020.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section 56-202(b) Idaho Code and Senate Bill 1204 (2019).

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

This chapter makes reference to the federal Institutions for Mental Disease (IMD) exclusion, which will no longer apply as of the effective date of the approved Medicaid waiver or state plan authority. All mentions of this exclusion in rule are being deleted to allow Medicaid reimbursement for IMD services.

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

This rule change will allow Medicaid reimbursement for services delivered to eligible adults in an IMD setting. Currently such services cannot be reimbursed, so this change confers a benefit to citizens needing treatment for substance use disorders and/or mental health disorders in an IMD setting.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Clay Lord at (208) 364-1979.

Dated this 19th day of March, 2020.

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**THE FOLLOWING IS THE TEMPORARY RULE FOR DOCKET NO. 16-0309-2002
(Only Those Sections With Amendments Are Shown.)**

701. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants are eligible who have a diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: (7-1-18)

- a. A freestanding psychiatric hospital; (7-1-18)
- b. A hospital psychiatric unit; and ~~(7-1-18)~~(3-20-20)T
- c. Subject to federal approval, an institutions for mental diseases. ~~for participants meeting the conditions in Subsections 701.01.c.i. and 701.01.c.ii. of this rule:~~ ~~(7-1-18)~~(3-20-20)T
 - i. ~~Participants must be under the age of twenty-one (21); and~~ (7-1-18)
 - ii. ~~If a participant reaches age twenty-one (21) while receiving services, he may continue inpatient treatment until services are no longer required, or he reaches age twenty-two (22), whichever comes first.~~ (7-1-18)

02. Inpatient Substance Use Disorder Services. Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. ~~Services may be provided in:~~ ~~(7-1-18)~~(3-20-20)T

- ~~a. A freestanding psychiatric hospital; or~~ (7-1-18)
- ~~b. A hospital psychiatric unit.~~ (7-1-18)

03. Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. (7-1-18)

a. Severity of illness criteria. The participant must meet one (1) of the following criteria related to the severity of ~~his~~ their psychiatric illness: ~~(7-1-18)~~(3-20-20)T

- i. Is currently dangerous to self as indicated by at least one (1) of the following: (3-30-07)
 - (1) Has actually made an attempt to take ~~his~~ their own life in the last seventy-two (72) hours (details of the attempt must be documented); or ~~(3-30-07)~~(3-20-20)T
 - (2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (3-30-07)
 - (3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the participant or a reliable source and details of the participant's plan must be documented); or (7-1-18)
 - (4) The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk of making an attempt without immediate intervention; or (7-1-18)
- ii. Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms ~~which that~~ indicate ~~they is~~ are a probable danger to others as indicated by one (1) of the following: ~~(7-1-18)~~(3-20-20)T
 - (1) The participant has engaged in, or threatened, behavior harmful or potentially harmful to others or

caused serious damage to property ~~which that~~ would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or ~~(7-1-18)~~(3-20-20)T

(2) The participant has made threats to kill or seriously injure others or to cause serious damage to property ~~which that~~ would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or ~~(7-1-18)~~(3-20-20)T

(3) A mental health professional has information from the participant or a reliable source that the participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (7-1-18)

iii. Participant is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-18)

(1) The participant has such limited functioning that ~~his~~ ~~their~~ physical safety and well being are in jeopardy due to ~~his~~ ~~their~~ inability for basic self-care, judgment, and decision making (details of the functional limitations must be documented); or ~~(7-1-18)~~(3-20-20)T

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the participant unmanageable and unable to cooperate in non-hospital treatment (details of the participant's behaviors must be documented); or (7-1-18)

(3) There is a need for treatment, evaluation, or complex diagnostic testing where the participant's level of functioning or communication precludes assessment ~~and~~ or treatment, or both, in a non-hospital based setting, and may require close supervision of medication or behavior or both. ~~(7-1-18)~~(3-20-20)T

(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. (7-1-18)

04. Intensity of Service Criteria. The participant must meet all of the following criteria related to the intensity of services needed for treatment. (7-1-18)

a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and (7-1-18)

b. The services provided can reasonably be expected to improve the participant's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-18)

c. Treatment of the participant's condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation. (7-1-18)

d. Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the participant is in ~~his~~ ~~their~~ current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. ~~(7-1-18)~~(3-20-20)T

05. Exclusions. If a participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (7-1-18)

a. The participant is unable to actively participate in an outpatient treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-18)

b. The participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability. (7-1-18)

702. INPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Initial Length of Stay. An initial length of stay, or a prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will never be more restrictive than requirements for non-behavioral health services in a general hospital. (7-1-18)

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for inpatient days in excess of the initial length of stay or previously approved extended stay. (7-1-18)

~~**03. Excluded Services.** Placement in an IMD for participants between the ages of twenty one (21) and sixty four (64) is not a covered service. (7-1-18)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2003

NOTICE OF RULEMAKING – ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 13, 2020.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section 56-202(b), Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

This temporary rulemaking is being done in anticipation on increased demands for Medicaid services due to the COVID-19 pandemic. These rule changes will allow Medicaid flexibility to ensure eligible participants receive necessary services throughout the emergency.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the purpose of protecting public health, safety, or welfare.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Michael Case at (208) 364-1878

Dated this 26th day of March, 2020.

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**THE FOLLOWING IS THE TEMPORARY RULE FOR DOCKET NO. 16-0309-2003
(Only Those Sections With Amendments Are Shown.)**

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." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at <https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx>. ~~(3-30-07)~~(3-13-20)T

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. 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 870.02 of these rules. (4-7-11)

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. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-20-14)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-30-07)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (3-30-07)

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. (3-20-14)

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-30-07)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-20-14)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-30-07)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-30-07)

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-30-07)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-20-14)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

09. Services Delivered Via Telehealth. Services delivered via telehealth as defined in Title 54, Chapter 57, Idaho Code, must be identified as such in accordance with billing requirements published in the Idaho Medicaid Provider Handbook. Telehealth services billed without being identified as such are not covered. Services delivered via telehealth may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for a ~~telephone conversation~~, electronic mail message (e-mail), or facsimile transmission (fax) ~~between a physician and a participant.~~ (3-25-16)(3-13-20)T

(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 Section 502 of these rules. ~~(7-1-18)~~ (3-13-20)T

~~02. Telehealth. Telehealth as defined in Title 54, Chapter 57, Idaho Code. (3-25-16)~~

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. **Sterilization Procedures.** Restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (7-1-18)

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

03. **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 for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (7-1-18)

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

05. **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)

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

~~07. Telehealth. Synchronous interaction telehealth encounters, delivered as defined in Title 54, Chapter 57, Idaho Code, are reimbursable as follows: (3-25-16)~~

~~a. Physician services delivered via telehealth are subject to primary care provider communication requirements in Section 210 of these rules. The Department will define limitations for telehealth in the Idaho Medicaid Provider Handbook to promote quality services and program integrity. (3-25-16)~~

~~b. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. (3-25-16)~~

(BREAK IN CONTINUITY OF SECTIONS)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. **Capitated Payments.** Healthy Connections providers are compensated for their patient care services on a per participant per month basis. (3-25-16)

02. **Capitated Payment Amounts.** Capitated payment amounts are determined by the Department and reflect the complexity of the patient's health combined with the provider's ability to impact patient health outcomes. This monthly payment to a provider is based on the number of participants assigned to the provider on the first day of

each month. (3-25-16)

~~03. **Advanced Practice Registered Nurse Telehealth Services.** Services provided via telehealth by advanced practice registered nurse enrolled as Healthy Connections providers will be reimbursed within the limitations defined by the Department for telehealth services in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between an advanced practice registered nurse and a participant. (3-25-16)~~

(BREAK IN CONTINUITY OF SECTIONS)

571. CHIS: DEFINITIONS.

01. Annual. Every three hundred sixty-five (365), days except during a leap year which equals three hundred sixty-six (366) days. (3-20-20)

02. Aversive Intervention. Uses unpleasant physical or sensory stimuli in an attempt to reduce undesired behavior. The stimuli usually cannot be avoided, is pain inducing, or both. (3-20-20)

03. Community. Natural, integrated environments outside the participant's home, outside of DDA center-based settings, or at school outside of school hours. (3-20-20)

04. Developmental Disabilities Agency (DDA). A DDA is an agency that is: (3-20-20)

a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; (3-20-20)

b. Certified by the Department to provide services to participants with developmental disabilities; and (3-20-20)

c. A business entity, open for business to the general public. (3-20-20)

05. Duplication of Services. Services are considered duplicate when: (3-20-20)

a. Goals are not separate and unique to each service provided; or (3-20-20)

b. When more than one (1) service is provided at the same time, unless otherwise authorized. (3-20-20)

06. Educational Services. Services that are provided in buildings, rooms or areas designated or used as a school or as educational facilities; that are provided during 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 that are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related service; and such services are provided to school age individuals defined in Section 33-201, Idaho Code. (3-20-20)

07. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. (3-20-20)

08. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual, who are not certified or credentialed in an evidence-based model. (3-20-20)

09. Human Services Field. A diverse field that is focused on improving the quality of life for

participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, and psychology or other areas of academic study as referenced in the Medicaid Provider Handbook. (3-20-20)

10. Practitioner of the Healing Arts, Licensed. Advanced practice registered nurse, nurse practitioner, or physician assistant. (3-20-20)

11. Recreational Services. Activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (3-20-20)

12. Restrictive Intervention. Any intervention that is used to restrict the rights or freedom of movement of a person and includes chemical restraint, mechanical restraint, physical restraint, and seclusion. (3-20-20)

~~**13. Telehealth.** *Telehealth is an electronic real-time synchronized audio-visual contact between a qualified professional and participant for the purpose of treatment. The professional and participant interact as if they were having a face-to-face service. Telehealth services must be delivered in accordance with the Idaho Medicaid Telehealth Policy.* (3-20-20)~~

143. Treatment Fidelity. The consistent and accurate implementation of children's habilitation services accordance with the modality, manual, protocol or model. (3-20-20)

154. Vocational Services. Services or programs that are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general workforce within one (1) year. (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

573. CHIS: COVERAGE AND LIMITATIONS.

01. Excluded for Medicaid Payment. The following are excluded for Medicaid payment: (3-20-20)

- i. Vocational services; (3-20-20)
- ii. Educational services; and (3-20-20)
- iii. Recreational services. (3-20-20)

02. Service Delivery. The CHIS allowed under the Medicaid state plan authority include evaluations, diagnostic and therapeutic treatment services provided on an outpatient basis. These services help improve individualized functional skills, develop replacement behaviors, and promote self-sufficiency of the participant. CHIS may be delivered in the community, the participant's home, or in a DDA in accordance with the requirements of this chapter. Duplication of services is not reimbursable. (3-20-20)

03. Required Recommendation. CHIS must be recommended by a physician or other practitioner of the healing arts within his or her scope of practice, under state law. (3-20-20)

a. The CHIS provider may not seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated recommendation. (3-20-20)

b. The recommendation is only required to be completed once and must be received prior to submitting the initial prior authorization request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, then and new recommendation must be received. (3-20-20)

04. Required Screening. Needs are determined through the current version of the Vineland Adaptive Behavior Scales or other Department-approved screening tools that are conducted by the family's chosen CHIS provider, the Department, or its designee, and are administered in accordance with the protocol of the tool. The screening tool is only required to be completed once and must be completed prior to submitting the initial prior authorization request. The following apply: (3-20-20)

a. If a screening tool has been completed by the Department, or its designee, a new screening is not required. (3-20-20)

b. If the participant has been determined eligible by the Department, a new screening tool is not required. (3-20-20)

~~c. If the participant has not accessed CHIS for more than three hundred sixty five (365) calendar days, a new screening must be completed. (3-20-20)~~

~~d.~~ The screening cannot be billed more than once unless an additional screening is required in accordance with guidelines as outlined in the Medicaid Provider Handbook. (3-20-20)

05. Services. All CHIS recommended on a participant's assessment and clinical treatment plan must be prior authorized by the Department, or its contractor. The following CHIS are available for eligible participants and are reimbursable services when provided in accordance with these rules: (3-20-20)

a. **Habilitative Skill Building.** This direct intervention service includes techniques used to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~two (2) or three (3)~~ up to six (6) participants. ~~(3-20-20)~~(3-13-20)T

ii. As the number and needs of the participants increase, the participant ratio in the group must be adjusted ~~from three (3) to two (2)~~ accordingly. ~~(3-20-20)~~(3-13-20)T

iii. Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. (3-20-20)

b. **Behavioral Intervention.** This service utilizes direct intervention techniques used to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs. These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation. Services include individual or group interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~two (2) or three (3)~~ up to six (6) participants. ~~(3-20-20)~~(3-13-20)T

ii. As the number and severity of the participants with behavioral issues increase, the participant ratio in the group must be adjusted ~~from three (3) to two (2)~~ accordingly. ~~(3-20-20)~~(3-13-20)T

iii. Group services should only be delivered when the participant's objectives relate to benefiting from group interaction. (3-20-20)

c. Interdisciplinary Training. This is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is to be utilized for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, behavioral or mental health professional. (3-20-20)

d. Crisis Intervention. This service may include providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis typically not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: (3-20-20)

- i. Hospitalization; (3-20-20)
- ii. Out of home placement; (3-20-20)
- iii. Incarceration; or (3-20-20)
- iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-20-20)

e. Assessment and Clinical Treatment Plan (ACTP). The ACTP is a comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. The qualified provider conducts an assessment to evaluate the participant's strengths, needs, and functional abilities across environments. This process guides the development of intervention strategies and recommendations for services related to the participant's identified needs. The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant's parent or legal guardian. The ACTP must be completed on a Department approved form as referenced in the Medicaid Provider Handbook and contain the following minimum standards: (3-20-20)

- i. Clinical interview(s) must be completed with the parent or legal guardian; (3-20-20)
- ii. Administer or obtain an objective and validated comprehensive skills or developmental assessment approved by the Department. The most current version of the assessment must be used ~~and the assessment must have been completed within the last three hundred and sixty five (365) days;~~ (3-20-20)(3-13-20)T
- iii. Review of assessments, reports, and relevant history; (3-20-20)
- ~~iv. Observations in at least one (1) environment;~~ (3-20-20)
- ~~v. A reinforcement inventory or preference assessment;~~ (3-20-20)
- ~~vi. A transition plan; and~~ (3-20-20)
- ~~vii. Be signed by the individual completing the assessment and the parent or legal guardian.~~ (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

575. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.

CHIS are delivered by individuals who meet or exceeds one (1) of the qualifying criteria below in Subsections 575.01 through 575.07 of this rule, and are employed by a certified DDA, or who meet the criteria as defined in Subsection 575.08 of this rule and is enrolled as an independent CHIS provider. All providers of CHIS must meet the continuing

training requirements in Subsection 575.09 of this rule. (3-20-20)

01. Crisis Intervention Technician. A crisis intervention technician can deliver crisis intervention directly with the eligible participant and must meet the qualifications of a community-based supports staff as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 526. The technician must be under the supervision of a specialist or professional who is observing and reviewing the direct crisis intervention services performed. Supervision must occur ~~monthly, or more often as necessary~~, to ensure the technician demonstrates the necessary skills to correctly provide the crisis intervention service. ~~(3-20-20)~~(3-13-20)T

02. Intervention Technician. An intervention technician can deliver habilitative skill building, behavioral intervention, and crisis intervention. This is a provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. An intervention technician must be an employee of a DDA and be under the supervision of a specialist or professional who is observing and reviewing the direct services performed by the intervention technician. Supervision must occur ~~monthly, or more often as necessary~~, to ensure the intervention technician demonstrates the necessary skills to correctly provide the intervention. Provisional status is limited to a single eighteen (18) successive month period. The qualifications for this type of provider can be met by one (1) of the following: ~~(3-20-20)~~(3-13-20)T

a. An individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or (3-20-20)

b. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. (3-20-20)

03. Intervention Specialist. An intervention specialist can deliver all CHIS, complete assessments and implementation plans, and must be under the supervision of a specialist or professional who is observing and reviewing the direct CHIS performed. Supervision must occur ~~monthly, or more often as necessary~~, to ensure the intervention specialist demonstrates the necessary skills to correctly provide the service. An intervention specialist who will complete assessments or supervise an individual completing assessments must have a minimum of ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for participants with functional or behavioral needs. The qualifications for this type of provider can be met by one (1) of the following: ~~(3-20-20)~~(3-13-20)T

a. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later, will be allowed to continue providing services as an intervention specialist as long as there is not a gap of more than three (3) successive years of employment as an intervention specialist; or (3-20-20)

b. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field; and (3-20-20)

i. Can demonstrate one thousand forty (1,040) hours of supervised experience working with participants birth to twenty-one (21) years of age who demonstrate functional or behavioral needs; and (3-20-20)

ii. Meets the competency requirements by completing one (1) of the following: (3-20-20)

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; or (3-20-20)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-20-20)

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university internship or practicum experience and may be documented within the supervised experience listed in Subsection 575.02.b.i. of this rule, and have one (1) of the following: (3-20-20)

i. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or (3-20-20)

ii. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or (3-20-20)

iii. 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, counseling, or nursing. This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework, or can be in addition to the degree coursework. Courses must cover the following as defined in the Medicaid Provider Handbook: (3-20-20)

(1) Promotion of development and learning for children from birth to five (5) years of age. (3-20-20)

(2) Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; (3-20-20)

(3) Building family and community relationships to support early interventions; (3-20-20)

(4) Development of appropriate curriculum for young children; (3-20-20)

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and (3-20-20)

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (3-20-20)

04. Intervention Professional. An intervention professional can deliver all CHIS and complete assessments and implementation plans. Intervention professionals must meet the following minimum qualifications: (3-20-20)

a. Hold a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (3-20-20)

b. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.03.c. of this rule. (3-20-20)

05. Evidence-Based Model (EBM) Intervention Paraprofessional. An EBM intervention paraprofessional can deliver habilitative skill building, crisis intervention, and behavioral intervention, and must be supervised in accordance with the evidence-based model. The qualifications for this type of provider are: (3-20-20)

- a. An individual who holds a high school diploma or general equivalency diploma; and (3-20-20)
- b. Holds a para-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

06. Evidence-Based Model (EBM) Intervention Specialist. An EBM intervention specialist can deliver all CHIS and complete assessments and implementation plans. This individual must be supervised in accordance with the evidenced-based model and may also supervise the evidence-based paraprofessional working within the same evidence-based model. The qualifications for this type of provider are: (3-20-20)

- a. An individual who holds a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)
- b. Holds a bachelor-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must also have a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university activities. (3-20-20)

07. Evidence-Based Model (EBM) Intervention Professional. An EBM intervention professional can deliver all CHIS and complete assessments and implementation plans. The qualifications for this type of provider are: (3-20-20)

- a. An individual who holds a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)
- b. Holds a masters-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.06.c. of this rule. (3-20-20)

08. Independent CHIS Provider. This type of provider can deliver all types of CHIS, complete assessments and implementation plans in accordance with their provider qualification as defined in Subsections 575.03, 575.04, 575.06, and 575.07 of these rules. Documentation of supervision must be maintained in accordance with the Department's record retention requirements. The following must be met: (3-20-20)

- a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; (3-20-20)
- b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; (3-20-20)
- c. Complete a criminal history and background check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (3-20-20)
- d. Follow all applicable requirements in Sections 570 through 577 of these rules; and (3-20-20)
- e. Not receive supervision from an individual that they are directly supervising. (3-20-20)

09. Continuing Training Requirements. Each individual providing CHIS must complete a minimum of twelve (12) hours of training each calendar year, including one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based intervention. The following criteria applies: (3-20-20)

- a. Training must be relevant to the services being delivered. (3-20-20)
- b. Continuing training requirements for new independent providers or employees of a DDA who have not provided CHIS for a full calendar year, may be prorated as defined in the Medicaid Provider Handbook. (3-20-20)
- c. Individuals who have not completed the required training during the previous calendar year, may not provide services in the current calendar year until the required number of training hours have been completed. (3-20-20)
- d. Training hours may not be earned in the current calendar year to be applied to a future calendar year. (3-20-20)
- e. Training topics can be repeated but the content of the continuing training must be different each calendar year; and (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

644. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Outpatient diabetes education and training services will be covered under the following conditions: (3-30-07)

01. Meets Program Standards of the ADA. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association. (3-30-07)

02. Conducted by a Certified Diabetic Educator. The education and training services are provided by a Certified Diabetic Educator through a formal program ~~conducted in a hospital outpatient department, or in a physician's office.~~ (3-30-07)(3-13-20)T

(BREAK IN CONTINUITY OF SECTIONS)

752. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: COVERAGE AND LIMITATIONS.

The Department will purchase or rent, when medically necessary, reasonable and cost-effective, durable medical equipment (DME) and medical supplies that are suitable for use in any setting in which normal life activities take place. Medical supplies, equipment, and appliances provided by a home health agency under a home health plan of care must meet the requirements found in Sections 750 through 779 of these rules and the requirements found in Sections 720 through 729 of these rules. (7-1-17)

01. Medical Necessity Criteria -- Equipment and Supplies. Department standards for medical necessity are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the CMS/Medicare DME coverage manual. Exceptions to Medicare coverage are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Items for convenience, comfort, or cosmetic reasons are not covered. (7-1-17)

02. Prior Authorization -- Equipment and Supplies. (7-1-17)

a. Unless otherwise specified by the Department in the provider handbook, durable medical equipment and medical supplies require prior authorization by the Department. (7-1-17)

b. Each request for prior authorization must include all medical necessity documentation required under Section 753 of these rules. (7-1-17)

c. The Medicaid fee schedule that identifies medical supplies, equipment, and appliances commonly ordered for Medicaid participants, is not a comprehensive list of all medical supplies, equipment, and appliances available to Medicaid participants. If a participant requires an item that is not listed on the fee schedule, a request may be submitted to the Department to assess items for coverage. This request must include justification of the medical necessity, amount of, and duration for the item or service. (7-1-17)

03. Coverage Conditions -- Equipment. Medical equipment is subject to coverage limitations in the CMS/Medicare DME coverage manual. Exceptions to these coverage conditions and coverage conditions for medically necessary equipment not included in that manual are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Exceptions must be established using evidence-based or best clinical practice standards as determined by the Department. (7-1-17)

04. Coverage Conditions -- Supplies. (7-1-17)

a. The Department will purchase no more than ~~a one (1)~~ **three (3)** months ~~supply~~ of necessary medical supplies ~~per in a three (3) month period~~ for the treatment or amelioration of a medical condition identified by the attending physician. Supplies in excess of the limitations in the CMS/Medicare DME coverage manual must be prior authorized by the Department. ~~(7-1-17)~~**(3-13-20)T**

b. Medical supplies are subject to the coverage limitations in the CMS/Medicare DME coverage manual. Exceptions to these coverage conditions and coverage conditions for medically necessary supplies not included in that manual are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Exceptions must be established using evidence-based or best clinical practice standards as determined by the Department. (7-1-17)

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROCEDURAL REQUIREMENTS.

01. Physician Orders. (7-1-17)

a. All medical supplies, equipment, and appliances must be ordered by a physician ~~or non-physician practitioner acting within the scope of their licensure~~. Such orders must meet the requirements described in the CMS/Medicare DME coverage manual. ~~(7-1-17)~~**(3-13-20)T**

b. Date of delivery is considered the date of service. (7-1-17)

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

d. The following information to support the medical necessity of the item(s) must be included in the physician's order and accompany all requests for prior authorization, or be kept on file with the DME provider for items that do not require prior authorization: (7-1-17)

i. The participant's medical diagnosis, including current information on the medical condition that requires the use of the supplies or medical equipment, or both; (7-1-17)

ii. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; (7-1-17)

iii. For medical equipment, a full description of the equipment needed. All modifications or attachments to the basic equipment must be supported; (7-1-17)

iv. For medical supplies, the type and quantity of supplies necessary must be identified; and (7-1-17)

v. Documentation of the participant's medical necessity for the item, that meets coverage criteria in the CMS/Medicare DME coverage manual. (7-1-17)

vi. Additional information may be requested by the Department for specific equipment or supplies, or

both, including equipment for which CMS/Medicare has established no coverage criteria. (7-1-17)

02. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with the face-to-face encounter requirements in Section 723 of these rules. (7-1-17)

03. Plan of Care Requirements for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. (7-1-17)

04. Prior Authorizations. (7-1-17)

a. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (7-1-17)

i. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. (7-1-17)

ii. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it. (7-1-17)

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

c. A valid prior authorization request is a written, faxed, or electronic request from a provider of Medicaid for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. (3-30-07)

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

06. Equipment Rental -- Purchase Procedures. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: (7-1-17)

a. Rental payments, including intermittent payments, are to be automatically applied to the purchase of the equipment. (3-30-07)

b. The Department may choose to continue to rent certain equipment without purchasing it. Such items include apnea monitors, ventilators, and other respiratory equipment. (3-30-07)

c. The total monthly rental cost of a DME item must not exceed one-tenth (1/10) of the total purchase price of the item. (3-30-07)

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

754. (RESERVED)

755. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any participant's DME or medical supplies that are included in the per diem payment while such an individual is an inpatient in a hospital nursing facility or ICF/ID. (3-30-07)

02. Least Costly Limitation. When multiple features, models or brands of equipment or supplies are available, coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs. (3-30-07)

03. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department is required, the authorization number must be included on the claim form. (3-30-07)

04. Fees and Upper Limits. The Department will reimburse according to Section 230 of these rules. (3-30-07)

05. Date of Service. Unless specifically authorized by the Department the date of services for durable medical equipment and supplies is the date of delivery of the equipment or supply(s), ~~or both. The date of service cannot be prior to the vendor receiving all medical necessity documentation~~ for items provided in-person or the date of shipment for supplies mailed through a third-party courier. (~~3-20-20~~)(3-13-20)T

06. Manually Priced Codes. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If the pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping, if that documentation is provided. (7-1-17)

07. Warranties and Cost of Repairs. No reimbursement will be made for the cost of repairs (materials or labor, or both) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME vendor. The following warranty periods are required to be provided on equipment purchased by the Department: (7-1-17)

- a.** A power drive wheelchair must have a minimum one (1) year warranty period; (7-1-17)
- b.** An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; (7-1-17)
- c.** All other wheelchairs must have a minimum one (1) year warranty period; (7-1-17)
- d.** All electrical components and new or replacement parts must have a minimum six (6) month warranty period; (7-1-17)
- e.** All other DME not specified in Subsections 755.07.a. through 755.07.d. of this rule must have a minimum one (1) year warranty period; (7-1-17)
- f.** If the manufacturer denies the warranty due to user misuse or abuse, or both, that information must be forwarded to the Department at the time of the request for repair or replacement; (7-1-17)
- g.** The monthly rental payment must include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. (7-1-17)

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

- 01. Activities of Daily Living (ADL).** The performance of basic self-care activities in meeting a participant's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-20-20)
- 02. Children's Habilitation Intervention Services (CHIS).** CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid eligible students with identified developmental limitations that impact the student's functional skills and behaviors across an array of developmental domains. CHIS include habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services. ~~(3-20-20)~~(3-13-20)T
- 03. Educational Services.** Services that are provided in buildings, rooms, or areas designated or used as a school or an educational setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the school day and period of time for these students, which are included in the individual educational plan (IEP) for the student. (7-1-16)
- 04. Evidence-Based Interventions.** Interventions that have been scientifically researched and reviewed in peer reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. (3-20-20)
- 05. Evidence-Informed Interventions.** Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual who are not certified or credentialed in an evidence-based model. (3-20-20)
- 06. Human Services Field.** A diverse field that is focused on improving the quality of life for participants. Areas of academic study include sociology, special education, counseling, and psychology, or other areas of academic study as referenced in the Medicaid Provider Handbook. (3-20-20)
- 07. School-Based Services.** School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (7-1-13)
- 08. The Psychiatric Rehabilitation Association (PRA).** An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. <http://www.psychrehabassociation.org>. (7-1-16)
- 09. PRA Credential.** Certificate or certification in psychiatric rehabilitation based upon the primary population with whom the individual works in accordance with the requirements set by the PRA. (7-1-19)
- 10. 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)
- 11. Serious Mental Illness (SMI).** In accordance with 42 CFR 483.102(b)(1), a person with SMI: (3-20-14)
- 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 (3-20-14)
- b.** Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment

criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (3-20-14)

12. 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. (3-20-14)

~~**13. Telehealth.** Telehealth is an electronic real time synchronized audio visual contact between a qualified professional and participant for the purpose of treatment. The professional and participant interact as if they were having a face-to-face service. Telehealth services must be delivered in accordance with the Idaho Medicaid Telehealth Policy. (3-20-20)~~

(BREAK IN CONTINUITY OF SECTIONS)

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.

Skills Building/Community Based Rehabilitation Services (CBRS). Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. (7-1-19)

01. Skills Building/Community Based Rehabilitation Services (CBRS). To be eligible for Skills Building/CBRS, the student must meet one (1) of the following: (7-1-19)

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. 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 school record. A Department-approved assessment must be used to obtain the child’s initial functional impairment score. ~~Subsequent scores must be obtained at least annually in order to determine the child’s change in functioning that occurs as a result of mental health treatment. (7-1-16)(3-13-20)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 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: (7-1-16)

- i. Vocational or educational; (3-20-20)
- ii. Financial; (3-20-14)
- iii. Social relationships or support; (3-20-20)
- iv. Family; (3-20-14)
- v. Basic living skills; (3-20-14)

- vi. Housing; (3-20-14)
- vii. Community or legal; or (3-20-20)
- viii. Health or medical. (3-20-20)

02. CHIS. Students eligible to receive habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services must have a standardized Department-approved assessment to identify functional, or behavioral needs, or both, that interfere with the student's ability to access an education or require intervention services to correct or ameliorate their condition in accordance with Section 880 of these rules. (3-20-20)

a. A functional need is determined when the student exhibits a deficit in an overall adaptive composite or deficits in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. A deficit is defined as one point five (1.5) or more standard deviations below the mean for all functional areas. (3-20-20)

b. A behavioral need is determined when the student exhibits 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 a rater 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 a rater familiar with the student, on a standardized behavioral assessment approved by the Department. (3-20-20)

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool 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. (7-1-16)

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.

The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (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)

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (7-1-16)

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 more than thirty (30) days prior to the signed and dated recommendation or referral; (3-28-18)

b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of

these rules; (3-20-14)

- c. Be directed toward a diagnosis; (7-1-16)
- d. Include recommended interventions to address each need; and (7-1-16)
- e. Include name, title, and signature of the person conducting the evaluation. (7-1-16)

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 more than thirty (30) days prior to the signed and dated recommendation or referral. *The recommendations or referrals are valid up to three hundred sixty five (365) days.* ~~(3-28-18)~~ (3-13-20)T

a. Behavioral Intervention. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified rehabilitative skill building needs and the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan with the purpose of preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~two (2) or three (3)~~ up to six (6) students. ~~(3-20-20)~~ (3-13-20)T

ii. As the number and severity of the students with behavioral issues increases, the student ratio in the group must be adjusted accordingly ~~from three (3) to two (2)~~. ~~(3-20-20)~~ (3-13-20)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-20-20)

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. Crisis Intervention. Crisis intervention services may include providing training to staff directly involved with the student, delivering intervention directly with the eligible student, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. This service is provided on a short-term basis typically not to exceed thirty (30) school days and is available for students who have an unanticipated event, circumstance, or life situation that places a student at risk of at least one (1) of the following: (3-20-20)

i. Hospitalization; (3-20-20)

ii. Out-of-home placement; (3-20-20)

iii. Incarceration; or (3-20-20)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-20-20)

d. Habilitative Skill Building. Habilitative skill building is a direct intervention service that includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a student. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible student. Services include individual or group interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~two (2) or three (3)~~ up to six (6) students. ~~(3-20-20)~~ (3-13-20)T

ii. As the number and needs of the students increase, the student ratio in the group must be adjusted ~~from three (3) to two (2)~~ accordingly. ~~(3-20-20)~~ (3-13-20)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-20-20)

e. Interdisciplinary Training. Interdisciplinary training is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a student's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the student's needs. This service is to be utilized for collaboration, with the student present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, or behavioral or mental health professional. (3-20-20)

f. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician, and prior authorized. Authorized items must be for use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. (7-1-16)

g. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his or her practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (7-1-16)

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

i. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements. Personal care services do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: (7-1-16)

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 bathroom routines; (7-1-16)

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

iv. 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)

v. 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)

- j.** Physical Therapy and Evaluation. (3-30-07)
- k.** Psychological Evaluation. (3-30-07)
- l.** Psychotherapy. (3-30-07)
- m.** Skills Building/Community Based Rehabilitation Services (CBRS). Skills Building/CBRS are interventions to reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills. These services are intended to prevent placement of the student into a more restrictive educational situation. (7-1-19)
- n.** Speech/Audiological Therapy and Evaluation. (3-30-07)
- o.** Social History and Evaluation. (3-30-07)
- p.** Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home and school when: (7-1-16)
- i.** The student requires special transportation assistance, a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student; (3-28-18)
- 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 855 of these rules for documentation requirements. (3-20-14)
- q.** Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-13)
- i.** Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid reimbursable health-related service being provided while the interpretive service is provided. (7-1-16)
- 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)

854. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.

The following documentation must be maintained by the provider and retained for a period of five (5) years: (7-1-16)

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), 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 that~~ indicates^{ing} 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: ~~(7-1-16)~~(3-13-20)T

- a. Type, frequency, and duration of the service(s) provided; (7-1-13)
- b. Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; (7-1-13)
- c. Measurable goals, when goals are required for the service; and (7-1-13)
- d. Specific place of service, if provided in a location other than school. (7-1-16)
- 02. Evaluations and Assessments.** Evaluations and assessments must: (3-20-20)
 - a. Support services billed to Medicaid; ~~and~~ ~~(3-20-20)~~(3-13-20)T
 - b. Accurately reflect the student's current status; ~~and~~. ~~(3-20-20)~~(3-13-20)T
 - ~~c. Be completed at least every (3) years. (3-20-20)~~
- 03. Service Detail Reports.** A service detail report that includes: (7-1-13)
 - a. Name of student; (7-1-13)
 - b. Name, title, and signature of the person providing the service; (7-1-16)
 - 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)~~(3-13-20)T
- 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 within thirty (30) days of the provision of services for which the school district or charter school is seeking reimbursement. Therapy requirements for the physician's order are identified in Section 733 of these rules. (3-28-18)
 - ~~c. A recommendation or referral must be obtained for the service at least every three hundred sixty five (365) days. (7-1-16)~~
- 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 854.08 of this rule. (3-20-14)

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' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. (7-1-16)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must document 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 document that they provided the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (7-1-16)

b. Primary Care Physician (PCP). School districts and charter schools must request the name of the student's primary care physician and request a written consent to release and obtain information between the PCP and the school from the parent or guardian. (7-1-16)

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)

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.

Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (7-1-13)

01. Behavioral Intervention. Behavioral intervention must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: (3-20-20)

a. Intervention Paraprofessional. Intervention paraprofessionals may provide direct services. The specialist or professional must observe and review the direct services performed by the paraprofessional ~~monthly, or more often as necessary~~; to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: ~~(3-20-20)~~(3-13-20)T

i. Be at least eighteen (18) years of age; (3-20-20)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; and (3-20-20)

iii. Meet the paraprofessional requirements as defined in IDAPA 08.02.02, "Rules Governing Uniformity." (3-20-20)

b. Intervention Technician. Intervention technician is a provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. Provisional status is limited to a single eighteen (18) successive month period. The specialist or professional must observe and review the direct services performed by the technician monthly, ~~or more often as necessary~~; to ensure the technician demonstrates the necessary skills to correctly provide the direct service. An intervention technician under the direction of a qualified intervention specialist or professional, must: ~~(3-20-20)~~(3-13-20)T

i. Be an individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or (3-20-20)

ii. Hold a bachelor's degree from an accredited institution in a human services field or a has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. (3-20-20)

c. Intervention Specialist. Intervention specialists may provide direct services, complete assessments, and develop implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (3-20-20)

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in IDAPA 08.02.02, "Rules Governing Uniformity," Sections 021-024; or (3-20-20)

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later, and does not have a gap of more than three (3) years of employment as an intervention specialist, or (3-20-20)

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (3-20-20)

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; (3-20-20)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-20-20)

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. (3-20-20)

d. Intervention Professional. Intervention professionals may provide direct services, complete assessments, and develop implementation plans. Intervention professionals who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (3-20-20)

i. An individual who holds a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (3-20-20)

ii. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-20-20)

e. Evidence-Based Model (EBM) Intervention Paraprofessional. EBM intervention paraprofessionals may provide direct services. EBM intervention paraprofessionals must be supervised in accordance with the evidence-based model in which they are certified or credentialed. The EBM intervention specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An EBM intervention paraprofessional must: (3-20-20)

i. Hold a high school diploma; and (3-20-20)

ii. Hold a para-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

f. Evidence- Based Model (EBM) Intervention Specialist. EBM intervention specialists may provide direct services, complete assessments, and develop implementation plans. EBM intervention specialists must be supervised in accordance with the evidence-based model in which they are certified or credentialed. The EBM intervention professional must observe and review the direct services performed by the specialist to ensure the specialist demonstrates the necessary skills to correctly provide the direct service. The specialist may supervise the EBM intervention paraprofessional working within the same evidence-based model. An EBM intervention specialist must: (3-20-20)

i. Hold a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)

ii. Hold a bachelors-level certification or credential in an evidence-based model approved by the Department. ~~(3-20-20)~~(3-13-20)T

g. Evidence-Based Model (EBM) Intervention Professional. EBM intervention professionals may provide direct services, complete assessments, and develop implementation plans. EBM intervention professionals may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. An EBM intervention professional must: (3-20-20)

i. Hold a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)

ii. Hold a masters-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

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 (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: (3-20-20)

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in IDAPA 08.02.02, "Rules Governing Uniformity"; (3-20-20)

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," excluding a licensed registered nurse or audiologist; (3-20-20)

c. An occupational therapist who is qualified and registered to practice in Idaho; (3-20-20)

d. An intervention professional, as defined in Subsection 855.01 of this rule; or (3-20-20)

e. An ~~Evidence Based Model (EBM)~~ intervention professional, as defined in Subsection 855.01 of this rule. ~~(3-20-20)~~(3-13-20)T

03. Crisis Intervention. Crisis intervention must be provided by, or under the supervision of an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: (3-20-20)

a. An intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)

b. An intervention technician, as defined in Subsection 855.01 of this rule; (3-20-20)

c. An intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)

d. An intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)

- e. An EBM intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)
 - f. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)
 - g. An EBM intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)
 - h. A licensed physician, licensed practitioner of the healing arts; (3-20-20)
 - i. An advanced practice registered nurse; (3-20-20)
 - j. A licensed psychologist; (3-20-20)
 - k. A licensed clinical professional counselor or professional counselor; (3-20-20)
 - l. A licensed marriage and family therapist; (3-20-20)
 - m. A licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-20-20)
 - n. A psychologist extender registered with the Bureau of Occupational Licenses; (3-20-20)
 - o. A licensed registered nurse (RN); (3-20-20)
 - p. A licensed occupational therapist; or (3-20-20)
 - q. An endorsed or certified school psychologist. (3-20-20)
- 04. Habilitative Skill Building.** Habilitative skill building must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following: (3-20-20)
- a. An intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)
 - b. An intervention technician, as defined in Subsection 855.01 of this rule; (3-20-20)
 - c. An intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)
 - d. An intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)
 - e. An EBM intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)
 - f. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; or (3-20-20)
 - g. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-20-20)
- 05. Interdisciplinary Training.** Interdisciplinary Training must be provided by one (1) of the following: (3-20-20)
- a. An intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)
 - b. An intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)
 - c. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)
 - d. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-20-20)

- 06. Medical Equipment and Supplies.** See Subsection 853.03 of these rules. (3-20-14)
- 07. Nursing Services.** Nursing services must be provided by a licensed registered nurse (RN) or by a licensed practical nurse (LPN) licensed to practice in Idaho. (7-1-13)
- 08. Occupational Therapy and Evaluation.** For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-16)
- 09. 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.** Licensed Registered Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed registered 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; (7-1-16)
- iii.** Certified Nursing Assistant (CNA). A person currently certified by the State of Idaho; or (7-1-16)
- iv.** Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. (4-11-19)
- b.** The licensed registered nurse (RN) must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care ~~annually~~. Oversight provided by the RN must include all of the following: ~~(7-1-16)~~(3-13-20)T
- 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 service detail reports as maintained by the provider; and (7-1-16)
- iii.** Reevaluation of the plan of care as necessary, ~~but at least annually~~. ~~(7-1-13)~~(3-13-20)T
- c.** The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (7-1-16)
- 10. Physical Therapy and Evaluation.** For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-16)
- 11. 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.** Endorsed or certified school psychologist. (7-1-16)
- 12. 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)
- 13. Skills Building/Community Based Rehabilitation Services (CBRS).** Skills Building/CBRS must be provided by one (1) of the following. Skills Building/Community Based Rehabilitation Services (CBRS) provider who is not required to have a PRA credential or credential required for CBRS specialists must be one (1) of the following: ~~(7-1-19)~~(3-13-20)T
- a. Licensed physician, licensed practitioner of the healing arts; (7-1-16)
 - b. Advanced practice registered nurse; (7-1-16)
 - c. Licensed psychologist; (7-1-13)
 - d. Licensed clinical professional counselor or professional counselor; (7-1-13)
 - e. Licensed marriage and family therapist; (7-1-16)
 - 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 registered nurse (RN); (7-1-13)
 - i. Licensed occupational therapist; (7-1-13)
 - j. Endorsed or certified school psychologist; (7-1-16)
 - k. Skills Building/Community Based Rehabilitation Services specialist. A Skills Building/CBRS specialist must:
 - i. Be an individual who has a bachelor's degree and holds a current PRA credential; or (7-1-19)

~~ii. Be an individual who has a bachelor's degree or higher, but does not hold a current PRA credential and was hired on or after November 1, 2010, to work as a Skills Building/CBRS specialist to deliver Medicaid-reimbursable mental health services. This individual may continue to provide Medicaid-reimbursable Skills Building/CBRS without a current PRA credential for a period not to exceed thirty (30) months. This thirty month (30) period does not restart with new employment as a Skills Building/CBRS specialist when transferring to a new school district, charter school, or agency. The individual must show documentation that they are working towards obtaining the required PRA credential. In order to continue providing Skills Building/CBRS as a Skills Building/CBRS specialist beyond a total period of thirty (30) months, the individual must have obtained the required current PRA credential.~~ (7-1-19)

iii. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist to review treatment provided to student participants on an ongoing basis. The frequency of the one-to-one (1:1) supervision must occur at least monthly. Supervision can be conducted using telehealth when it is equally effective as direct on-site supervision; and (3-20-20)(3-13-20)T

~~iv~~ii. Have a credential required for CBRS specialists. (7-1-19)

~~(1) Skills Building/CBRS specialists who intend to work primarily with adults, age eighteen (18) or older, must obtain a current PRA credential to work with adults.~~ (7-1-19)

~~(2) Skills Building/CBRS specialists who intend to work primarily with adults, but also with participants under the age of eighteen (18), must obtain a current PRA credential to work with adults, and must have additional training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The individual's supervisor must determine the scope and amount of training the individual needs in order to work competently with children assigned to the individual's caseload.~~ (7-1-19)

~~(3) Skills Building/CBRS specialists who intend to work primarily with children under the age of eighteen (18) must obtain a current PRA credential to work with children.~~ (7-1-19)

~~(4) Skills Building/CBRS specialists who intend to primarily work with children, but also work with participants eighteen (18) years of age or older, must obtain a current PRA credential to work with children, and must have additional training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The individual's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the individual's caseload.~~ (7-1-19)

14. Speech/Audiological Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-16)

15. Social History and Evaluation. Social history and evaluation must be provided by a licensed registered nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (7-1-13)

16. 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)

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by 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. (7-1-16)

a. Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (7-1-16)

b. Physical Therapy (PT). Refer to IDAPA 24.13.01, “Rules Governing the Physical Therapy Licensure Board,” for qualifications, supervision and service requirements. (7-1-16)

c. Speech-Language Pathology (SLP). 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. (7-1-16)

i. Supervision must be provided by an SLP professional as defined in Section 734 of this chapter of rules. (7-1-16)

ii. The professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. (3-20-20)