

IDAHO ADMINISTRATIVE BULLETIN

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Preface

The Idaho Administrative Bulletin is published once each month by the Department of Administration, Office of the Administrative Rules Coordinator, pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all administrative rulemaking documents in Idaho. The Bulletin publishes the official text notice and full text of such actions.

State agencies are required to provide public notice of rulemaking activity and invite public input. The public receives notice of a rulemaking activity through the Idaho Administrative Bulletin and the Legal Notice published monthly in local newspapers. The Legal Notice provides reasonable opportunity for public input, either oral or written, which may be presented to the agency within the time and manner specified in the Legal Notice. After the comment period closes, the agency considers fully all information submitted in regard to the rule. Comment periods are not provided in temporary or final rulemaking activities.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is cited by year and issue number. For example, Bulletin 99-1 refers to the first Bulletin issued in calendar year 1999, Bulletin 00-1 refers to the first Bulletin issued in calendar year 2000, etc. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. 1 refers to January; Volume No. 2 refers to February; and so forth. Example: The Bulletin published in January of 1999 is cited as Volume 99-1, the December 1998 Bulletin is cited as Volume 98-12. The March 2000 Bulletin is cited as Volume 00-3.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

The Idaho Administrative Code is published once a year and is a compilation or supplemental compilation of all final and enforceable administrative rules in effect in Idaho. In an effort to provide the reader with current, enforceable rules, temporary rules are also published in the Administrative Code. Temporary rules and final rules that have been adopted and approved by the legislature during the legislative session, and published in the monthly Idaho Administrative Bulletin, supplement the Administrative Code. Negotiated, proposed, and pending rules are not printed in the Administrative Code and are published only in the Bulletin.

*To determine if a particular rule remains in effect, or to determine if a change has occurred, the reader should refer to the **Cumulative Index of Administrative Rulemaking**, printed in each Bulletin.*

TYPES OF RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

The state of Idaho administrative rulemaking process comprises five distinct activities; Proposed, Negotiated, Temporary, Pending, and Final rulemaking. In the majority of cases, the process begins with proposed rulemaking and ends with final rulemaking. The following is a brief explanation of each type of administrative rule.

NEGOTIATED RULE

Negotiated rulemaking is a process in which all interested parties and the agency seek a consensus on the content of the rule. Agencies are encouraged to proceed through this informal rulemaking whenever it is feasible to do so. Publication of the text in the Administrative Bulletin by the agency is optional. This process should lead the

rulemaking to the temporary and/or proposed rule stage.

PROPOSED RULE

A proposed rulemaking is an action by an agency in which the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a notice of proposed rulemaking in the Bulletin. The notice of proposed rulemaking must include:

- a) the specific statutory authority for the rulemaking including a citation to a specific federal statute or regulation if that is the basis of authority or requirement for the rulemaking;*
- b) a statement in nontechnical language of the substance of the proposed rule, including a specific description of any fee or charge imposed or increased;*
- c) the text of the proposed rule prepared in legislative format;*
- d) the location, date, and time of any public hearings the agency intends to hold on the proposed rule;*
- e) the manner in which persons may make written comments on the proposed rule, including the name and address of a person in the agency to whom comments on the proposal may be sent;*
- f) the manner in which persons may request an opportunity for an oral presentation; and*
- g) the deadline for public (written) comments on the proposed rule.*

As stated, the text of the proposed rule must be published in the Bulletin. After meeting the statutory rulemaking criteria for a proposed rule, the agency may proceed to the pending rule stage. A proposed rule does not have an assigned effective date unless published in conjunction with a temporary rule docket. An agency may vacate a proposed rulemaking if it decides not to proceed further with the promulgation process.

TEMPORARY RULE

Temporary rules may be adopted only when the governor finds that it is necessary for:

- a) the protection of the public health, safety, or welfare; or*
- b) compliance with deadlines in amendments to governing law or federal programs; or*
- c) conferring a benefit.*

If a rulemaking meets any one or all of the above requirements, a rule may become effective before it has been submitted to the legislature for review and the agency may proceed and adopt a temporary rule.

A temporary rule expires at the conclusion of the next succeeding regular session of the legislature unless the rule is approved, amended, or modified by concurrent resolution or when the rule has been replaced by a final rule.

In cases where the text of the temporary rule is the same as that of the proposed rule, the rulemaking can be done concurrently as a temporary/proposed rule. State law requires that the text of a proposed or temporary rule be published in the Administrative Bulletin. Combining the rulemaking allows for a single publication of the text.

An agency may rescind a temporary rule that has been adopted and is in effect if the rule is being replaced by a new temporary rule or has been published concurrently with a proposed rulemaking that is being vacated.

PENDING RULE

A pending rule is a rule that has been adopted by an agency under the regular rulemaking process and remains subject to legislative review before it becomes a final, enforceable rule.

When a pending rule is published in the Bulletin, the agency is required to include certain information in the Notice of Pending Rule. This includes:

- a) the reasons for adopting the rule;*
- b) a statement of any change between the text of the proposed rule and the pending rule with an explanation of the reasons for any changes;*
- c) the date the pending rule will become final and effective; and*
- d) an identification of any portion of the rule imposing or increasing a fee or charge.*

Agencies are required to republish the text of the rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule. With the permission of the Rules Coordinator, only the Section(s) that have changed from the proposed text are republished. If no changes have been made to the previously published text, it is not required to republish the text again and only the Notice of Pending Rule is published.

FINAL RULE

A final rule is a rule that has been adopted by an agency under the regular rulemaking process and is in effect.

No pending rule adopted by an agency will become final and effective until it has been submitted to the legislature for review. Where the legislature finds that the agency has violated the legislative intent of the statute under which the rule was made, a concurrent resolution will be adopted rejecting, amending, or modifying the rule or any part thereof. A Notice of Final Rule must be published in the Idaho Administrative Bulletin for any rule that is rejected, amended, or modified by the legislature showing the changes made. A rule that has been reviewed by the legislature and has not been rejected, amended, or modified will become final with no further legislative action. No rule shall become final and effective before the conclusion of the regular or special legislative session at which the rule was submitted for review. However, a rule which is final and effective may be applied retroactively, as provided in the rule.

AVAILABILITY OF THE ADMINISTRATIVE CODE AND BULLETIN

The Idaho Administrative Code and all monthly Bulletins are available for viewing and use by the public in all 44 county law libraries, state university and college and community college libraries, the state law library, the state library, the Public Libraries in Boise, Pocatello, Idaho Falls and Twin Falls, the Lewiston City Library, East Bonner County Library, Eastern Idaho Technical College Library, Ricks College Library, and Northwest Nazarene College Library.

SUBSCRIPTIONS AND DISTRIBUTION

For subscription information and costs of publications, please contact the Department of Administration, Office of the Administrative Rules Coordinator, 650 W. State Street, Room 100, Boise, Idaho 83720-0306, telephone (208) 332-1820.

The Administrative Bulletin is an official monthly publication of the State of Idaho. Yearly subscriptions or individual copies are available for purchase.

The Administrative Code, is an annual compilation or supplemental compilation of all final and enforceable temporary administrative rules and includes tables of contents, reference guides, and a subject index.

Individual Rule Chapters and *Individual Rulemaking Dockets*, are specific portions of the Bulletin and Administrative Code produced on demand.

Internet Access - The Administrative Code and Administrative Bulletin, as well as individual chapters and dockets, are available on the Internet at the following address:

<http://www.state.id.us/> - from Idaho Home Page select "Legislation" then "Administrative Rules" link.

EDITOR'S NOTE: All rules are subject to frequent change. Users should reference all current issues of the Administrative Bulletin for negotiated, temporary, proposed, pending, and final changes to all rules, or call the Office of the Administrative Rules at (208) 332-1820.

HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

Rulemaking documents produced by state agencies and published in the *Idaho Administrative Bulletin* are organized by a numbering system. Each state agency has a two-digit identification code number known as the "IDAPA" number. (The "IDAPA" Codes are listed in the alphabetical/numerical index at the end of this Preface.) Within each agency there are divisions or departments to which a two-digit "TITLE" number is assigned. There are "CHAPTER" numbers assigned within the Title and the rule text is divided among major sections with a number of subsections. An example IDAPA number is as follows:

IDAPA 38.05.01.060.02.c.ii.

"IDAPA" refers to Administrative Rules in general that are subject to the Administrative Procedures Act and are required by this act to be published in the Idaho Administrative Code and the Idaho Administrative Bulletin.

"IDAPA 38." refers to the Idaho Department of Administration.

"05." refers to Title 05 which is the Department of Administration's Division of Purchasing.

"01." refers to Chapter 01 of Title 05, "Rules of the Division of Purchasing".

"060." refers to Major Section 060, "Content of the Invitation to Bid".

"02." refers to Subsection 060.02.

"c." refers to Subsection 060.02.c.

"ii." refers to Subsection 060.02.c.ii.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. All rulemaking actions (documents) are assigned a "DOCKET NUMBER". The "Docket Number" is a series of numbers separated by a hyphen "-", (38-0501-9901). The docket numbers are published sequentially by IDAPA designation (e.g. the two-digit agency code). The following example is a breakdown of a typical rule docket:

"DOCKET NO. 38-0501-9901"

"38-" denotes the agency's IDAPA number; in this case the Department of Administration.

"0501-" refers to the TITLE AND CHAPTER numbers of the agency rule being promulgated; in this case the Division of Purchasing (TITLE 05), "Rules of the Division of Purchasing" (Chapter 01).

"9901" denotes the year and sequential order of the docket submitted and published during the year; in this case the first rulemaking action of the chapter published in calendar year 1999.

Within each Docket, only the affected sections of chapters are printed. (See **Sections Affected Index** in each Bulletin for a listing of these.) The individual sections affected are printed in the Bulletin sequentially (e.g. Section "200" appears before Section "345" and so on). Whenever the sequence of the numbering is broken the following statement will appear:

"(BREAK IN CONTINUITY OF SECTIONS)"

INTERNAL AND EXTERNAL CITATIONS TO ADMINISTRATIVE RULES IN THE CODE AND BULLETIN

When making a citation to another Section or Subsection that is part of the same rule, a typical internal citation may appear as follows:

"...as found in Section 201 of this rule." OR "...in accordance with Subsection 201.06.c. of this rule."

It may also be cited to include the IDAPA, Title, and Chapter number also, as follows:

"...in accordance with IDAPA 38.05.01.201."

"38" denotes the IDAPA number of the agency.

"05" denotes the TITLE number of the agency rule.

"01" denotes the Chapter number of the agency rule.

"201" references the main Section number of the rule that is being cited.

Citations made within a rule to a different rule chapter (external citation) should also include the name of the Department and the name of the rule chapter being referenced, as well as the IDAPA, Title, and Chapter numbers. The following is a typical example of an external citation to another rule chapter:

"...as outlined in the Rules of the Department of Administration, IDAPA 38.04.04, 'Rules Governing Capitol Mall Parking.'"

BULLETIN PUBLICATION SCHEDULE FOR CALENDAR YEAR 2000

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
00-1	January, 2000	*November 17, 1999	January 5, 2000
00-2	February, 2000	December 22, 1999	February 2, 2000
00-3	March, 2000	January 19, 2000	March 1, 2000
00-4	April, 2000	February 23, 2000	April 5, 2000
00-5	May, 2000	March 22, 2000	May 3, 2000
00-6	June, 2000	April 19, 2000	June 7, 2000
00-7	July, 2000	May 24, 2000	July 5, 2000
00-8	August, 2000	June 21, 2000	August 2, 2000
00-9	September, 2000	July 19, 2000	September 6, 2000
00-10	October, 2000	**August 22, 2000	October 4, 2000
00-11	November, 2000	September 20, 2000	November 1, 2000
00-12	December, 2000	October 25, 2000	December 6, 2000

BULLETIN PUBLICATION SCHEDULE FOR CALENDAR YEAR 2001

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
01-1	January, 2001	*November 15, 2000	January 3, 2001
01-2	February, 2001	December 20, 2000	February 7, 2001
01-3	March, 2001	January 24, 2001	March 7, 2001
01-4	April, 2001	February 21, 2001	April 4, 2001
01-5	May, 2001	March 21, 2001	May 2, 2001
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01-7	July, 2001	May 23, 2001	July 4, 2001
01-8	August, 2001	June 20, 2001	August 1, 2001
01-9	September, 2001	July 18, 2001	September 5, 2001
01-10	October, 2001	**August 22, 2001	October 3, 2001
01-11	November, 2001	September 19, 2001	November 7, 2001
01-12	December, 2001	October 24, 2001	December 5, 2001

**Last day to submit proposed rulemaking before moratorium begins and last day to submit pending rules to be reviewed by the legislature.*

***Last day to submit proposed rules in order to complete rulemaking for review by legislature.*

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IDAPA 01 - IDAHO BOARD OF ACCOUNTANCY

01.01.01 - IDAHO ACCOUNTANCY RULES

DOCKET NO. 01-0101-0001

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: This temporary rule is effective July 1, 2000.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 54-204(1), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

The Idaho Accountancy Act has changes effective July 1, 2000. The changes are to require more college education to sit for the Uniform CPA Examination. The law (both current and with the change) allows for the demonstration of Educational Equivalencies to sit for the CPA Exam in place of the college requirement. The rules define what the standards are for the Educational Equivalencies. This rule change will update the Educational Equivalencies to reflect the higher education requirement.

There are two Educational Equivalencies, one is for a college degree and one is for business and accounting courses. Because Idaho will require five years of college after July 1, 2000 instead of the four it currently requires, the Educational Equivalency for a degree is being changed from a score of 450 on the GMAT (Graduate Management Admissions Test) to a score of 520. Because Idaho will require 48 semester credits in business and accounting after July 1, 2000 instead of the 30 it current requires, the Educational Equivalency for course work is being changed from a score of 55 on the ATAG (Achievement Test for Accounting Graduates) to a score of 63.

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

Compliance with deadlines in amendments to governing law.

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

No fee or charge imposed.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes were not controversial.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Barbara R. Porter, Executive Director, at 208-334-2490.

Anyone may submit written comments regarding this proposed rule. All written comments must be directed to the undersigned and must be delivered on or before June 28, 2000.

DATED this 18th day of April, 2000.

Barbara R. Porter, Executive Director
Idaho State Board of Accountancy
1109 Main Street, Owyhee Plaza Suite 470
PO Box 83720
Boise, Idaho 83720-0002
Phone: 208-334-2490
Fax: 208-334-2615
E-mail: bporter@boa.state.id.us

THE FOLLOWING IS THE TEXT OF DOCKET NO. 01-0101-0001

108. EQUIVALENCY (GMAT/ATAG) (Rule 108).

01. Equivalency For Bachelor's Degree. The board or the board's designee may use the Graduate Management Admissions Test (GMAT) prepared and given by an accredited college or university. Upon successful completion of the GMAT, by obtaining a total score of ~~four~~ five hundred ~~fifty~~ twenty (~~450~~) or above, the applicant may be eligible to take the CPA examination provided the applicant meets all other requirements set forth in Idaho Code, Section 54-208. ~~(7-1-93)~~(7-1-00)T

02. Equivalency Of Accounting Hours. The board or the board's designee may use the Achievement Test for Accounting Graduates, Level II, Form V (ATAG), which is prepared by the Psychological Testing Corporation to establish the equivalent of the number of required accounting hours set forth in Rule 107 to take the CPA examination. The board or the board's designee will grade the ATAG. Upon successful completion of the ATAG, by obtaining a raw score of ~~fifty-five~~ sixty-three (~~55~~) or more, the applicant may be approved to take the CPA examination provided the applicant meets all other requirements set forth in Idaho Code, Section 54-208. ~~(7-1-93)~~(7-1-00)T

**IDAPA 11 - DEPARTMENT OF LAW ENFORCEMENT
(IDAHO STATE POLICE)**

**11.10.01 - RULES GOVERNING THE ILETS SYSTEM - IDAHO CRIMINAL
JUSTICE INFORMATION SYSTEM**

DOCKET NO. 11-1001-0001

NOTICE OF PROPOSED AND TEMPORARY RULE

EFFECTIVE DATE: The temporary rule is effective May 1, 2000.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules and has proposed rulemaking. The action is authorized pursuant to Title 67, Chapter 30, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency at the address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the temporary and proposed rule: This proposed rule repeals this chapter in its entirety. The rules are being rewritten in Docket No. 11-1001-0002, "Rules Governing ILETS - Idaho Law Enforcement Teletypewriter System," in this Bulletin. The rewrite is a complete revision of current rules governing operation of the ILETS network. They include provisions relating to network security, user fee collection, and the board meetings that were previously adopted and published outside the structures of the Idaho Administrative Procedures Act.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: Protection of public health and welfare. The temporary rule repealing this chapter allows for the rewritten temporary rule to be put into effect as of the above mentioned date.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of the simple nature of the proposed rule change.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this proposed rule, contact Robert Taylor, Bureau of Criminal Identification, (208) 884-7132.

Anyone may submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked or delivered no later than June 28, 2000.

DATED this 19th day of April, 2000.

Margaret P. White
Deputy Attorney General
Department of Law Enforcement
P.O. Box 700
Meridian, ID 83680-0700
(208) 884-7050 (208) 884-7090 (FAX)

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

**IDAPA 11 - DEPARTMENT OF LAW ENFORCEMENT
(IDAHO STATE POLICE)**

**11.10.01 - RULES GOVERNING ILETS - IDAHO LAW ENFORCEMENT
TELETYPEWRITER SYSTEM**

DOCKET NO. 11-1001-0002

NOTICE OF PROPOSED AND TEMPORARY RULE

EFFECTIVE DATE: The temporary rule is effective May 1, 2000.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule and has proposed rulemaking. The action is authorized pursuant to Title 67, Chapter 30, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, no later than June 21, 2000.

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency at the address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule: The temporary and proposed rules are a complete revision and rewrite of current rules governing operation of the ILETS network. They include provisions relating to network security, user fee collection, and the board meetings that were previously adopted and published outside the structures of the Idaho Administrative Procedures Act. They also rename the chapter to "Rules Governing ILETS - Idaho Law Enforcement Teletypewriter System".

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: Protection of public health and welfare. The Idaho law enforcement teletypewriter system (ILETS) is supported partially by a use fee paid by subscribers, as authorized by Section 19-5202, Idaho Code. This temporary rule continues the fee schedule previously adopted by the ILETS Board. The collection of use fees is necessary for the continued operation of the Idaho law enforcement teletypewriter system (ILETS).

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: This temporary rule continues the fee schedule previously adopted by the ILETS Board, as authorized by Section 19-5202, Idaho Code. The collection of use fees is necessary for the continued operation of the Idaho law enforcement teletypewriter system (ILETS).

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of the simple nature of the proposed rule change.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Taylor, Bureau of Criminal Identification, (208) 884-7132.

Anyone may submit written comments regarding this proposed rule. All written comments and data concerning the proposed rule must be directed to the undersigned and must be postmarked or before June 28, 2000.

DATED this 19th day of April, 2000.

Margaret P. White
Deputy Attorney General
Department of Law Enforcement
P.O. Box 700
Meridian, ID 83680-0700
(208) 884-7050 (208) 884-7090 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 11-1001-0002

IDAPA 11
TITLE 10
Chapter 01

RULES GOVERNING ILETS - IDAHO LAW ENFORCEMENT TELETYPEWRITER SYSTEM

000. LEGAL AUTHORITY.

Title 19, Chapter 52, Idaho Code, creates a teletypewriter communications board and authorizes it to make rules necessary to establish and operate the Idaho law enforcement teletypewriter system. (5-1-00)T

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as IDAPA 11.10.01, "Rules Governing ILETS - Idaho Law Enforcement Teletypewriter System". (5-1-00)T

02. Scope. The rules relate to the governance and operation of the Idaho Law Enforcement Teletypewriter System. (5-1-00)T

002. WRITTEN INTERPRETATIONS.

There are no written interpretations of these rules. (5-1-00)T

003. ADMINISTRATIVE APPEALS.

Administrative appeals under this chapter shall be governed by the rules of administrative procedure of the attorney general, IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General". (5-1-00)T

004. INCORPORATION BY REFERENCE.

01. Incorporated Documents. IDAPA 11.10.01 incorporates by reference the full text of the requirement found in the following documents: (5-1-00)T

a. "Criminal Justice Information Systems," 28 CFR Part 20 (1999); (5-1-00)T

b. "Criminal Justice Information Systems--CJIS Security Policy," Federal Bureau of Investigation, National Crime Information Center (May 1999); (5-1-00)T

c. "National Crime Information Center, Operating Manual," Federal Bureau of Investigation, National Crime Information Center (April 1, 1998) (5-1-00)T

d. National Law Enforcement Telecommunication System, Users Guide," NLETS, Users Guide, (November 7, 1997) (5-1-00)T

e. "National Law Enforcement Telecommunication System, Policies and Procedures," NLETS, Policies and Procedures, (May 22, 1989) (5-1-00)T

02. Document Availability. The above listed documents are available during normal working hours for inspection and copying at the Idaho State Police, Bureau of Criminal Identification, 700 South Stratford Drive, Meridian, Idaho. (5-1-00)T

005. MAILING ADDRESS AND OFFICE HOURS.

The mailing address is Idaho State Police, Bureau of Criminal Identification, P.O. Box 700, Meridian, ID 83680-

0700. The office hours are Monday through Friday, 8 a.m. to 5 p.m. (5-1-00)T

006. -- 009. (RESERVED).

010. DEFINITIONS.

01. Administration Of Criminal Justice. (5-1-00)T

a. Administration of Criminal Justice means performance of any of the following activities: (5-1-00)T

i. Detection; (5-1-00)T

ii. Apprehension; (5-1-00)T

iii. Detention; (5-1-00)T

iv. Pretrial release; (5-1-00)T

v. Post-trial release; (5-1-00)T

vi. Prosecution; (5-1-00)T

vii. Adjudication; (5-1-00)T

viii. Correctional supervision; or (5-1-00)T

ix. Rehabilitation of accused persons or criminal offenders. (5-1-00)T

b. The administration of criminal justice includes: (5-1-00)T

i. Criminal identification activities; and (5-1-00)T

ii. The collection, storage, and dissemination of criminal history record information. (5-1-00)T

02. Associated System. Any automated or manual information system that is accessible through ILETS. (5-1-00)T

03. Criminal Justice Agency. (5-1-00)T

a. Federal and state courts having jurisdiction to hear criminal matters; and (5-1-00)T

b. A government agency or a subunit of an agency that performs the administration of criminal justice pursuant to a statute or executive order and that allocates a substantial part of its annual budget to the administration of justice. (5-1-00)T

04. Board. The board created, pursuant to Title 19, Chapter 52, Idaho Code, to establish priorities and operational policies and procedures relating to ILETS. (5-1-00)T

05. Department. The Idaho Department of Law Enforcement, or successor agency. (5-1-00)T

06. Executive Officer. As provided by Title 19, Chapter 52, Idaho Code, means the director of the Idaho Department of Law Enforcement, or successor agency. (5-1-00)T

07. III. The Interstate Identification Index, which is a cooperative federal-state system for the exchange of automated criminal history records and, to the extent of their participation in the III system, the criminal history repositories of the states. (5-1-00)T

08. ILETS. The Idaho Law Enforcement Teletypewriter (telecommunication) system established by the director of law enforcement pursuant to Title 19, Chapter 52, Idaho Code, and includes all hardware, software, electronic switches, peripheral gear, microwave links, circuitry, and terminal devices that comprise the system and includes access to the system. (5-1-00)T

09. Management Control Agreement. A written agreement between a criminal justice agency and a non-criminal justice agency that provides services (dispatching, record keeping, computer services, etc.) to the criminal justice agency. The agreement shall give the criminal justice agency authority to set and enforce policies governing the non-criminal justice agency's access to ILETS. (5-1-00)T

10. NCIC. The Federal Bureau of Investigation, National Crime Information Center, which is a computerized information system that includes telecommunications lines and any message facilities authorized by law regulation, or policy approved by the United States Attorney General to link local, state, tribal, federal, foreign, and international criminal justice agencies for the purpose of exchanging NCIC related information. The system includes information in the III system. (5-1-00)T

11. NLETS. The National Law Enforcement Telecommunication System, Incorporated, a national computerized message switching system that links national and state criminal justice information systems. (5-1-00)T

12. Non-Criminal Justice Agency. A state agency, federal agency, or unit of local government that is not a criminal justice agency. The term does not refer to private individuals, corporations, or non-governmental agencies or organizations. (5-1-00)T

011. (RESERVED).

012. EXECUTIVE OFFICER OF THE BOARD.

01. Authority Of Office. The executive officer shall represent the board in the day-to-day administration of ILETS and is responsible for ensuring that all policies and decisions of the board are promulgated pursuant to the authority of Chapter 52, Title 19, Idaho Code. The executive officer may delegate duties to employees and officers of the department and shall execute instruments for, and on behalf of, the board and ILETS. (5-1-00)T

02. Additional Responsibilities. In addition to the responsibilities assigned to the office by statute, the executive officer is responsible for ensuring, subject to adequate legislative appropriations, that the board receives adequate staff support and that the following staff duties are performed: (5-1-00)T

a. Preparation and dissemination of agendas, posting of legal notices of all meetings, and maintenance of a written record of the proceedings of board meetings; and (5-1-00)T

b. Management and safekeeping of all documents relating to the board and ILETS operations. (5-1-00)T

03. Governing Policies And Rules. The executive officer and any department employees and officials assigned by the executive officer to support ILETS operations will be governed by policies and rules of the State of Idaho and the department concerning, but not limited to, fiscal, purchasing, and personnel matters. (5-1-00)T

013. ILETS BOARD; MEETINGS AND QUORUM.

01. Schedule Of Meetings. The board shall hold regular meetings at least twice annually and may hold special meetings at other times as the executive officer deems necessary or upon the written request of a majority of the board. The regular semi-annual meetings of the board shall be scheduled on such dates and at such times as the executive officer may determine after consultation with the members. Meeting announcements and agendas shall be mailed to each member not less than ten (10) working days before a regular meeting. (5-1-00)T

02. Quorum. When meeting, four (4) members of the board shall constitute a quorum necessary for transacting business. (5-1-00)T

03. Representation At Meetings. A board member may not appoint an alternate to attend a meeting and exercise the voting privilege of that member. (5-1-00)T

04. Posting And Minutes Of Meetings. Board meetings shall be posted and conducted in compliance with the "Idaho Open Meeting Law", Sections 67-2340 through 67-2347, Idaho Code. Minutes of all regular and special meetings of the board shall be prepared and maintained by staff assigned by the executive director to support the board. (5-1-00)T

014. ILETS BOARD; POWERS AND DUTIES, CHAIRMAN, AND AD HOC ADVISORY COMMITTEES.

01. Powers And Duties. Pursuant to its authority under Title 19, Chapter 52, Idaho Code, the board establishes policies relating to management and operation of ILETS. The board shall enforce compliance with all laws and regulations governing ILETS operations. (5-1-00)T

02. Election Of Chairman. At the first regular meeting of a calendar year, the board shall elect from its membership a chairman by majority vote of the board. The chairman shall serve a term of one (1) year and may succeed himself. (5-1-00)T

03. Presiding Officer. The chairman shall preside at all meetings and conduct the meetings pursuant to "Roberts' Rules of Order, Current Revised Edition". If the chairman is absent at a meeting, the executive officer shall preside at that meeting. (5-1-00)T

04. Advisory Committees. With the approval of the board, the chairman may appoint ad hoc advisory committees to assist the board in the execution of its statutory duties. A committee may include non-board members who would be of value to the committee's assigned task. A committee shall include not less than one (1) member of the board. Committee reports shall be submitted to the board in writing. (5-1-00)T

015. ILETS BOARD; RESIGNATIONS AND REPLACEMENTS, NOTIFICATION.

01. Members Who No Longer Qualify. Any board member who ceases to qualify as a member shall at once notify the Governor and the executive officer. (5-1-00)T

02. Resignations. Any board member who desires to terminate that member's service on the board shall at once notify the Governor and the executive officer of that intention. (5-1-00)T

03. Notification Of Relevant Professional Associations. The executive officer shall forward any notification received from a member to the relevant professional association representing Idaho sheriffs and chiefs of police. (5-1-00)T

016. ILETS NETWORK.

01. Establishment. Pursuant to Title 19, Chapter 52, Idaho Code, the executive officer shall establish ILETS as a program of the department of law enforcement or successor agency. (5-1-00)T

02. Responsibilities. The program established by the executive officer shall have the following responsibilities: (5-1-00)T

a. Develop and operate a computerized criminal justice telecommunications and information system that provides message switching and record inquiry and retrieval capabilities. (5-1-00)T

b. Publish an ILETS Operations Manual and distribute copies to each user agency. (5-1-00)T

c. Function as the NCIC control terminal agency and the NLETS control terminal agency for the State of Idaho. (5-1-00)T

- d. Assist and train criminal justice agencies regarding information retrieved from ILETS and associated systems for use in administration of criminal justice. (5-1-00)T
- e. Develop and maintain linkages with the Idaho Transportation Department, Idaho Department of Correction, other agencies and systems to make appropriate information available to Idaho criminal justice agencies that will assist them in the enforcement of state criminal and traffic laws and regulations. (5-1-00)T
- f. Provide staff support to the ILETS board. (5-1-00)T
- g. Operate a program of record validation, quality control, and audits to ensure that records entered into ILETS and NCIC files by the department and user agencies are kept accurate and complete and that compliance with state and national standards is maintained. (5-1-00)T
- h. Create model management control agreements between criminal justice agencies and non-criminal justice agencies. (5-1-00)T
- i. Provide assistance and information access to non-criminal justice user agencies for statutory licensing, employment and regulatory purposes and for other purposes authorized by law and approved by the board. (5-1-00)T

017. AGENCY ACCESS TO ILETS.

01. Authorized Agencies. Consistent with Title 19, Chapter 52, Idaho Code, which mandates the exclusive use of ILETS for law enforcement and traffic safety purposes, access to ILETS shall be restricted to the following governmental agencies: (5-1-00)T

- a. Criminal justice agencies; (5-1-00)T
- b. Non-criminal agencies that provide computer services, dispatching support, or other direct support service to one (1) or more criminal justice agencies, and which have signed an ILETS-approved management control agreement with the criminal justice agency; (5-1-00)T
- c. Non-criminal justice agencies with a statutory requirement to use information capabilities that may be available via ILETS, and use of terminal access will not adversely affect criminal justice agency users, and use of the terminal will be for the administration of criminal justice; and (5-1-00)T
- d. Non-criminal justice agencies that provide information or capabilities needed by criminal justice agencies for a criminal justice purpose, and access or use of a terminal will improve the ability to provide such information or capabilities. (5-1-00)T

02. Management Control Agreements. The management control agreement between a criminal justice agency and a non-criminal justice agency will grant to the criminal justice agency the authority to set and enforce: (5-1-00)T

- a. Priorities of service; (5-1-00)T
- b. Standards for the selection, supervision, and termination of personnel authorized to access ILETS; (5-1-00)T
and
- c. Policies governing the operation of computers, circuits, and telecommunications terminals used to process, store, or transmit information to or receive information from ILETS. (5-1-00)T

03. Board Approval. The board shall review all requests for access to ILETS and determine whether an agency meets the criteria for access and whether access is appropriate based on system resources. Approved non-criminal justice agencies may have access to ILETS information on a limited basis (for example, motor vehicle information only) as authorized by the board. (5-1-00)T

018. USER ACCESS FEES.

01. Fee Schedule. The access fees approved by the board and to be collected by the department are as follows: (5-1-00)T

a. The fee for a communication interface is one hundred seventy-five dollars (\$175) for each month of service. (5-1-00)T

b. The fee for an ILETS terminal is fifty dollars (\$50) for each month of service. (5-1-00)T

c. The fee for an ILETS printer is fifty dollars (\$50) for each month of service. (5-1-00)T

02. Billing And Payment. The department shall mail statements quarterly to all user agencies, and payment of the fee is due by the first day of the month of each quarter (October 1, January 1, April 1, and July 1), unless it is a Saturday, a Sunday, or a legal holiday, in which event the payment is due on the first successive business day. (5-1-00)T

03. Delinquent Unpaid Fees. A user agency will be delinquent in payment if its quarterly fee assessment has not been received by the department by the last day of the fee period. (5-1-00)T

04. Sanctions For Delinquency. Any user agency delinquent in payment of assessed fees shall be subject to sanctions under Section 028. (5-1-00)T

019. ADJUSTED ACCESS FEES DURING PILOT PROJECTS.

The board may adjust access fees of user agencies participating in pilot projects being conducted by the department in behalf of ILETS. The fee adjustment shall be based on any cost savings, actual or anticipated, realized by the ILETS network. (5-1-00)T

020. USER RESPONSIBILITIES.

01. User Agreement. Any agency using a terminal to access ILETS, whether directly or through another agency, is responsible for adhering to all applicable ILETS rules and policies and must have signed an agreement with ILETS to that effect. (5-1-00)T

02. Record Validation. Any agency that enters information into ILETS or NCIC files is responsible for the accuracy, timeliness and completeness of that information. ILETS will send a record validation review list, regularly, to each agency. Validation is accomplished by reviewing the original entry and current supporting documents. Recent consultation with any appropriate complainant, victim, prosecutor, court, motor vehicle registry files, or other appropriate source or individual also is required with respect to the wanted person, missing person, and vehicle files. In the event the agency is unsuccessful in its attempts to contact the victim, complainant, etc., the entering authority must make a determination based on the best information and knowledge available whether or not to retain the original entry in the file. Validation procedures must be formalized and copies of these procedures must be on file for review during an ILETS or NCIC audit. When the agency has completed the validation they must return a signed certification of their validity within an appropriate time as established by ILETS. (5-1-00)T

03. Minimum Training. Each agency employee who operates a terminal or computer to access ILETS must complete ILETS training at a level consistent with the employee's duties. Each employee who operates a terminal or computer to access ILETS must be re-certified by the agency every two (2) years per schedules and procedures as prescribed by ILETS. (5-1-00)T

04. Hit Confirmation. When another agency receives a positive record response (Hit) from ILETS or NCIC and requests confirmation of the status of the record (warrant, stolen vehicle, etc.), the agency responsible for entry of the record must respond within ten (10) minutes for urgent hit confirmation requests or within one (1) hour for routine hit confirmation requests, with an answer indicating the status of the record or indicating a time frame when the record status will be confirmed. (5-1-00)T

05. Terminal Agency Coordinators. The agency administrator of each agency with terminal or

computer access to ILETS must designate one (1) or more terminal agency coordinators who shall be the primary contacts for all matters relating to use of ILETS by the agency. A terminal agency coordinator must complete ILETS training at the highest level required by any person in the agency. (5-1-00)T

06. Background Checks Of Terminal Operators Required. Policies for access to the FBI-NCIC system require background screening of all terminal operators with access to the NCIC system. For efficiency and consistency, the key elements of the NCIC background screening policies are also adopted for all ILETS access. (5-1-00)T

021. INFORMATION ACCESS AND DISSEMINATION.

01. General Policy. Information is made available to ILETS users from various sources and agencies, including ILETS and other state justice information system files, motor vehicle departments, NCIC, and NLETS. Each user must observe any restrictions placed on the use or dissemination of information by its source. It is ILETS' responsibility to advise user agencies of any restrictions which apply to any information accessed via ILETS. (5-1-00)T

02. Criminal History Records. Criminal history information on an individual accessed via ILETS from a state or national computerized file shall be made available only to criminal justice agencies for criminal justice purposes. This precludes the dissemination of such information for use in connection with licensing applications; regulatory activities; or local or state employment, other than with a criminal justice agency. (5-1-00)T

03. Administrative Messages. An administrative message (AM) is a free text message from one (1) agency to one (1) or more agencies. All administrative messages transmitted via ILETS must be by the authority of an authorized user and must relate to criminal justice purposes or matters of interest to the user community. Administrative messages sent within Idaho, either statewide, regionally or to individual terminal identifiers are subject to the following restrictions: (5-1-00)T

- a. No messages supportive or in opposition to political issues, labor management issues, or announcements of meetings relative to such issues. (5-1-00)T
- b. No messages supportive or in opposition of legislative bills. (5-1-00)T
- c. No requests for criminal history record information. (5-1-00)T

022. -- 023. (RESERVED).

024. ILETS SECURITY.

01. General Policy. The data stored in the ILETS, NCIC, and other criminal justice information system files is documented criminal justice information. This information must be protected to ensure its integrity and its correct, legal and efficient storage, dissemination and use. It is incumbent upon an agency operating an ILETS terminal, or a terminal on another system that has access to the ILETS network, to implement the procedures necessary to make the terminal secure from any unauthorized use and to ensure ILETS is not subject to a malicious disruption of service. ILETS user agencies shall participate in ILETS training and compliance activities to ensure that all agency personnel authorized to access the ILETS network are instructed in the proper use and dissemination of the information and that appropriate agency personnel are aware of security requirements and of the dangers to network integrity. ILETS retains the authority to disconnect a user agency or network connection when serious security threats and vulnerabilities are detected. (5-1-00)T

- 02. Definitions.** The following is a list of terms and their meanings as used in the ILETS security rule: (5-1-00)T
- a. Computer interface capabilities means any communication to ILETS allowing an agency to participate in the system using devices other than ILETS-provided terminal equipment. (5-1-00)T
 - b. Firewall means a collection of components placed between two (2) networks that keep the host

network secure by having the following properties: (5-1-00)T

- i. All traffic from inside the network to outside, and vice-versa, must pass through it; (5-1-00)T
 - ii. Only authorized traffic is allowed to pass; and (5-1-00)T
 - iii. The components as a whole must be immune to unauthorized penetration and disablement. (5-1-00)T
- c. ILETS security officer means the department staff member designated by the executive officer to monitor and enforce agency compliance with site and network security requirements. (5-1-00)T
- d. Peer networks means computer interfaces between cooperative governmental agencies in Idaho where none of the participating entities exercise administrative or management control over any other participating entity. (5-1-00)T
- e. Primary site means an agency that has management control of a computer system directly connected to ILETS. (5-1-00)T
- f. Untrusted system means a system that does not employ sufficient hardware or software integrity measures to allow its use for simultaneously processing a range of sensitive or confidential information. (5-1-00)T

03. Site Security Agreements. To ensure agencies having computer interface capabilities to ILETS are fully aware of their duties and of the consequences of failure to carry out those duties, a written and binding security agreement shall exist between ILETS and all primary sites. This agreement will clarify that the primary site is equally responsible for actions by secondary and affiliated systems connected through their site to ILETS. Primary sites must put in place similar subsidiary security agreements with secondary and affiliated systems to protect its network and ILETS. A site security agreement shall be an addendum to the ILETS user agreement. (5-1-00)T

- 04. ILETS Security Officer.** The ILETS Security Officer shall be responsible for the following duties: (5-1-00)T
- a. Disseminating to user agencies copies of ILETS security policies and guidelines; (5-1-00)T
 - b. Communicating to user agencies information regarding current perceived security threats and providing recommended measures to address the threats; (5-1-00)T
 - c. Monitoring use of the ILETS network either in response to information about a specific threat, or generally because of a perceived situation; (5-1-00)T
 - d. Directing a primary site, through its nominated contact, to rectify any omission in its duty of responsibility; (5-1-00)T
 - e. When an agency is unable or unwilling to co-operate, reporting the issue to the executive officer and initiating the procedure for achieving an emergency disconnection; and (5-1-00)T
 - f. Provide support and coordination for investigations into breaches of security. (5-1-00)T

05. Agency Security Contacts. A terminal agency coordinator shall serve as that agency's security contact for ILETS, unless another individual is specifically selected for this purpose and approved by the ILETS Security Officer. ILETS primary sites shall ensure the agency's security contact, or another person or position designated in an incident contingency plan, can be contacted by the ILETS security officer at any time. (5-1-00)T

06. Peer Networks. The security responsibilities of the operators of peer networks connected to ILETS, with respect to their user organizations, are parallel to those of ILETS user organizations in respect to their individual users. The ILETS Security Officer shall ensure that a written agreement exists between ILETS and a primary site, signed by the agency heads, that embodies these principles. (5-1-00)T

07. Physical Security Standards. User agencies will observe standards and procedures to ensure security of the physical premises and computing equipment. The minimum standards and procedures include the following: (5-1-00)T

a. Access to computer rooms will be limited to staff who require access for the normal performance of their duties. (5-1-00)T

b. Electrical power protection devices to suppress surges, reduce static, and provide battery backup in the event of a power failure will be used as necessary. (5-1-00)T

c. Computer system backups shall be stored in a secure location with restricted access. (5-1-00)T

d. Network infrastructure components will be controlled with access limited to only support personnel with a demonstrated need for access. (5-1-00)T

e. Physical labeling of infrastructure components will be done to assist in proper identification. Additionally, all components will be inventoried at regular intervals for asset management and physical protection. (5-1-00)T

08. Network Security Standards. User agencies shall exercise appropriate security precautions when connecting ILETS and computer systems linked to ILETS with external untrusted systems. The primary objective of such precautions is to prevent unauthorized access to sensitive information while still allowing authorized users free access. The minimum standards and procedures include the following: (5-1-00)T

a. Agencies shall routinely audit for and remove unused or unneeded services/accounts, review accounts periodically, and enforce aggressive and effective password strategies. (5-1-00)T

b. Agencies shall ensure that the software security features of the networks they manage are installed and functioning correctly. (5-1-00)T

c. Agencies shall monitor network security on a regular basis. Adequate information concerning network traffic and activity will be logged to ensure that breaches in network security can be detected. (5-1-00)T

d. Agencies shall implement and maintain procedures to provide the ILETS network adequate protection from intrusion by external and unauthorized sources. (5-1-00)T

e. No computer connected to the network can have stored, on its disk(s) or in memory, information that would permit access to other parts of the network. For example, scripts used in accessing a remote host may not contain passwords. (5-1-00)T

f. No connection to ILETS may be established utilizing dial-up communications. Asynchronous communications connections should be limited and tightly controlled as they pose a serious risk because they can circumvent any security precaution enacted to protect networks from untrusted sources. (5-1-00)T

g. Network management protocols shall be limited to internal or trusted networks. (5-1-00)T

h. Any system having direct or indirect access to the Internet via their computer network shall have in place services that allow no access to ILETS from the Internet. Organizations with large distributed Wide Area Networks connecting many remote sites may choose to incorporate many security layers and a variety of strategies. These strategies shall incorporate the implementation of a firewall to block network traffic, and restriction of remote user access. (5-1-00)T

025. -- 027. (RESERVED).

028. USER AGENCY SANCTIONS.

01. Review Of Violations. The board shall review violations of ILETS rules and may impose appropriate sanctions on user agencies. (5-1-00)T

02. Objective Of Sanctions. The objectives of the sanction procedure shall be as follows: (5-1-00)T

a. To ensure the security, integrity, and financial stability of the ILETS. (5-1-00)T

b. To create an awareness among user agencies of the importance of following rules, regulations, and procedures in order to minimize the risk to liabilities that may be incurred by misuse of the system and access to its information. (5-1-00)T

03. Class Of Sanctions. Sanctions shall be based upon the class of violation, any previous violations, and any exposure to criminal and civil liabilities that the violation might place on the system, its officials, and the offending agency. Violations shall be classed as either administrative (minor) or security (serious) violations. Security violations being defined as one which has or could result in access of ILETS data by unauthorized individuals. All other violations are classed as administrative. (5-1-00)T

04. Form Of Sanctions. When imposing sanctions, the board shall consider the severity of the violation, the violation type, either administrative or security, and previous sanctions issued, if any. The board may impose as sanctions one (1) or more of the following: (5-1-00)T

a. Written warning. (5-1-00)T

b. Written notice of violation. (5-1-00)T

c. Written notice of probation. (5-1-00)T

d. Written notice of temporary suspension. (5-1-00)T

e. Written notice of permanent suspension. (5-1-00)T

05. Effective Date Of Sanctions. Temporary or permanent suspension of service will not begin, unless an emergency exists, until fifteen (15) days after the agency head has received written notice by certified mail or personal service. (5-1-00)T

06. Reinstatement. An agency placed on permanent suspension may apply to the board for reinstatement. (5-1-00)T

029. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.01.02 - WATER QUALITY STANDARDS AND WASTEWATER TREATMENT REQUIREMENTS
DOCKET NO. 16-0102-0001

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule was effective April 24, 2000.

AUTHORITY: In compliance with Sections 67-5226(1) and 67-5221(1), Idaho Code, notice is hereby given that the Board of Health and Welfare (Board) has adopted a temporary rule and the Division of Environmental Quality (DEQ) is commencing proposed rulemaking to promulgate a final rule. The action is authorized by Sections 39-105, 39-107, and 39-3601 et seq., Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this proposed rulemaking will be held as follows:

Wednesday, June 21, 2000, 7:00 p.m.
Shilo Inn, Coeur d'Alene Room
702 W. Appleway
Coeur d'Alene, Idaho

Before opening the record to receive oral comments, DEQ staff intends to make a brief presentation and answer questions regarding the rule.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made no later than five (5) days prior to the hearing. For arrangements, contact the undersigned at (208)373-0418.

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

This rule adopts for the Spokane River the most recent U. S. Environmental Protection Agency (EPA) recommended aquatic life criteria for ammonia. The previous ammonia criteria were based upon an EPA 1984 recommended criteria, whereas this temporary rule is based on 1999 EPA updated guidance. As was the case with the 1984 criteria, the 1999 criteria is the EPA's recommendation for full protection of aquatic life, based upon the scientific data available at the time. The 1999 criteria allows for higher concentrations of ammonia than did the 1984 criteria. Despite the allowable concentrations being higher, EPA has concluded that the updated criteria will sufficiently protect aquatic life including salmonids; thus the revision is expected to fully protect aquatic life in the Spokane River. Because of the desire for additional scrutiny into whether the criteria are protective for threatened or endangered salmonids under all circumstances, we are soliciting further comment before wider, or statewide, application of the national 1999 ammonia guidance. This temporary rule applies only to the Spokane River because the rule may facilitate the financing and construction schedule for wastewater plant upgrades for the City of Coeur d'Alene. There are no threatened or endangered fishes known to be present in the Spokane River.

After consideration of public comments, DEQ intends to present the final proposal to the Board of Environmental Quality in the fall of 2000 for adoption of a pending rule.

NEGOTIATED RULEMAKING: Negotiated rulemaking was not conducted because the temporary rulemaking schedule did not allow for the timing of it.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in that the rule confers a benefit to the City of Coeur d'Alene. The City of Coeur d'Alene is under a compliance schedule that will include a major facility upgrade in order to comply with current ammonia criteria. Updating the ammonia criteria would allow the city to petition EPA for a modified compliance schedule which would allow the opportunity to fund priority infrastructure upgrades (e.g. new headworks) first. The change would be expected to reduce expenditures for the city's ratepayers, yet still sufficiently protect aquatic life in the Spokane River.

GENERAL INFORMATION: For more information about DEQ's programs and activities, visit DEQ's web site at www.state.id.us/deq.

ASSISTANCE ON TECHNICAL QUESTIONS AND SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this rule, contact Chris Mebane at (208)373-0502 or cmebane@deq.state.id.us.

Anyone can submit written comments by mail, fax or e-mail at the address below regarding this proposed rule. DEQ will consider all written comments received by the undersigned on or before July 7, 2000. DEQ specifically seeks comments regarding whether the criteria are protective of threatened or endangered species under all circumstances and whether this rule change should apply to a wider range of water bodies in the state.

DATED this 21st day of April, 2000.

Paula Junae Saul
Environmental Quality Section
Attorney General's Office
1410 N. Hilton
Boise, Idaho 83706-1255
Fax No. (208)373-0481
psaul@deq.state.id.us

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0102-0001

281. -- ~~299~~2. (RESERVED).

283. SPOKANE RIVER, SUBSECTION 110.12, HUC 17010305, UNITS P-3 AND P-4, SITE-SPECIFIC CRITERIA FOR AMMONIA.

The following criteria are to be met dependent upon the temperature, T (degrees C), and pH of the water body: (4-24-00)T

01. Acute Criterion (Criterion Maximum Concentration (CMC)). The one (1) hour average concentration of total ammonia nitrogen (in mg N/L) is not to exceed, more than once every three (3) years, the value calculated using the following equation:

$$CMC = \frac{0.275}{1 + 10^{7.204 - pH}} + \frac{39.0}{1 + 10^{pH - 7.204}} \quad (4-24-00)T$$

02. Chronic Criterion (Criterion Continuous Concentration (CCC)).

a. The thirty (30) day average concentration of total ammonia nitrogen (in mg N/L) is not to exceed, more than once every three (3) years, the value calculated using the following equation:

$$CCC = \left(\frac{0.0577}{1 + 10^{7.688 - pH}} + \frac{2.487}{1 + 10^{pH - 7.688}} \right) \bullet MIN(2.85, 1.45 \cdot 10^{0.028 \cdot (25 - T)}) \quad (4-24-00)T$$

b. The highest four (4) day average within the thirty (30) day period should not exceed two and five tenths (2.5) times the CCC. (4-24-00)T

284. -- 299. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-0001
NOTICE OF PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

Current rules are not specific enough to cover all of the reimbursement issues. Further clarification is needed that will inform the vendor that documentation is required when an item or service can not be paid off of the pricing file.

If the services or items do not have a specific price on file, the vendor must submit documentation to the Department and reimbursement will be based on the documentation.

The temporary rule was published in the Idaho Administrative Bulletin, Volume 99-3, March 1, 2000, pages 21 and 22. With this publication the Department is initiating proposed rulemaking.

NEGOTIATED RULEMAKING. Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted. A temporary rulemaking was published in the March 1, 2000, Idaho Administrative Bulletin, Volume 00-3, pages 21 through 22 in compliance with Section 67-5226, Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Colleen Osborn at (208) 364-1923..

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before June 28, 2000.

DATED this 21st day of April, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax

Pursuant to Section 67-5221(1) this docket is being published as a Proposed Rule.

**This docket has been previously published as a Temporary Rule.
The temporary effective date is October 1, 1999.**

The text of the temporary rule was published in the Idaho Administrative Bulletin, Volume 99-3, March 1, 2000, pages 21 through 22.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0001

060. FEES AND UPPER LIMITS.

01. Inpatient Hospital Fees. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho". Inpatient payments shall not exceed the Upper Payment limit set forth in the Code of Federal Regulations. (7-1-97)

02. Outpatient Hospital Fees. The Department will not pay more than the combined payments the provider is allowed to receive from the beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year end cost settlement. (7-1-97)

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. (5-25-93)

b. Maximum payment for outpatient hospital diagnostic radiology procedures will be limited to the blended rate of costs and the Department's established fee schedule specified in IDAPA 16, Title 03, Chapter 10, Subsection 457.02, at the time of cost settlement. (7-1-97)

c. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. (5-5-93)

d. Maximum payment for hospital out-patient surgical procedures will be limited to the blended rate of costs and the Department's fee schedule for ambulatory surgical centers specified in IDAPA 16.03.10, Subsection 457.01, at the time of cost settlement. (7-1-97)

e. Hospital based ambulance services will be reimbursed according to Medicare cost reimbursement principles. All other ambulance providers will be reimbursed according to the Department's established fee schedule for medical transportation. (7-1-97)

03. Long-Term Care Facility Fees. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment which would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (11-10-81)

04. Individual Provider Fees. The Department will not pay the individual provider more than the lowest of: (11-10-81)

a. The provider's actual charge for service; or (11-10-81)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or ~~(11-10-81)~~ (____)

c. The Medicare upper limitation of payment on those services where a beneficiary is eligible under both programs and Medicaid is responsible only for the deductible and co-insurance payment. (11-10-81)

05. Fees For Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325 and 42 CFR Section 447.352 and Section 1902(a)(13)(E) of the Social Security Act. (7-1-97)

06. Fees For Speech, Occupational And Physical Therapy Services. The fees for physical, occupational, and speech therapy include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. (7-1-99)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-0002

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are January 1, 2000 and February 1, 2000.

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

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the temporary and proposed rule:

In Section 015 of these rules, requirements for authorization of out-of-state medical care in non-bordering counties will be the same as for medical care received within the state of Idaho.

Section 070, Physician Services, Medicaid assesses a penalty to certain physicians who fail to obtain a timely pre-admission PRO review in accordance with Department requirements. The methodology for computing the penalty will be changed to conform to that used for hospital penalties. The Physician Penalty Chart will be revised to assess a penalty for certain dollar amount per day, depending upon the number of days the pre-admission review is late.

Section 079, Inpatient Psychiatric Hospital Services, retrospective late review, by the Department or its designee, will be allowed to determine if the admission meets medical necessity criteria for psychiatric admissions of Medicaid clients under age 21, when the pre-admission or continued stay review was not requested in a timely manner. The Department will impose a set monetary penalty, according to a hospital penalty chart and a physician penalty chart, to responsible providers who fail to request such review, instead of denying the provider's entire reimbursement for those days not reviewed timely. Documented emergency admissions may be reviewed for medical necessity on the next business day, including emergency admissions that occur during normal business hours.

Section 080, In-patient Hospital Services, will be changed to comply with the change in length of stay criteria for admissions. Admissions require a length of stay review by the Department's peer review organization (PRO) after a number of days as determined by the PRO or as set by the Department. PRO no longer notifies hospitals of approval certifications by mail. Hospitals are informed within a time frame as determined by the PRO or as set by the Department.

A change in wording in Section 150.02.a. which says "round trip mileage" to say "transportation costs" for out-of-state medical care. Transportation costs will no longer be dependent on prior authorization for out-of-state care.

In Section 135, Chiropractic Services, removes the requirement of x-ray to demonstrate subluxation to pay for manipulation of the spine. This follows Medicare's rules.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule was being amended to clarify existing language.

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

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before June 28, 2000.

DATED this 14th day of March, 2000

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0002

015. CHOICE OF PROVIDERS.

01. Service Selection. Each recipient may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in a coordinated care plan. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the MA Program, or from setting standards relating to the qualifications of providers of such care. (6-1-94)

02. Lock-In Option. (7-1-93)

a. The Department may implement a total or partial lock-in program for any recipient found to be misusing the MA Program according to provisions in ~~Subsections 190.05~~ 226 through 233 of these rules; but ~~(12-31-91)~~(1-1-00)T

b. In situations where the recipient has been restricted to a recipient lock-in program, that recipient may choose the physician and pharmacy of his choice. The providers chosen by the lock-in recipient will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (7-1-98)

03. ~~Out-Of-State~~ Medical Care Provided Outside The State Of Idaho. ~~All~~ Out-of-state medical care requires preauthorization by the Department or the Department's designated Peer Review Organization (PRO), with the exception of bordering counties and emergency or urgent 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. ~~(2-15-93)~~(1-1-00)T

a. ~~MA recipients may receive medical care and services from providers located in counties bordering Idaho without preauthorization by the Department. However PRO review may be required pursuant to Subsections 070.04 and 080.02. Approval by the Bureau of Medicaid Policy and Reimbursement, or its successor, is required for all long-term care outside the state of Idaho pursuant to Subsection 015.03.e. If payment is requested for transportation costs to receive the out-of-state medical care, the Department or its designee will determine if~~

appropriate, comparable medical care is available closer to the recipient's residence. If such care is available, the Department or its designee will limit authorization to payment for transportation costs associated with a trip to the closer location. If it is determined necessary and appropriate for the medical care to be rendered at the out-of-state location, then the Department or its designee will authorize payment for transportation costs associated with a trip to the out-of-state location. Transportation costs to receive out-of-state medical care requires authorization pursuant to Section 150. (2-15-93)(1-1-00)T

- b. ~~Emergency/urgent out-of-state care.~~ (2-15-93)
 - i. ~~Emergency/urgent inpatient hospital care must be reviewed using the same procedures and guidelines as in-state emergency hospital admissions by the PRO. Transfers from an Idaho hospital to an out-of-state nonadjacent county hospital must be reviewed using the same procedures and guidelines as in-state transfers by the PRO.~~ (7-1-97)
 - ii. ~~Emergency/urgent out-of-state outpatient hospital, clinic and/or physician services do not require review by the Department or the Department's approved PRO. The provider must supply sufficient information to support a finding that the care provided was for an emergency/urgent situation.~~ (2-15-93)
 - e. ~~The Department or its designee will preauthorize all nonemergency care provided out-of-state for outpatient hospital services, rural health clinics, federally qualified health centers, physician services and physician extender services, dental services, podiatrists services, optometric services, chiropractor services, home health services, physical therapy services, occupational therapy services, speech and audiology services, private duty nursing, clinic services, rehabilitative services, and personal care services.~~ (7-1-97)
 - i. ~~A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs.~~ (2-15-93)
 - ii. ~~There will be no Medicaid payment if the service is determined to be available closer to the recipient's residence or if no preauthorization was obtained prior to the date of the service as required.~~ (7-1-97)
 - iii. ~~The only exceptions to the preauthorization requirement are:~~ (2-15-93)
 - (1) ~~When eligibility for Medicaid is determined after the service was provided. The service still must be determined to be not available closer to the recipient's residence.~~ (2-15-93)
 - (2) ~~Out-of-state nonadjacent county lab and x-ray services when the recipient does not have to travel outside the state for the services to be provided.~~ (2-15-93)
 - (3) ~~Mail order pharmacies will not require preauthorization when the recipient is not required to travel outside the state to receive the service.~~ (2-15-93)
 - (4) ~~Services for which Medicare is the primary payer of service.~~ (2-15-93)
 - d. ~~The Department's designated Peer Review Organization (PRO) will preauthorize all nonemergency inpatient hospital care provided out-of-state in a nonadjacent county.~~ (2-15-93)
 - i. ~~A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs.~~ (2-15-93)
 - ii. ~~There will be no Medicaid payment if the service is determined to be available closer to the recipient's residence or if no preauthorization was obtained prior to the date of the service as required.~~ (7-1-97)
 - iii. ~~The treating physician and the admitting facility is responsible for assuring that the Department's~~

~~designated PRO has preauthorized the out-of-state nonemergency service for inpatient care. (2-15-93)~~

~~iv. No payment for services not preauthorized by the Department's designated PRO may be obtained from the recipient, absent the Medicaid recipient's informed decision to incur the cost of services. (2-15-93)~~

~~v. The only exceptions to the preauthorization requirement are: (2-15-93)~~

~~(1) When eligibility for Medicaid is determined after the service was provided. The service still must be determined not to be available closer to the recipient's residence. (2-15-93)~~

~~(2) Services for which Medicare is the primary payer of service. (2-15-93)~~

~~vi. The PRO review will be governed by provisions of the PRO provider manual as amended. (2-15-93)~~

~~eh. Long-term care outside the State may be approved by the Department on an individual basis in temporary or emergency situations. Nursing home care will be limited to the period of time required to safely transport the recipient to an Idaho facility. Out-of-state care will not be approved on a permanent basis. (11-10-81)~~

(BREAK IN CONTINUITY OF SECTIONS)

070. PHYSICIAN SERVICES.

01. Services Provided. The Department will reimburse for 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 065 and Subsection 070.02. All services not specifically included in this chapter are excluded from reimbursement. (12-31-91)

02. Restriction Of Coverage. (7-1-93)

a. Out-patient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible recipient in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (11-10-81)

b. Particular restrictions pertaining to payment for sterilization procedures are contained in Section 090; and (12-31-91)

c. Restrictions governing payment for abortions are contained in Section 095; and (12-31-91)

d. 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 recipients over the age of forty (40). This limitation does not apply to recipients receiving continuing treatment for glaucoma. (10-25-88)

e. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis; and (11-10-81)

f. 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. (11-10-81)

g. Corneal transplants and kidney transplants are covered by the MA program. (5-15-84)

03. Misrepresentation Of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited. (6-1-86)

04. Physician Penalties For Late PRO Review. Medicaid will assess the physician a penalty for failure to have a preadmission review in accordance with Subsection 080.02.a. and Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, "Rules Governing Provider Reimbursement in Idaho," as amended. A penalty will be assessed according to Subsection 070.05 entitled "Physician Penalty Chart". The ~~assessed~~ penalty will be ~~based on the total Medicaid allowed amount for the physician services for the entire stay~~ assessed after ~~any third party payment~~ billing for physician services has occurred. ~~(3-1-92)(2-1-00)T~~

05. Physician Penalty Chart. (3-1-92)

a. A request for preadmission PRO review that is one (1) day late will result in a penalty. ~~Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of five percent (5%) or fifty dollars (\$50).~~ ~~(3-1-92)(2-1-00)T~~

b. A request for preadmission PRO review that is two (2) days late will result in a penalty. ~~Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of ten percent (10%) or one hundred dollars (\$100).~~ ~~(3-1-92)(2-1-00)T~~

c. A request for preadmission PRO review that is three (3) days late will result in a penalty. ~~Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of fifteen percent (15%) or one hundred and fifty dollars (\$150).~~ ~~(3-1-92)(2-1-00)T~~

d. A request for preadmission PRO review that is four (4) days late will result in a penalty. ~~Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of twenty percent (20%) or two hundred dollars (\$200).~~ ~~(3-1-92)(2-1-00)T~~

e. A request for preadmission PRO review that is five (5) days late or later will result in a penalty. ~~Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of twenty-five percent (25%) or two hundred and fifty dollars (\$250).~~ ~~(3-1-92)(2-1-00)T~~

06. Physician Excluded From The Penalty. Any physician who provides care but has no control over the admission, continued stay or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty. (3-1-92)

07. Procedures For Medicare Cross-Over Claims. If a MA recipient is eligible for Medicare, the physician must bill Medicare first for the services rendered to the recipient. (11-10-81)

a. If a physician accepts a Medicare assignment, the payment for the Medicare co-insurance and deductible will be made and forwarded to the physician automatically based upon the EOMB information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (11-10-81)

b. If a physician does not accept a Medicare assignment, a Medicare EOMB must be attached to the appropriate claim form and submitted to the Bureau for the billing of Medicare co-insurance and deductible. (11-10-81)

c. In order for the Department to make payment, the physician must agree to accept the payment from Medicare and Medicaid as payment in full for covered services. (11-10-81)

(BREAK IN CONTINUITY OF SECTIONS)

079. INPATIENT PSYCHIATRIC HOSPITAL SERVICES.

Pursuant to the philosophy and principles governing children's mental health services in Chapter 24, Title 16, Idaho Code, the Department will pay for medically necessary in-patient psychiatric hospital services in a free standing psychiatric hospital (IMD) or psychiatric unit of a general hospital for recipients under the age of twenty-one (21). Recipients must have a DSM IV diagnosis with substantial impairment in thought, mood, perception or behavior. Admissions must be *prior*-authorized by the Department or its designee ~~or, during non-business hours, authorized on a retrospective basis.~~ Failure to request a preadmission or continued stay review in a timely manner will result in a retrospective review being conducted by the Department or its designee. If the retrospective review determines the admission is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 079.11. The primary care physician will be assessed a penalty for failure to request a preadmission review in a timely manner as specified in Subsection 079.12. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the recipient is not subject to this penalty. ~~(7-1-99)~~(2-1-00)T

01. Medical Necessity 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. (7-1-99)

a. Severity of illness criteria. The child must meet one (1) of the following criteria related to the severity of his psychiatric illness: (7-1-99)

i. Is currently dangerous to self as indicated by at least one (1) of the following: (7-1-99)

(1) Has actually made an attempt to take his own life in the last seventy-two (72) hours (details of the attempt must be documented); or (7-1-99)

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (7-1-99)

(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 child or a reliable source and details of the child's plan must be documented); or (7-1-99)

(4) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm himself and is at significant risk to making an attempt to carry out the plan without immediate intervention (details must be documented); or (7-1-99)

ii. Child is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others as indicated by one (1) of the following: (7-1-99)

(1) The child has actually engaged in behavior harmful or potentially harmful to others or caused serious damage to property which 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 (7-1-99)

(2) The child has made threats to kill or seriously injure others or to cause serious damage to property which 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 (7-1-99)

(3) A mental health professional has information from the child or a reliable source that the child 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 (7-1-99)

iii. Child is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-99)

(1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (7-1-99)

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child's behaviors must be documented); or (7-1-99)

(3) There is a need for treatment, evaluation or complex diagnostic testing where the child's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication and/or behavior. (7-1-99)

b. Intensity of service criteria. The child must meet all of the following criteria related to the intensity of services needed to treat his mental illness: (7-1-99)

i. It is documented by the Regional Mental Health Authority that less restrictive services in the community do not exist or do not meet the treatment or diagnostic needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. The services considered, tried, and/or needed must be documented; and (7-1-99)

ii. The services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-99)

iii. Treatment of the child's psychiatric condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist. The child requiring this treatment must not be eligible for independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other. (7-1-99)

c. 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 child is in his 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. (7-1-99)

02. Exclusions. If a child meets one (1) or more of the following criteria, Medicaid reimbursement under IDAPA 16.03.09, "Rules Governing Medical Assistance," will be denied: ~~(7-1-99)~~(2-1-00)T

a. The child is unable to actively participate in an outpatient psychiatric treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-99)

b. The child demonstrates anti-social or criminal behavior or has criminal or legal charges against him and does not meet the severity of illness or intensity of service criteria; or (7-1-99)

c. The child has anti-social behaviors or conduct problems that are a danger to others but are not attributable to a mental illness (DSM IV) with substantial impairment in thought, mood or perception; or (7-1-99)

d. The child has a primary diagnosis of mental retardation and the primary treatment need is related to the mental retardation; or (7-1-99)

e. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria; or (7-1-99)

f. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria; or (7-1-99)

g. Substance abuse is the primary diagnosis and the primary treatment need. (7-1-99)

03. Prior Authorization for Elective Admissions. To qualify for reimbursement, ~~p~~prior authorization must be obtained from the Department or its designee prior to an elective admission. ~~Only those admissions during non-business hours will be considered emergency admissions for prior authorization purposes.~~ An elective admission is defined as one that is planned and scheduled in advance, and is not emergency in nature, as "emergency" is defined in Subsection 079.04. Requests for prior authorization must include: ~~(7-1-99)~~(2-1-00)T

- a. Diagnosis; and (7-1-99)
- b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (7-1-99)
- c. Medical history; and (7-1-99)
- d. Mental and physical functional capacity; and (7-1-99)
- e. Prognosis; and (7-1-99)
- f. Recommendation by a physician for admission, preferably the primary care physician. If the child is enrolled in the Healthy Connection (HC) program, a HC referral is required. (7-1-99)

04. Emergency Admissions. ~~Only those admissions which occur during other than normal business hours will be considered for payment without prior authorization.~~ An emergency for purposes of a waiver of the prior authorization requirement is defined as, “the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person.” A court-ordered admission or physician’s emergency certificate does not, in itself, justify characterizing the admission as an emergency admission. The severity of illness and intensity of services criteria must be met. The hospital medical record of the admission must include documentation to support that the recipient’s status upon admission meets the definition of an emergency, as defined in this Section. The information for authorization of services must be FAXED, or otherwise delivered to the Department or its designee on the next business day following the emergency admission. Requests for authorization of emergency admissions must include the same information as required for elective admissions. ~~(7-1-99)~~(2-1-00)T

05. Length Of Stay. An initial length of stay will be established by the Department or its designee. An initial length of stay will usually be for no longer than five (5) days. For first time admissions where intensity of services criteria is not met the initial length of stay may not exceed forty-eight (48) hours. A hospital may request a ~~an extension~~ continued stay review from the Department or its designee when the appropriate care of the recipient indicates the need for hospital days in excess of the originally approved number. The ~~extension~~ continued stay review request may be made no later than the ~~last date authorized day or last business day before the last authorized day by the Department or its designee.~~ Extensions will be considered on a case by case basis and will be for no longer than three (3) days at a time. Approval of additional days will be based on the following criteria:

~~(7-1-99)~~(2-1-00)T

a. Documentation sufficient to demonstrate the medical necessity criteria that was present upon admission is still exists met; and ~~(7-1-99)~~(2-1-00)T

b. A plan of care that includes documentation sufficient to demonstrate that the child’s psychiatric condition continues to require services which are required to can only be provided on an in-patient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental disease; and ~~(7-1-99)~~(2-1-00)T

c. ~~There is d~~Documentation that supports sufficient to demonstrate the need for continued hospitalization, and that additional days at in-patient level of care will improve the recipient’s condition.

~~(7-1-99)~~(2-1-00)T

06. Individual Plan Of Care. The individual plan of care is a written plan developed for the recipient upon admission to an in-patient psychiatric hospital to improve his condition to the extent that acute psychiatric care is no longer necessary. The plan of care must be developed and implemented within seventy-two (72) hours of admission, reviewed at least every three (3) days, and must: (7-1-99)

a. Be based on a diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the recipient’s situation and reflects the need (medical necessity criteria) for in-patient care; and (7-1-99)

- b. Be developed by an interdisciplinary team capable of assessing the child's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the child's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: (7-1-99)
- i. Board-certified psychiatrist (preferably with a specialty in child psychiatry); or (7-1-99)
 - ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or (7-1-99)
 - iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed professional counselor-private practice; and (7-1-99)
 - iv. Either a certified social worker-private practice or a registered nurse with specialized training or one (1) year's experience in treating mentally ill individuals (preferably children); or (7-1-99)
 - v. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating mentally ill individuals (preferably children); and (7-1-99)
 - vi. The recipient and his parents, legal guardians, or others into whose care he will be released after discharge. (7-1-99)
- c. State treatment objectives (related to conditions that necessitated the admission); and (7-1-99)
- d. Prescribe an integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the child), and experiences designed to meet the objectives; and (7-1-99)
- e. Include a discharge and post discharge plan designed to achieve the child's discharge at the earliest possible time and include plans for coordination of community services to ensure continuity of care with the recipient's family, school and community upon discharge. (7-1-99)

07. Provider Qualifications. Inpatient hospital psychiatric services for individuals under age twenty-one (21) must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the State of Idaho or the state in which they provide services. Facilities currently providing psychiatric hospital services under the authority of Family and Community Services that are certified by the Health Care Financing Administration have until October 1, 1998 to comply with this requirement. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services to children. General hospitals licensed to provide services in Idaho which are not JCAHO certified may not bill for psychiatric services beyond emergency screening and stabilization (7-1-99)

08. Payment. Reimbursement for ~~the~~ recipient's admission and length of stay is subject to preadmission, concurrent ~~and~~ or retrospective review by the Department or its designee. The hospital and the recipient's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. (~~7-1-99~~)(2-1-00)T

- a. In reimbursing for inpatient hospital psychiatric services the Department will pay the lessor of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". (7-1-99)
- b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (7-1-99)
- c. The recipient may be charged for services only when he or she has made an informed decision to incur expenses for services deemed not medically necessary by the Department or its designee. (2-1-00)T

d. Reimbursement for services originally identified as not medically necessary by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Cases and Declaratory Rulings," Section 301, et seq. (2-1-00)T

09. Record Keeping. A written report of each evaluation and the plan of care must be entered into the child's record at the time of admission or if the child is already in the facility, immediately upon completion of the evaluation or plan. (7-1-99)

10. Utilization Review (UR). The facility must have in effect a written utilization review plan that provides for review of each child's need for the services that the hospital furnishes him. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. (7-1-99)

11. Hospital Penalty Chart. Failure to request a preadmission or continued stay review from the Department or its designee in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission: (2-1-00)T

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars (\$260). (2-1-00)T

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars (\$520). (2-1-00)T

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars (\$780). (2-1-00)T

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars (\$1,040). (2-1-00)T

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars (\$1,300). (2-1-00)T

12. Physician Penalty Chart. Failure to request a preadmission review from the Department or its designee in a timely manner will result in the primary care physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the recipient. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: (2-1-00)T

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars (\$50). (2-1-00)T

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars (\$100). (2-1-00)T

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars (\$150). (2-1-00)T

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars (\$200). (2-1-00)T

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars (\$250). (2-1-00)T

080. IN-PATIENT HOSPITAL SERVICES.

01. Exceptions And Limitations. The following exceptions and limitations apply to in-patient hospital services: (11-10-81)

- a. Payment is limited to semi-private room accommodations. (11-10-81)
 - i. The Department must not authorize reimbursement for any part of a private room unless the attending physician orders a private room for the patient because of medical necessity. (11-10-81)
 - ii. If a patient or the family of a patient desires a private room, the party ordering the private room will be responsible for full payment for the private room. (11-10-81)
- b. If a MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)
- c. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)
- d. Hospital care associated with noncovered services as contained in Section 065 is excluded from MA payment. (12-31-91)

02. Payment Procedures. The following procedures are applicable to in-patient hospitals: (11-10-81)

a. The patient's admission and length of stay is subject to preadmission, concurrent and retrospective review by a Peer Review Organization (PRO) designated by the Department. PRO review will be governed by provisions of the PRO Provider Manual as amended. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely PRO review as required by Section 080, and as outlined in the PRO Provider Manual as amended, will result in the PRO conducting a late review. After a PRO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in Subsection 080.04 entitled "Hospital Penalty Chart". (3-1-92)

i. ~~The hospital must submit claims for care and services provided to the MA recipient on the appropriate claim forms and attach the PRO approval certification for those diagnoses where preadmission approval is required as well as PRO approval certification for any hospital stay with a length of stay which exceeds the 75th percentile for the primary diagnosis (according to Western Regional P.A.S. Length of Stay published by Health Knowledge System). All admissions are subject to PRO review to determine if continued stay in inpatient status is medically necessary. A PRO continued stay review is required when the recipient's length of stay exceeds the number of days certified by the PRO. If no initial length of stay certification was issued by the PRO, a PRO continued stay review is required when the admission exceeds a number of days as specified by the Department. (12-3-90)(2-1-00)T~~

ii. Reimbursement for services originally identified as not medically necessary by the PRO will be made if such decision is reversed by the appeals process required in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 301, et seq., "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

iii. Absent the Medicaid recipient's informed decision to incur services deemed unnecessary by the PRO, or not authorized by the PRO due to the negligence of the provider, no payment for denied services may be obtained from the recipient. (12-3-90)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for in-patient hospital care in accordance with the rules set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho". The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (12-31-91)

c. If a MA recipient is eligible for Medicare the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

i. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the

EOMB cross-over information. (11-10-81)

ii. For all other services, a Medicare EOMB must be attached to the appropriate claim form and submitted to ~~the Bureau~~ Medicaid for the billing of Medicare co-insurance and deductible charges. ~~(11-10-81)~~(2-1-00)T

d. Diagnostic tests and procedures, including laboratory tests, pathological, and x-ray examinations whether provided on an in-patient or an out-patient basis, are reimbursable only if related to the diagnosis and treatment of a covered medical condition. (12-3-90)

e. Only tests or evaluations specifically ordered by a physician will be reimbursed. (12-3-90)

03. Duties Of The Designated PRO. The designated PRO shall prepare, distribute and maintain a provider manual. The PRO provider manual shall be distributed by the PRO and periodically updated thereafter. The manual will include, and is not limited to, the following: (10-1-89)

a. The PRO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (10-1-89)

b. Department selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (10-1-89)

c. A provision that the PRO will mail inform the hospital of a ~~completed~~ certification ~~statement~~ within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. ~~(10-1-89)~~(2-1-00)T

d. The method of notice to hospitals of PRO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (10-1-89)

e. The procedures which providers or recipients will use to obtain reconsideration of a denial by the PRO prior to appeal to the Department in accordance with the provisions of Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Section 301, et seq., "Rules Governing Contested Cases and Declaratory Rulings". Such requests for reconsideration by the PRO must be made in writing to the PRO within sixty (60) days of the issuance of the "Notice of Non-Certification of Hospital Days". (12-31-91)

04. Hospital Penalty Chart. (3-1-92)

a. A request for a preadmission and/or continued stay PRO review that is one (1) day late will result in a penalty of two hundred and sixty dollars (\$260), from the total Medicaid paid amount of the inpatient hospital stay ~~after any third party payment~~. ~~(3-1-92)~~(2-1-00)T

b. A request for a preadmission and/or continued stay PRO review that is two (2) days late will result in a penalty of five hundred and twenty dollars (\$520), from the total Medicaid paid amount of the inpatient hospital stay ~~after any third party payment~~. ~~(3-1-92)~~(2-1-00)T

c. A request for a preadmission and/or continued stay PRO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars (\$780), from the total Medicaid paid amount of the inpatient hospital stay ~~after any third party payment~~. ~~(3-1-92)~~(2-1-00)T

d. A request for a preadmission and/or continued stay PRO review that is four (4) days late will result in a penalty of one thousand and forty dollars (\$1,040), from the total Medicaid paid amount of the inpatient hospital stay ~~after any third party payment~~. ~~(3-1-92)~~(2-1-00)T

e. A request for a preadmission and/or continued stay PRO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars (\$1,300), from the total Medicaid paid amount of the inpatient hospital stay ~~after any third party payment~~. ~~(3-1-92)~~(2-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

135. CHIROPRACTIC SERVICES.

The Department will pay for a total of two (2) ~~office~~ manipulation visits during any calendar month for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition ~~demonstrated to exist by x-ray.~~ ~~(9-1-82)~~(1-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

150. TRANSPORTATION.

“Transportation” includes expenses for transportation, cost of meals and lodging en route to and from receiving medical care or treatment, and while receiving medical care or treatment. It also includes the cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant’s transportation, meals, lodging and, if the attendant is not a member of the recipient’s family, salary. Review of “transportation” is required to insure that only necessary and reasonable expenses are paid. Certain transportation services require preapproval, and other services require review after the services have been rendered. An exception to preapproval can be made when the service was an emergency or when eligibility for Medicaid is determined after the service was provided, or when a retrospective approval is required by the Department. (7-1-98)

01. Scope of Coverage And General Requirements For Transportation. (7-1-98)

a. The Department will pay for necessary transportation for a Medicaid recipient to receive medical care or treatment from providers of Medicaid approved medical services. ~~Out-of-state transportation will not be reimbursed without obtaining authorizations required in Subsection 015.03.~~ Transportation services are subject to review by the Department or its designee prior to services being rendered, or on a retrospective basis. Transportation service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that a transportation service is not covered, then no Medicaid payment will be made for the transportation service. Reimbursement for transportation services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings”. ~~(7-1-98)~~(1-1-00)T

b. The Department or its designee may authorize the transportation, meals, and lodging costs of an attendant or one (1) immediate family member to accompany the recipient, if necessary, and salary for the attendant, if he is not a member of the recipient’s family. The Department will not pay the meals or lodging costs for of a salaried attendant once the recipient being escorted is admitted to an inpatient facility. The Department will pay the meals and lodging costs of one (1) immediate family member while the recipient is an inpatient in a facility, if deemed necessary due to the recipient’s age or other factors, and authorized by the Department or its designee. (7-1-98)

c. When lodging is required, the Department or its designee will authorize it insuring that the least expensive yet most appropriate lodging is provided. Receipts for lodging may be required by the Department. (7-1-98)

d. For any requests for transportation costs to receive covered medical care or treatment, the Department or its designee will only authorize transportation costs to the nearest available, appropriate Medicaid provider. In some cases, a referral from the recipient’s primary care physician is also required. (7-1-98)

e. If private vehicle transportation is used, the Department will pay for such transportation at rates established by the Department. The private carrier is responsible for providing all necessary insurance at no cost to the Department. (7-1-98)

f. If other than private vehicle transportation is used, the transportation must be the least expensive yet the most appropriate form available. The Department will make payment for such transportation at rates established by the Department. The carrier is responsible for providing all necessary insurance at no cost to the Department.

(7-1-98)

g. Reimbursement will be made by the Department for necessary transportation to any person, including but not limited to the recipient, or a relative or friend of the recipient. The Department will make payment to the recipient if the recipient has paid for or provided the transportation service, or to the actual provider of the transportation service. Each billing invoice must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Providers must bill on a HCFA 1500 claim form. If no attachments to the claim are required, the provider may bill electronically. Payment for transportation costs will not be issued prior to the service being rendered.

(7-1-98)

h. Commercial transportation companies, such as taxi, intra-city bus or van, inter-city bus or van, intrastate bus or van, interstate bus or van, airlines, car rental agencies, or lodging facilities, must not charge Medicaid recipients more than is charged to the general public for the same service.

(7-1-98)

i. If the recipient has two (2) or more separate medical appointments in a day which necessitate separate trips by the same or a different transporter, the Department will pay for a round trip to transport the recipient to each appointment.

(7-1-98)

j. In order for the Department to pay for transportation services, the recipient must be taking the trip to actually receive medical care or treatment from a Medicaid provider.

(7-1-98)

k. The Department will not pay for transportation or lodging when those services are available and provided at no cost by organizations such as Red Cross, Easter Seal Society, Cancer Society, fraternal and church organizations, Ronald McDonald Houses, and other private or social agencies.

(7-1-98)

02. Preauthorization For Transportation To A Distant Point. Preauthorization of transportation to a distant point, either in or out-of-state, is required. For purposes of these rules, a "distant point" is defined as more than ten (10) miles from the recipient's residence. The Department or its designee must determine the following: (7-1-98)

a. That adequate and comparable medical services are not available locally. When the services are available locally and/or more than one (1) service provider is within the local area, the Department's reimbursement is limited to ~~round trip mileage~~ transportation costs to the closest provider of the necessary service; and

~~(7-1-97)(1-1-00)T~~

b. That an appointment for covered medical care or treatment has been made with a provider at the distant point; and

(7-1-98)

c. If applicable, that a referral has been made by the patient's attending physician. (1-16-80)

~~d. Transportation will not be authorized unless out-of-state care authorizations have been obtained as required in Subsection 015.03. Exceptions to this requirement are: Veteran's Hospitals and specialty hospitals which do not make a charge to the general public. Therefore, no authorization for hospitalization is made by Medicaid.~~

~~(2-15-93)~~

~~ed.~~ The Department will only authorize meals when overnight travel to a distant point is required and cooking facilities are not available. The actual cost of the meals will be authorized up to the amount set by the Department. Meals and lodging costs will not be paid if the recipient and/or the attendant stays in a private home that is not a lodging facility.

(7-1-98)

03. Scope Of Coverage And General Requirements For Ambulance Services. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department or its designee. Ambulance services are subject to review by the Department or its designee prior to the service being rendered, and on a retrospective basis. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that an ambulance service is not

covered, then no Medicaid payment will be made for the ambulance service. Reimbursement for ambulance services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". Payment for ambulance services is subject to the following limitations: (7-1-98)

a. If a Medicaid recipient is also a Medicare recipient, a provider must first bill Medicare for services rendered. (7-1-98)

b. If Medicare does not pay the entire bill for ambulance service, the provider is to secure an "Explanation of Benefits" (EOB) from Medicare, attach it to the appropriate claim form and submit it to the Department. (7-1-98)

c. For Medicare recipients, the Department will reimburse providers for deductible and co-insurance not to exceed the Medicaid allowed amount for the services billed. (7-1-98)

d. Before payment is made by the Department, a Medicaid recipient must utilize any available insurance benefits to pay for ambulance services. (7-1-98)

e. Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a recipient manifests acute symptoms and/or signs which, by reasonable medical judgement of the Department or its designee, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. If such condition exists, and treatment is required at the recipient's location, or transport of the recipient for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department or its designee. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department or its designee that travel by ambulance is medically necessary due to the medical condition of the recipient, and that any other mode of travel would, by reasonable medical judgement of the Department or its designee, result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. (7-1-98)

f. Each billing invoice for ambulance service must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Ambulance units that are not hospital- based must bill on a HCFA 1500 claim form and are reimbursed on a fee for service schedule. Hospital- based ambulance units must bill on a UB-92 claim form and are reimbursed at the hospital's outpatient reimbursement rate. If no attachments to the claim are required, the provider may bill electronically. (7-1-98)

g. All Emergency Medical Services (EMS) Providers that provide services to Medicaid recipients in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department, and must be governed by IDAPA 16.02.03, "Rules Governing Emergency Medical Services". Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (7-1-98)

h. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the recipient was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department or its designee. (7-1-98)

i. Ambulance services providers cannot charge Medicaid recipients more than is charged to the general public for the same service. (7-1-98)

04. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (7-1-98)

a. The point of pickup is inaccessible by land vehicle; or (11-10-81)

b. Great distances or other obstacles are involved in getting the recipient to the nearest appropriate facility and speedy admission is essential; and (11-10-81)

c. Air ambulance service will be covered where the recipient's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (11-10-81)

d. Air ambulance services must be approved in advance by the Department or its designee except in emergency situations. Emergency air ambulance services must be authorized by the Department or its designee on a retrospective basis. (7-1-98)

e. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the recipient. (7-1-98)

05. Ambulance Reimbursement. (7-1-98)

a. Base rate for ambulance services includes customary patient care equipment including such items as stretcher, clean linens, reusable devices, and reusable equipment. (11-10-81)

b. Not to be included as a base rate and to be billed separately are charges for each nonreusable item and disposable supply, such as oxygen, triangular bandage and dressing, which may be required for the care of the recipient during transport. Oxygen will be reimbursed according to volume used by the recipient during transport. The volume must appear in the appropriate field on the claim. (7-1-98)

c. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department or its designee. (7-1-98)

d. If a physician is in attendance during transport, he is responsible for the billing of his services. (11-10-81)

e. Reimbursement for waiting time will not be considered unless documentation submitted to the Department or its designee identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. (7-1-98)

f. Ambulance units are licensed by the EMS Bureau of the Department, or other states' EMS licensing authority according to the level of training and expertise its personnel maintains. At least, this level of personnel are required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the level of ambulance license the unit has been issued. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Intermediate Life Support (ILS) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Advanced Life Support (ALS) rate. In addition to the base rate, the Department will reimburse mileage. These rates are set by the Department. (7-1-98)

g. If multiple licensed EMS providers are involved in the transport of a recipient, only the ambulance provider which actually transports the recipient will be reimbursed for the services. In situations where personnel and equipment from a licensed ALS provider boards an ILS or BLS ambulance, the transporting ambulance may bill for ALS services as authorized by the Department or its designee. In situations where personnel and equipment from a licensed ILS provider boards a BLS ambulance, the transporting ambulance may bill for ILS services as authorized by the Department or its designee. In situations where medical personnel and equipment from a medical facility are present during the transport of the recipient, the transporting ambulance may bill at the ALS level of service. The transporting provider must arrange to pay the other provider for their services. The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALS, ILS, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the recipient during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as

authorized by the Department or its designee. The ground ambulance provider may also bill for their part of the trip as authorized by the Department or its designee. (7-1-98)

h. If multiple licensed EMS providers transport a recipient for different legs of a trip, each provider must bill their base rate, mileage, and for nonreusable supplies and oxygen used, as authorized by the Department or its designee. (7-1-98)

i. If a licensed transporting EMS provider responds to an emergency situation and treats the recipient, but does not transport the recipient, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate and will pay for nonreusable supplies and oxygen used at the scene. This service requires authorization from the Department or its designee, usually on a retrospective basis. (7-1-98)

j. If an ambulance vehicle and crew have returned to a base station after having transported a recipient to a facility and the recipient's physician orders the recipient to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (7-1-98)

k. Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the recipient is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. (7-1-98)

l. If a licensed transporting EMS provider responds to a recipient's location and upon examination and evaluation of the recipient, finds that their condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department or its designee, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the recipient has left the scene. No payment will be made for mileage, supplies or oxygen, nor will payment be made to an EMS provider who is licensed as a non-transporting provider. (7-1-98)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-0003

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is November 1, 1999.

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

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

The minimum age for Targeted Service Coordination (TSC) is lowered to eighteen (18) years, to reflect a change made to the Developmental Disabilities (DD) and Idaho State School and Hospital (ISSH) waivers.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(l)(b) and 67-5226(c), Idaho code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s): To confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted. The Targeted Service Coordination (TSC) changes are needed to accommodate the reduction of the age on the Developmental Disabilities waiver. TSC is required for all DD waiver clients.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Jean Christensen at (208) 364-1828.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before June 28, 2000.

DATED this 13th day of March, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0003

118. TARGETED DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.

The Department will purchase targeted case management, hereafter referred to as Targeted Service Coordination (TSC) for adult Medicaid eligible recipients with developmental disabilities when authorized by the Regional ACCESS Unit and provided by an organized service coordination provider agency who has entered into a written provider agreement/contract with the Department. The Department will only provide Targeted Service Coordination in a geographic area where such service is not available through a private provider who has entered into a provider agreement/contract with the Department. The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. (3-16-95)

01. Eligible Target Group. Only Medicaid eligible adults, ~~twenty-one~~ eighteen (21~~8~~) years of age or older, ~~and eligible individuals between the ages of eighteen (18) and twenty-one (21) who have transition plans developed by the school system which identify service coordination as necessary; and~~ who desire to live, learn, or work in community based settings are eligible. All participants must have a primary diagnosis of Developmental Disability. ~~(10-1-94)~~(11-1-99)T

a. The following diagnostic and functional criteria will be applied to determine membership in the target population: (1-7-94)

i. "Developmental Disability" means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (10-1-94)

(1) Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (10-1-94)

(2) Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (10-1-94)

(3) Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned or coordinated. (10-1-94)

b. Eligible individuals may reside in adult foster care, residential care, semi-independent living, room and board, their own homes, or be homeless. (1-7-94)

c. Eligible individuals may be receiving habilitation, supportive assistance, respite, or other services. (1-7-94)

02. Service Description. TSC shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational, residential, and social services using the least restrictive and most appropriate procedures and settings. TSC shall consist of the following core functions: (10-1-94)

a. **Individual Assessment and Service Planning.** Unless specifically excluded by the recipient, an Individual Support Plan (ISP) shall be developed in conjunction with the recipient, service providers, the recipient's family and/or guardian and other individuals selected by the recipient. (3-16-95)

i. The ISP shall replace existing service plans, except when such plans are required by other rules, and be developed from a person centered planning process and include information obtained from evaluations (assessments), consumer interview, observation in community settings, and other pertinent information. (10-1-94)

ii. The plan shall be directed at meeting the individual recipient's needs, primarily by building on, maintaining, and utilizing the recipient's identified strengths and abilities. Services proposed must: be the result of on-going planning; be built around the recipient's wants and needs; encourage the recipient to choose the locality in which he lives and works; be age appropriate; include, whenever possible, two (2) or more options from which the recipient may choose; be aimed at maximizing community participation; be culturally appropriate; be designed to

promote and utilize natural and informal community supports, including family, friends, and other non-paid citizens; and be designed with supports and services necessary to succeed in his chosen environment. (1-7-94)

iii. The plan must be completed within ninety (90) days of the selection of the service coordinator, unless documentation of a delay based on consumer need is submitted to the regional ACCESS unit. (5-24-95)

iv. The plan must be written in language that is easily understood by the consumer and his team. (5-24-95)

b. The service coordinator is responsible for writing the plan, and submitting it to the Regional ACCESS Unit for authorization of Medicaid and state general fund eligibility. The service coordinator will be responsible for finding alternative funding/resources for services and supports not deemed eligible for Medicaid or state general fund reimbursement. (10-1-94)

c. Implementation. The service coordinator shall arrange for services necessary to execute the ISP. (10-1-94)

d. Monitoring. The service coordinator shall review, update and monitor the plan continuously to meet the recipient's changing needs. (10-1-94)

i. Discuss the status of the ISP with the recipient in at least one face-to-face contact per month. (10-1-94)

ii. Discuss all proposed changes and the options related to those changes with the recipient. (1-7-94)

iii. Maintain regular contact with all service providers active with the recipient, and participate in meetings to facilitate the coordination of services. (1-7-94)

iv. Discuss the recipient's (family or guardian if appropriate) satisfaction with the quantity and quality of services provided; (1-7-94)

v. Maintain documentation in the ISP of the service coordinator's (family member or guardian if appropriate) observations of the recipient engaged in ISP objective-oriented behavior; (10-1-94)

vi. Evaluate progress toward outcomes identified on the ISP. (10-1-94)

vii. Modify, change, terminate or add services based on these evaluations. (1-7-94)

e. Enablement. The service coordinator shall enable the recipient whenever possible. Enablement includes but is not limited to the following: (10-1-94)

i. Providing information in ways that empower the recipient to make an informed decision; (1-7-94)

ii. Assuring that all placements in the service delivery system shall be to services which offer the individual the best available opportunity for personal development, provide an improved quality of life, and are within the least restrictive environment appropriate to the individual. (1-7-94)

iii. Ensure that all residential arrangements are community-based. Such arrangements may include, but are not limited to, the recipient's family's residence, or an independent living arrangement. (1-7-94)

Act. iv. Ensure that providers comply with clients' rights as specified in the Developmental Disabilities (10-1-94)

v. Assure that no one shall be denied TSC on the basis of the severity of physical or mental disability. (10-1-94)

vi. If the placement or services which are recommended are not immediately available, continued

attempts to try to access the service or placement for the recipient must be documented. (1-7-94)

vii. The service coordinator will foster the independence of the recipient (family or guardian if appropriate) by demonstrating to the individual how best to access service delivery systems. (10-1-94)

03. Targeted Service Coordination Agency Qualifications. Targeted Service Coordination agencies must meet the following criteria: (10-1-94)

a. Demonstrated ability to provide all the core elements listed in Subsection 119.02 of TSC to the target population; and (10-1-94)

b. Provide consumers of the agency, the availability of a care coordinator on a twenty-four (24) hour basis to assist them in obtaining needed services. (10-1-94)

c. May contract with individual service coordinators or case management agencies to provide TSC services. (10-1-94)

d. Not provide service coordination to any individual for whom the agency, owners or employees also provide direct services. Agencies must disclose any interest by the owners of the agency or their employees/contractors in any other agency that provides services to people with developmental disabilities. (10-1-94)

e. The individual or agency employees successfully complete the service coordination certification training specified by the Department; (10-1-94)

f. The individual or agency follows the written procedures for service coordination authorized and adhered to by the Department; (10-1-94)

g. Adheres to the Department's mission and value statements; and (10-1-94)

h. Adheres to the Department's contract requirements, billing, and reimbursement procedures. (10-1-94)

04. TSC Provider Staff Qualifications. All individual service coordinators must be employees or contractors of an organized provider agency that has a valid provider agreement/contract with the Department. The employing entity will supervise the individual service coordinators and assure that the following qualifications are met for each individual service coordinator: (10-1-94)

a. Must be a psychologist, Ph.D., Ed.D., M.A./M.S.; nurse, B.S.N., M.S., Ph.D.; Q.M.R.P.; Developmental Specialist; M.D.; D.O.; or possess a valid Idaho social work license issued by the Board of Social Work Examiners; and (10-1-94)

b. Must have documentation of at least eighteen (18) months, at an average of twenty (20) hours per week, of on-the-job experience providing service to the target population, or be working under the supervision of a fully qualified service coordinator; and (10-1-94)

c. A criminal history check with finger printing shall be obtained; and (10-1-94)

d. Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the recipient's needs are not met; provider agencies will supervise their service coordinators; and (10-1-94)

e. Cannot be the service coordinator for any recipient for whom the service coordinator has individual responsibility for the provision of any other care or treatment; and (10-1-94)

f. Cannot be responsible for the service coordination of more than fifty (50) individuals when using one or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35). At no time will the total caseload of a service coordinator be

so large as to violate the purpose of the program or adversely affect the health and welfare of any recipient served by the service coordinator. A waiver of the caseload limit may be granted by the Regional ACCESS Unit on a case by case basis and must meet the following criteria: (5-24-95)

- i. The availability of service coordinators is not sufficient to meet the needs of the service area; or (10-1-94)
- ii. The recipient who has chosen a particular service coordinator who has reached their limit, has just cause to need that particular provider over other available providers; or (10-1-94)
- iii. The individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) consumers. (10-1-94)
- iv. The request for waiver must include: (10-1-94)
 - (1) The time period for which the waiver is requested; and (10-1-94)
 - (2) The alternative caseload limit requested; and (10-1-94)
 - (3) Documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and welfare of any of the service coordinator's consumers. (10-1-94)
- v. The Bureaus may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of TSC services provided. (10-1-94)
- g. Paraprofessionals may be used to assist in the implementation of the ISP. Paraprofessionals must meet the following qualifications: (10-1-94)
 - i. Must be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); and (1-7-94)
 - ii. Must be able to read and write at a level commensurate with the general flow of paperwork and forms; and (1-7-94)
 - iii. Must complete a training program developed by the Division of Family and Community Services and be working under the supervision of a fully qualified service coordination; and (10-1-94)
 - iv. A criminal background check will be obtained. (10-1-94)

05. Recipient's Choice. The choice of whether or not to receive TSC services will be the eligible recipient's. All recipients who choose TSC services will have free choice of authorized TSC providers, as well as, the providers of medical and other services under the Medicaid Program. (10-1-94)

06. Payment For Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as TSC services, however the actual provision of the services does not constitute TSC. Medicaid will only reimburse for core services (Subsection 118.02) provided to members of the eligible target group by qualified staff. (10-1-94)

- a. Payment for TSC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)
- b. Payment will not be made for TSC services provided to individuals who are inpatients in NFs, ICFs/MRs, or hospitals. (10-1-94)
 - i. Medicaid will reimburse for TSC on the same date a recipient is admitted or discharged from NF, ICF/MR or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of

the service delivery. (10-1-94)

ii. TSC may be provided during the last thirty (30) days of inpatient stay or when the inpatient stay is not expected to last longer than thirty (30) days when not duplicating those services included in the responsibilities of the facility. (10-1-94)

c. Reimbursement for TSC services shall be made on a fee-for-service basis for service provided as established by the Department. (10-1-94)

d. The Department will not provide Medicaid reimbursement for on-going TSC services delivered prior to the completion of assessments and ISP. (10-1-94)

e. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and ISP. (10-1-94)

f. Medicaid reimbursement will be provided only for the following TSC services: (10-1-94)

i. Face-to-face contact between the service coordinator and the recipient, the recipient's family members, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)

ii. Telephone contact between the service coordinator and the recipient, the recipient's family, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)

iii. Development, review, revision of the ISP. (10-1-94)

g. The provider will provide the Department with access to all information required to review compliance with these rules. (1-7-94)

h. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (1-7-94)

i. The Department will not provide Medicaid reimbursement for TSC provided to a group of individuals. (10-1-94)

j. The TSC agency must release all pertinent information to direct service providers when written informed consent is obtained from the recipient. (5-24-95)

07. Record Requirements. In addition to the development and maintenance of the ISP, the following documentation must be maintained by the provider: (10-1-94)

a. Name of recipient; (1-7-94)

b. Name of provider agency and person providing the service; (1-7-94)

c. Date, time, and duration of service; (1-7-94)

d. Place of service delivery; (1-7-94)

e. Activity record describing the service(s) provided; (1-7-94)

f. Documented review of progress toward each service plan goal, and assessment of the recipient's need for TSC and other services as the recipient's needs change; (10-1-94)

g. Documentation justifying the provision of crisis assistance to the recipient; and (1-7-94)

h. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of TSC. (10-1-94)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-0004

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are February 1, 2000 and March 1, 2000.

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

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

Section 506 of these rules are being changed to provide greater specificity to assure that all eligible persons for nursing home, Aged and Disabled Waiver, and the Traumatic Brain Injury Waiver services are properly identified. The use of the Uniform Assessment Instrument (UAI) is included so that the process is standardized for all program applicants.

Section 561 is changed to clarify who can order/recommend/refer a Medicaid Reimbursable service other than a physician.

Section 699 is changed to reflect the current citation for NF Level of Care.

Subsection 664.03 is changed to reflect the current citation for NF Level of Care.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the Department identified that the number of individuals accessing the Aged and Disabled Waiver was exceeding projections. If the rule change is not made promptly the program would not remain general fund neutral.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Lloyd Forbes at (208) 364-1831.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before June 28, 2000.

DATED this 14th day of March, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0004

506. CRITERIA FOR DETERMINING NEED FOR NF CARE.

The recipient requires NF level of care when ~~one (1) or more of~~ the following conditions exist, ~~and the skills of an R.N., P.T., or O.T. are required on a daily or regular basis~~: A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years. ~~(7-1-99)(3-1-00)T~~

01. ~~Supervision Required.~~ *Where the inherent complexity of a service prescribed by the physician is such that it can be safely and/or effectively performed only by or under the supervision of a licensed nurse or licensed physical therapist.* **Required Assessment, Adults. A standard assessment will be administered by the Department or its designee to all adults requesting services with requirements for Nursing Facility (NF) level of care. The Department will specify the instrument to be used. ~~(7-1-99)(3-1-00)T~~**

02. ~~Preventing Deterioration.~~ *Skilled care is needed to prevent, to the extent possible, deterioration of the resident's condition or to sustain current capacities, regardless of the restoration potential of a resident, even where full recovery or medical improvement is not possible.* **Functional Level, Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department or its designee. In determining need for NF care a person must require the level of assistance listed in Subsections 506.03 through 506.05. ~~(7-1-99)(3-1-00)T~~**

03. Critical Indicator (Twelve (12) Points Each). ~~(3-1-00)T~~
a. Total or extensive assistance with preparing or eating meals. ~~(3-1-00)T~~
b. Total or extensive assistance in toileting. ~~(3-1-00)T~~
c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. ~~(3-1-00)T~~

04. High Indicator (Six (6) Points Each). ~~(3-1-00)T~~
a. Total or extensive assistance with routine medications. ~~(3-1-00)T~~
b. Total, extensive or moderate assistance with transferring. ~~(3-1-00)T~~
c. Total or extensive assistance with mobility. ~~(3-1-00)T~~
d. Total or extensive assistance with personal hygiene. ~~(3-1-00)T~~
e. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). ~~(3-1-00)T~~

05. Medium Indicator (Three (3) points each). ~~(3-1-00)T~~
a. Moderate assistance with personal hygiene. ~~(3-1-00)T~~
b. Moderate assistance with eating. ~~(3-1-00)T~~
c. Moderate assistance with mobility. ~~(3-1-00)T~~
d. Moderate assistance with medications. ~~(3-1-00)T~~
e. Moderate assistance with toileting. ~~(3-1-00)T~~

- f. Total, extensive, or moderate assistance with dressing. (3-1-00)T
- g. Total, extensive or moderate assistance with bathing. (3-1-00)T
- h. Frequent or continuous supervision in one (1) or more of the following cognitive areas from Section IV of the UAI: (3-1-00)T
- i. Orientation: (3-1-00)T
- ii. Memory: (3-1-00)T
- iii. Judgement: (3-1-00)T
- iv. Wandering: (3-1-00)T
- v. Disruptive/socially inappropriate behavior: (3-1-00)T
- vi. Assaultive/destructive behavior: (3-1-00)T
- vii. Self preservation; or (3-1-00)T
- viii. Danger to self. (3-1-00)T

036. **Specific Needs.** When the plan of care, risk factors, and/or aggregate of health care needs is such that the assessments, interventions, or supervision of the resident necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and/or therapy notes. **NF Level Of Care, Adults.** In order to qualify for NF level of care, the individual must score twelve (12) points in one (1) of the following ways. (7-1-99)(3-1-00)T

- a. One (1) or more critical indicators = Twelve (12) points (3-1-00)T
- b. Two (2) or more high indicators = Twelve (12) points (3-1-00)T
- c. One (1) high and two (2) medium indicators = Twelve (12) points (3-1-00)T
- d. Four (4) or more medium indicators = Twelve (12) points (3-1-00)T

07. **Supervision Required, Children.** Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. (3-1-00)T

08. **Preventing Deterioration, Children.** Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. (3-1-00)T

09. **Specific Needs, Children.** When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. (3-1-00)T

10. **NF Level Of Care, Children.** Using the criteria found in Subsections 506.07, 506.08, and 506.09, plus consideration of the developmental milestones, based on the age of the child, the Department's RMU will determine NF level of care. (3-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

561. RECIPIENT ELIGIBILITY.

To be eligible for medical assistance reimbursement for covered services, a student shall: (4-5-00)

01. Education Disability. Be identified as having an educational disability pursuant to IDAPA 08.02.03, "Rules Governing Thoroughness," Subsection 100.09.b., Department of Education standards for the education of disabled students or, for children birth to three (3) years of age, being identified as needing early intervention services due to a developmental delay or disability in accordance with the eligibility criteria of the Idaho Infant Toddler Program; and (4-5-00)

02. Individualized Education Program. Have a current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) which indicates the need for one (1) or more medically necessary health related services; and lists all Medicaid reimbursable services for which the school district or agency is requesting reimbursement; and (4-5-00)

03. Age. Be less than twenty-two (22) years of age; and (4-5-00)

04. Medicaid Eligible. Be eligible for Medicaid and the service for which the school district is seeking reimbursement; (4-5-00)

05. School District Is Enrolled As A Provider. Be served by a school district or other public educational agency that is an enrolled medical assistance provider pursuant to these rules; and (4-5-00)

06. Referred By A Physician. Have a recommendation or referral from a physician, or other practitioner of the healing arts such as: a nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed and approved by the state of Idaho to make such recommendations or referrals, for all Medicaid services for which the school district/other educational agency is receiving reimbursement. ~~(4-5-00)~~(2-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

664. WAIVER SERVICES FOR AGED OR DISABLED ADULTS.

The Department provides waiver services to eligible participants: to prevent unnecessary institutional placement; to provide for the greatest degree of independence possible; to enhance the quality of life; to encourage individual choice; and to achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant: (4-5-00)

01. Has A Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and (4-5-00)

02. Safe In A Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (4-5-00)

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility (NF) as set forth in ~~Subsection 180.03~~ 506. ~~(4-5-00)~~(3-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

699. PARTICIPANT ELIGIBILITY DETERMINATION.

Waiver eligibility will be determined by the RMU. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)". In addition, waiver

participants must meet the following requirements. (4-5-00)

01. Requirements For Determining Participant Eligibility. The RMU must determine that: (4-5-00)

a. The participant would qualify for NF level of care as set forth in Section ~~480~~ 506 of these rules, if the waiver services listed in Section 664 of these rules were not made available; and ~~(4-5-00)~~ (3-1-00)T

b. The participant could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must be made by the RMU. Prior to any denial of services on this basis, the case manager must verify that services to correct the concerns of the team are not available. (4-5-00)

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of NF care. (4-5-00)

d. Following the approval by the RMU for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (4-5-00)

02. Admission To A Nursing Facility. A participant who is determined by the RMU to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to an NF. (4-5-00)

03. Redetermination Process. Case Redetermination will be conducted by the RMU or its contractor. The redetermination process will verify that the participant continues to meet NF level of care and the participant's continued need for waiver services. (4-5-00)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO
DOCKET NO. 16-0310-0001
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective February 15, 2000.

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

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

The proposed rule change identifies the addition of a special rate for consumers who have long term care needs beyond the scope of facility services. The payment for this specialized care will be in addition to any payments made in accordance with this chapter. Determination for a special rate will be made on a case-by-case basis.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, a notice of negotiated rulemaking was not published. Paul Swatsenbarg, Family and Community Service and Jean Christensen, Division of Medicaid, met with Bill Benkula, Tony Decker, and Dennis Snyder who represented the ICF/MR providers to discuss the ICF/MR special rates.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to confer a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Jean Christensen at (208) 364-1828.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before June 28, 2000.

DATED this 13th day of March, 2000

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-0001

248. —249. (RESERVED) SPECIAL RATES FOR ICF'S/MR.

In accordance with Section 56-117, Idaho Code, the Director may pay facilities a special rate for care given to consumers who have long-term care needs beyond the normal scope of facility services. These individuals must have needs which are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-113, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 248, will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement".

(2-15-00)T

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source.

(2-15-00)T

02. Approval. Authorization of a special rate is required prior to admission. In an emergency situation if necessary to divert the consumer from a more restrictive placement, prior authorization is not required for up to seventy-two (72) hours. An emergency situation constitutes a diversion from a more restrictive placement.

(2-15-00)T

03. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately.

(2-15-00)T

04. Limitations. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services.

(2-15-00)T

249. (RESERVED).

IDAPA 27 - IDAHO BOARD OF PHARMACY
27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY
DOCKET NO. 27-0101-0001
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 6, 2000.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

This rulemaking is to provide for the change of physical address of the Idaho Board of Pharmacy.

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

This rulemaking is necessary to provide the correct physical address of the Idaho Board of Pharmacy.

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

The rulemaking does not impose or increase a fee or charge.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the change is nontechnical and noncontroversial.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Richard K. Markuson, Director, at (208) 334-2356.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 28, 2000.

DATED this 10th day of April, 2000.

Richard K. Markuson
Director
Idaho Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
(208) 334-2356 (Telephone)
(208) 334-3536 (Facsimile)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-0001

011. FILING OF DOCUMENTS.

01. Place And Time For Filing. All documents in rulemakings or contested cases shall be filed with the executive director of the Board of Pharmacy at the office of the Board of Pharmacy in Boise, Idaho, between the hours of 8 a.m. and 5 p.m. each day except Saturdays, Sundays and holidays. For purposes of such filing, the mailing and street addresses, telephone number, and facsimile number of the Board are as follows:

Idaho State Board of Pharmacy
~~280 N. 8th Street~~ 3380 Americana Terrace, Suite 204 320
P.O. Box 83720
Boise, Idaho 83720-0067
Telephone: (208) 334-2356
Facsimile: (208) 334-3536

~~(4-5-00)~~(4-6-00)T

02. Manner Of Filing. One (1) original of each document is sufficient for filing, provided, however, the person or officer presiding over a particular rulemaking or contested case proceeding may issue orders requiring the filing of additional copies for use in such proceeding. Any pleading or document, not over ten (10) pages in length, and not requiring a filing fee, may be transmitted to the Board for filing by a facsimile machine process (FAX), provided such FAX transmission must be received legibly, and in its entirety, during the office hours set forth in Subsection 011.01. It shall be the responsibility of the filing party to verify with Board staff that a FAX transmission was successfully, and legibly, completed in its entirety. (4-5-00)

IDAPA 29 - IDAHO POTATO COMMISSION
29.01.02 - RULES GOVERNING PAYMENT OF ADVERTISING TAX AND
USAGE OF FEDERALLY REGISTERED TRADEMARKS

DOCKET NO. 29-0102-0001

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is June 30, 2000.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 22-1207(7) and (8), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

**June 21, 2000, 3:00 p.m.,
Offices of the Idaho Potato Commission,
599 West Bannock St. Boise, ID 83702.**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

This rule will authorize the packing of Number 2 Grade Idaho potatoes in cardboard box containers under defined conditions. The purpose of the rule is to meet changes within the food service industry, but to limit the possibility of putting non-Idaho® potatoes into containers bearing the certification marks owned or administered by the Idaho Potato Commission.

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

This rule will confer an economic benefit on the Idaho Potato industry by permitting more opportunities for the sale of Idaho® potatoes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased. None.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this requested rulemaking was initiated by the potato industry itself, and the Idaho Potato Commission is responding to the request of the industry.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Patrick J. Kole, Vice-President, Legal & Governmental Affairs and Assistant to the Director, Idaho Potato Commission, 208-334-2350.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 28, 2000.

DATED this 19th day of April, 2000.

Patrick J. Kole
Vice President,
Legal & Governmental Affairs
& Assistant to the Director
Idaho Potato Commission

599 West Bannock
Post Office Box 1068
Boise, ID 83701
Phone: 208-334-2350 Facsimile: 208-334-2274

THE FOLLOWING IS THE TEXT OF DOCKET NO. 29-0102-0001

102. CERTIFICATION MARKS FOR IDAHO® (~~Registered Trademark~~) POTATO CONTAINERS.

01. Containers. All potatoes grown in Idaho and packed or repacked in containers in Idaho shall be in containers printed, labeled or stenciled in a plain and legible manner with one of the Commission's registered Certification Marks, and the "GROWN IN IDAHO® (~~Registered Trademark~~)" Certification Mark. An exact reproduction of the Commission's Certification Marks appears in ~~appendices~~ A. Certification Marks may not be stamped on any Idaho® (~~Registered Trademark~~) potato container. (7-1-93)(6-30-00)T

02. Marks. No person, firm or corporation packing or repacking potatoes or potato products outside of the state of Idaho shall use any of the Commission's Certification Marks on any containers of potatoes or potato products packed or repacked outside the state of Idaho unless they have first executed an agreement for the use of the Certification Marks with the Idaho Potato Commission, and unless they are actually packing or repacking in such containers Idaho grown potatoes or potato products made from Idaho® (~~Registered Trademark~~) grown potatoes. (7-1-93)(6-30-00)T

03. Agreement. No person, including without limitation manufacturers, container manufacturers, growers, shippers, processors and repackers, shall use or reproduce any of the Commission's Certification Marks on any container without first executing an agreement for the use of the marks with the Idaho Potato Commission. (7-1-93)

04. Recognition. Whenever the "GROWN IN IDAHO® (~~Registered Trademark~~)," "IDAHO® (~~Registered Trademark~~)" or other Certification Marks are used, recognition must be given that the marks are registered under the appropriate Federal statute. This recognition must be: by printing a legible capital "R" inside a circle (®), immediately after the word "IDAHO". (7-1-93)(6-30-00)T

05. No Certification Mark. No Certification Mark shall be incorporated into any private label, brand or seal but shall be portrayed without embellishment as shown in ~~appendices~~ A. (7-1-93)(6-30-00)T

06. Not Incorporated. The word "IDAHO® (~~Registered Trademark~~)" shall not be incorporated into any private label, brand or seal unless such label, brand or seal was registered with the U.S. Patent Office prior to January 1, 1966. (7-1-93)(6-30-00)T

07. Size. When a Certification Mark is used on the front of a one hundred pound (100) sack type container, it shall not be less than five (5) inches in diameter or width and shall not be placed closer than two (2) inches from the bottom of said container. When any Certification Mark is used on the rear of a one hundred pound (100) sack type container, it shall not be less than twelve (12) inches in diameter or width. The marks may also be used on both the front and back of one hundred pound (100) sack type containers, if placed as indicated and in the sizes indicated. (7-1-93)

08. Limitation Of Use. On fifty (50) pound sack type containers, a Certification Mark shall be used as on the one hundred (100) pound containers, but in proportionate sizes. (7-1-93)

09. Other Type Containers. On all sack type containers of less than fifty (50) pounds, a Certification Mark shall appear plainly visible on the front of the containers; and it shall be in relative proportion to brands, labels

or other printed matter thereon, but not less than one and one-half (1 1/2) inches in diameter or width. (7-1-93)

10. Box Type Containers. (6-30-00)T

a. On all box type containers in which number 1 grade Idaho® Potatoes will be packed, a Certification Mark may be located on the sides, ends or top of the container as desired, but shall be so placed and of such size as to be plainly visible. (~~7-1-93~~)(6-30-00)T

b. On all box type containers in which number two (2) grade Idaho® Potatoes will be packed, packing is permitted only when the following requirements are met: (6-30-00)T

i. The container must be manufactured in a kraft, or non-colored cardboard material and be of a single piece construction: (6-30-00)T

ii. The rectangular “Grown in Idaho®” certification mark shall be placed on each side and end panel of the container, with a width measurement of three and one-half (3 1/2) inches and length measurement of five and one-half (5 1/2) inches. The mark shall be located as shown in Appendix B: (6-30-00)T

iii. The certification mark “Idaho® Potatoes” shall be printed on all four (4) sides of the container in one (1) inch lettering in the locations shown in Appendix B: (6-30-00)T

iv. The words “U. S. NO. 2” shall be printed on all four (4) sides of the container in one (1) inch lettering in the locations shown in Appendix B and on one (1) of the top flaps of the container: (6-30-00)T

v. The top one and three quarters (1 3/4) inches of the carton shall contain no preprinting on all four (4) sides of the container: (6-30-00)T

vi. One (1) of the elongated top flaps shall contain the “Grown in Idaho®” certification mark with a width of three and one-half (3 1/2) inches and length of five and one-half (5 1/2) inches, together with the certification mark “Idaho® Potatoes” in one (1) inch height and the words “U. S. NO. 2” in one (1) inch height; and (6-30-00)T

vii. All other requirements regarding container packaging set forth in these rules and the license agreements of the Idaho Potato Commission apply to the use of this type of container. (6-30-00)T

11. Tote Bin Type. On all tote bin type containers, Certification Marks must be used on the front of said container but may be used elsewhere and shall not be less than twelve (12) inches in diameter or width. (7-1-93)

12. Identity Of Commodity. All containers bearing the marks shall specify the identity of the commodity contained therein and the name and place of business of the manufacturer, packer or distributor of the commodity. Containers which do not comply with the rules of the Idaho Potato Commission shall not be used by any manufacturer, packer or distributor for any potatoes or potato products subject to these rules. (7-1-93)

13. Words Printed. All potatoes grown in Idaho and packed or repacked in Idaho shall have the words “PACKED IN IDAHO” printed on the container. (7-1-93)

14. Sack Type Containers -- Fifty Pounds Or Over. On all sack type containers for fifty (50) pounds or over the words “PACKED IN IDAHO” shall be located on the front lower half of the container but not closer than six (6) inches to the bottom thereof. (7-1-93)

15. Sack Type Containers -- Less Than Fifty Pounds. On all sack type containers containing less than fifty (50) pounds of potatoes the words “PACKED IN IDAHO” may be placed anywhere on the container but shall be so placed as to be plainly visible. (7-1-93)

16. Location Of Words. On all box type containers the words “PACKED IN IDAHO” may be located on the ends, sides or top of the container but shall be so placed as to be plainly visible. (7-1-93)

17. Colors. All marks when used and the words “PACKED IN IDAHO” shall be in color or colors in

contrast with the color of the container.

(7-1-93)

18. Use. Only in connection with potatoes and potato products grown within the state of Idaho may growers, shippers and packers use the name “IDAHO® (~~Registered Trademark~~)” in any mark, label or stencil applied to containers for such produce and products. The growers, shippers and packers of potatoes within the state of Idaho are not precluded from processing, packing and shipping potatoes grown outside the state of Idaho so long as such potatoes are not misrepresented or misbranded as Idaho® (~~Registered Trademark~~) Potatoes. (~~7-1-93~~)(6-30-00)T

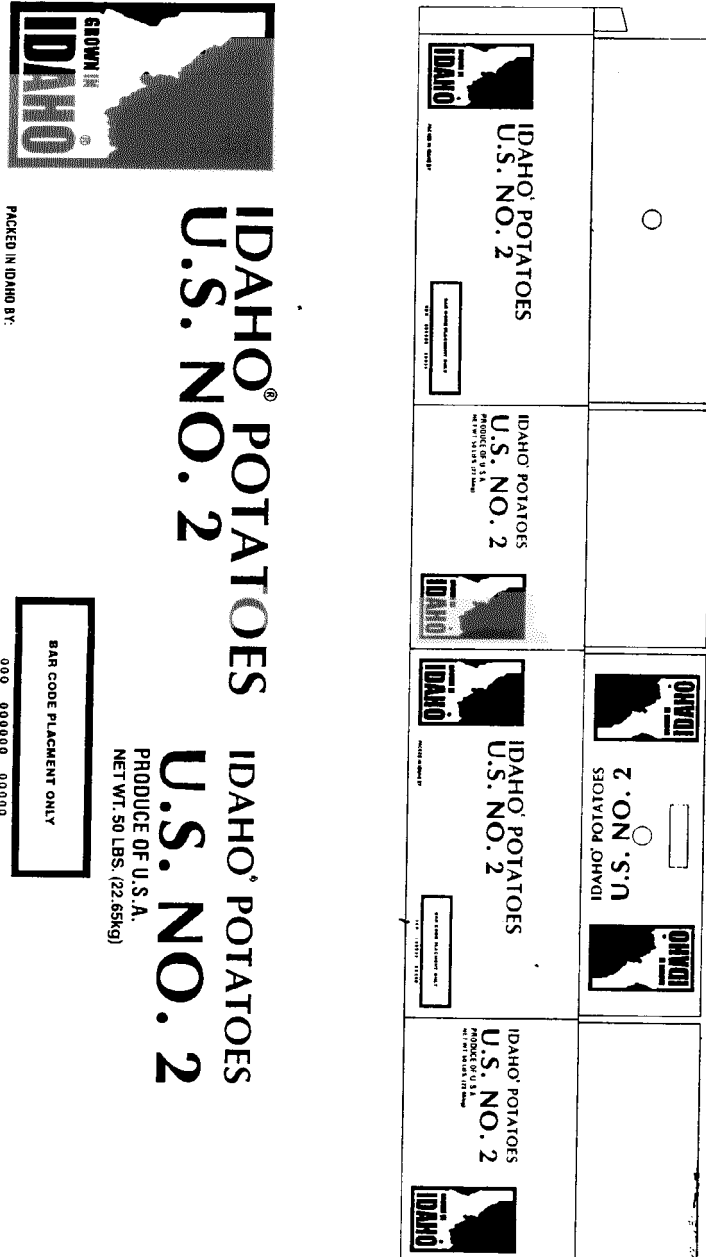
19. Compulsory Printing. Printing of the mark “GROWN IN IDAHO® (~~Registered Trademark~~)” and the words “PACKED IN IDAHO” is compulsory on all potato containers printed or contracted for after December 1, 1964. (~~7-1-93~~)(6-30-00)T

20. Idahos. The word “IDAHOS” shall not be used on any container for potatoes, potato products nor on any other printing or advertising material or correspondence used to identify or promote Idaho® (~~Registered Trademark~~) potatoes. (~~7-1-93~~)(6-30-00)T

21. Exemption. Only shipments of certified seed potatoes to destinations outside of the state of Idaho are exempt from this rule. (7-1-93)

22. Other Rules. Other rules on containers, grade and size are covered under Title 22, Chapter 9, Idaho Code, and applicable marketing orders. (7-1-93)

APPENDIX B



IDAPA 33 - IDAHO REAL ESTATE COMMISSION
33.01.01 - RULES OF THE IDAHO REAL ESTATE COMMISSION
DOCKET NO. 33-0101-0001
NOTICE OF TEMPORARY RULES AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

AUTHORITY: In compliance with Section 67-5221(1), and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-2027, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking: Repeal existing rules chapter, IDAPA 33.01.01. New temporary rules are being adopted to replace it under Docket No. 33-0101-0002 following this notice in this Bulletin.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: The repeal and replacement of the existing rules chapter is necessary to comply with the new law, SB 1312, which repeals and replaces the existing licensing statute, Chapter 20, Title 54, Idaho Code.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: No new fee is involved.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking has been undertaken to conform to SB 1312, the existing state statute governing licensure.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Donna Jones, (208) 334-3285 ext. 232.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 28, 2000.

DATED This 19th day of April, 2000.

Donna M. Jones
Executive Director
Idaho Real Estate Commission
633 N. Fourth St., Boise, ID 83702
PO Box 83720, Boise, ID 83720
Phone/Fax: (208) 334-3285/Fax: (208) 334-2050

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 33 - IDAHO REAL ESTATE COMMISSION
33.01.01 - RULES OF THE IDAHO REAL ESTATE COMMISSION
DOCKET NO. 33-0101-0002
NOTICE OF TEMPORARY RULE AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

AUTHORITY: In compliance with Section 67-5221(1), and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-2027, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 21, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

A new chapter is being adopted to replace the existing rules chapter, IDAPA 33.01.01. The new chapter consists of former rules that were not codified in the new statute, and reflects changes necessitated by the enactment of the new statute, SB 1312. No significant substantive changes from the existing rules have been made.

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

The repeal and replacement of the existing rules chapter is necessary to comply with the new law, SB 1312, which repeals and replaces the existing licensing statute, Chapter 20, Title 54, Idaho Code.

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

No new fees involved.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking has been undertaken to conform to SB 1312, the existing state statute governing licensure.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Donna Jones, (208) 334-3285 ext. 232.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 28, 2000.

DATED this 19th day of April, 2000.

Donna M. Jones
Executive Director
Idaho Real Estate Commission
633 N. Fourth St., Boise, ID 83702
PO Box 83720, Boise, ID 83720
Phone/Fax: (208) 334-3285/Fax: (208) 334-2050

THE FOLLOWING IS THE TEXT OF DOCKET NO. 33-0101-0002

IDAPA 33
TITLE 01
Chapter 01

RULES OF THE IDAHO REAL ESTATE COMMISSION

000. LEGAL AUTHORITY.

The Rules of the Idaho Real Estate Commission contained herein have been adopted pursuant to Section 54-2007, Idaho Code. Any violation of these Rules, or of any provision of Chapter 20, Title 54, shall be sufficient cause for disciplinary action as prescribed in Sections 54-2059 and 54-2060, Idaho Code. (7-1-00)T

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as IDAPA 33.01.01, "Rules of the Idaho Real Estate Commission," IDAPA 33, Title 01, Chapter 01. (7-1-00)T

02. Scope. These rules contain the requirements for implementation and enforcement of the Real Estate Licensing Law and the Real Estate Brokerage and Representation Act, contained in Chapter 20, Title 54, Idaho Code. (7-1-00)T

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(16)(b)(iv), this agency has written statements which pertain to the interpretation of the rules of this chapter, or to documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost at the Idaho Real Estate Commission, 633 North 4th Street, Boise, Idaho, 83702. (7-1-00)T

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by IDAPA 33.01.02.000 et seq., "Rules of Practice and Procedure of the Idaho Real Estate Commission." (7-1-00)T

004. INCORPORATION BY REFERENCE.

There are no materials incorporated by reference. (7-1-00)T

005. OFFICE HOURS, MAILING AND PHYSICAL ADDRESS, PHONE NUMBERS.

The office hours for Real Estate Commission are 8:00 a.m. to 5:00 p.m., Monday through Friday, excepting state holidays. The Real Estate Commission is located at 633 North 4th Street, Boise, Idaho, 83702. The mailing address is P.O. Box 83720, Boise, Idaho, 83720-0077. The telephone number is (208) 334-3285. (7-1-00)T

006. -- 009. (RESERVED).

010. DEFINITIONS.

As used in these Rules, and in the Idaho Real Estate License Law, Chapter 20, Title 54, Idaho Code, the following words or phrases shall have the following meaning: (7-1-00)T

01. Active Licensee. A person who holds a current license in good standing. (7-1-00)T

02. Active License Experience. Practicing the business of real estate, which requires a license, on a full-time basis. The productiveness from such licensed work activity must have been generally commensurate with that of the other licensees working in a similar brokerage capacity. Listings, sales, options, or other activities may be used as some of the criteria to determine proper license experience in conjunction with application for the broker's

- license. (7-1-00)T
- 03. Branch Office.** An office operated by a licensed real estate broker or licensed legal business entity, separate and apart from the “Main Office”. (7-1-00)T
- 04. Brokerage Agreement.** A written contract or agreement between a buyer, seller, or both, and a real estate brokerage for agency representation in a regulated real estate transaction. (7-1-00)T
- 05. Business Name.** The name which appears on the real estate broker’s license issued by the Idaho Real Estate Commission. (7-1-00)T
- 06. Cancel.** With reference to a real estate license, means to inactivate the license. (7-1-00)T
- 07. Closed Transaction.** A transaction which has been finalized, including proper disbursement of all trust funds and documents. (7-1-00)T
- 08. Cooperative Sale.** A transaction involving two (2) or more brokers. (7-1-00)T
- 09. Expired License.** A license which was not renewed for the current license period. (7-1-00)T
- 10. Fee Or Commission.** A payment, either actual or promised, to a licensee as compensation for participating in a real estate transaction which requires a license. (7-1-00)T
- 11. Inactive Licensee.** A person who has paid all applicable fees, who is not affiliated with a designated broker, and who holds a current license, which is not revoked or suspended, and which has been placed on inactive status by the Commission. (7-1-00)T
- 12. Main Office.** The principal location where a real estate broker is licensed to transact business. (7-1-00)T
- 13. Successfully Completed.** As used in reference to a real estate course offering, completing all required course hours and, except where the licensee is seeking continuing education credit for having regularly attended a “live” course, passing a Commission-approved final examination. (7-1-00)T
- 14. Terminated License.** A license not renewed within one (1) year after the required renewal date, and which has been terminated, automatically, by the Commission. (7-1-00)T
- 011. -- 099. (RESERVED).**

Rules 100 through 199 --
APPLICATION, LICENSURE AND TERMINATION OF LICENSES

100. CERTIFICATE OF WAIVER OF LICENSING EXAM.

Any applicant seeking to obtain a written certificate from the Commission waiving a portion of the licensing exam, as authorized by statute, shall make a written request to the Commission. The request must indicate the address to which the Commission is to mail the certificate. (7-1-00)T

101. LICENSING TERM AND FEES.

Each new or reactivated license shall be for a period of one (1) year plus the months up to and including the next birth date of the licensee, not to exceed a period of two (2) years, and shall expire on a date to coincide with the last day of the month of the birth date of the licensee. (7-1-00)T

01. Fees. The fees for an initial or renewing license for broker, associate broker, or salesperson shall be two hundred twenty dollars (\$220), which fees include the twenty dollar (\$20) fee prescribed in Section 54-2070, Idaho Code. (7-1-00)T

02. Broker For More Than One Business. When an individual is licensed as designated broker for more than one (1) legal business entity, the Commission shall assess a broker's license fee for the second and each sequential legal business entity. (7-1-00)T

102. BROKER TO MAKE APPLICATION FOR LICENSE OF SALES ASSOCIATE, SALES ASSOCIATE LIMITED TO ONE BROKER.

The broker is required to make application to the Commission, on an approved form, for the licensing of each sales associate. The newly issued license will be mailed to the broker's office. A sales associate may be licensed under and associated with only one (1) broker at a time. (7-1-00)T

103. APPOINTMENT OF DESIGNATED BROKER FOR LICENSED BUSINESS ENTITIES.

The appointment of the designated broker for a legal business entity, and a list of the entity's officers, directors, members, or managers, shall be reflected in writing in the minutes, resolutions, or other similar business document of the entity, and submitted to the Commission with the entity license application. (7-1-00)T

104. RETURNED CHECKS DUE TO INSUFFICIENT FUNDS.

Payment of any licensing fee with a check which is returned by the banking institution due to insufficient funds wherein the reason for not paying the check is not the fault of the banking institution shall be grounds for denying the licensing application. If a license has been issued, the payment of the licensing fee by an insufficient funds check shall be grounds for expiration, termination, suspension or revocation of the license. (7-1-00)T

105. EXTENSIONS OF TIME TO MEET CONTINUING EDUCATION REQUIREMENTS AND LATE RENEWAL.

The Commission may extend the time for completing the education requirements for renewal of a license for three (3) months, as provided by statute. The Commission will not grant a further extension of time. An applicant's failure to satisfy the continuing education requirement within the three-month period granted by the Commission shall result in the automatic inactivation of the license. (7-1-00)T

01. Continuing Education Requirement And License Expiration Date. Any license issued after an extension of time has been granted shall be dated effective as of the original license expiration date, and not the extended date. (7-1-00)T

02. Late License Renewal And Fee. The Commission may grant an applicant's written request for late license renewal, provided that such request shall be made no later than one (1) year from the license renewal date, and provided the applicant pay the late renewal fee prescribed by statute. (7-1-00)T

106. CHANGE FROM INACTIVE TO ACTIVE LICENSE STATUS.

A person who holds an inactive Idaho license may activate the license upon meeting each of the requirements listed below: (7-1-00)T

01. Application And Fee. Making proper application and paying the fee; and (7-1-00)T

02. Supervision Or Establishing A Business. Licensing under an Idaho broker as a sales associate, or, if being licensed as a broker, establishing an office; and (7-1-00)T

03. Continuing Education. Providing evidence of having successfully completed the continuing education requirements, or their equivalent, as prescribed in Section 54-2023, Idaho Code. A continuing education course taken to make up a deficiency of the continuing education requirement from the previous renewal period may be used toward satisfying the continuing education requirements of the current period. (7-1-00)T

04. Errors And Omissions Insurance. Provide evidence of having errors and omissions insurance in the manner required by Section 54-2013, Idaho Code, and in accordance with the Rules of the Commission. (7-1-00)T

107. CHANGE OF BUSINESS NAME OR ADDRESS.

Whenever a broker changes the name, location, telephone number, or mailing address of his business, such broker

shall immediately notify the Commission in writing of such change. If the change necessitates the printing of a new license, the broker shall return to the Commission each wall license requiring change, along with the statutory fee for printing a new license. Upon receipt of the notice of change, the wall license, and payment of the required fee, the Commission shall issue a new license and mail it to the broker. (7-1-00)T

108. CHANGE OF PERSONAL ADDRESS OR TELEPHONE NUMBER.

All licensees, whether active or inactive, shall provide written notice to the Commission of any change of address of personal residence and of any change of personal telephone number. Such notice shall be provided within ten (10) days of the change of address or phone number. (7-1-00)T

109. PERSONAL NAME CHANGE.

Whenever a licensee changes his personal name, the licensee shall notify the Commission in writing of such change, along with legal proof of the name change and the statutory fee for printing a new license. An active licensee shall also return to the Commission the wall license bearing his former name. (7-1-00)T

110. BRANCH OFFICES.

A real estate broker is required to make application for establishing and licensing each branch office in which trust funds and original transaction files are maintained. No separate branch office license or manager is required for business locations other than the main office unless trust funds or original transaction records are kept at the branch. The wall license of the branch office shall be signed by the designated broker. Renewal of a branch office license shall coincide with the renewal of the designated broker's license. (7-1-00)T

01. Branch License Dependent On Broker License. A license issued to a branch office is valid only as long as the designated broker's license is valid. (7-1-00)T

02. Supervision. The designated branch manager shall regularly occupy the branch office and shall be responsible for its supervision. When a branch manager is a regular full-time employee, or engaged in a full-time activity, at a location other than where he is licensed to do business, a presumption will be made that such manager is unable to responsibly supervise a branch office; however, such presumption may be overcome by satisfactory evidence to the contrary, acceptable to the Commission. (7-1-00)T

03. Manager Limited To One Branch. A branch office manager shall not be licensed to manage more than one (1) branch office at a time. (7-1-00)T

04. Licensees. The wall licenses of each licensee conducting business from any licensed branch office shall be prominently displayed in the branch office at all times.

05. Same Name. A broker's branch office, whether licensed or unlicensed, must operate under the same name as the main office.

111. EFFECTIVE DATE OF LICENSE AND LICENSE CHANGES.

Application requests for licensure and for license changes shall become effective when the properly completed forms, attachments and required fees are received at and approved by the Commission. Applications which are incomplete or lacking proper fees shall be returned to the applicant, and no license will be issued until a completed application and proper fees are received at and approved by the Commission. Placing the application in the mail does not constitute its receipt by the Commission. Sending the license application and fees by "Certified Mail, Return Receipt Requested," will assure notice of its receipt by the Commission office, but does not constitute approval of the license application by the Commission. (7-1-00)T

112. LICENSEE TO SIGN LICENSE.

A license must be signed by the respective licensee to be valid. (7-1-00)T

113. LICENSEE'S DUTIES UPON SURRENDER, SUSPENSION, OR REVOCATION OF LICENSE.

Upon surrender of his real estate license, or upon notice of suspension or revocation of such license, a broker or sales associate shall immediately forward the license to the Commission. Any sales associate licensed with a broker whose license is to be surrendered, suspended or revoked shall return his license to the Commission on or before the effective date of the notice or order surrendering, suspending, or revoking the broker's license. (7-1-00)T

114. -- 116. (RESERVED).

117. CERTIFICATION OF MANDATORY ERRORS AND OMISSIONS INSURANCE.

Every licensee, upon obtaining or renewing an active real estate license in the state of Idaho, including nonresident and reciprocal licensees, shall have in effect and maintain a policy of errors and omissions insurance when required by Section 54-2013, Idaho Code, to cover all activities contemplated under Chapter 20, Title 54, Idaho Code and shall certify such coverage to the Commission in the form and manner prescribed by statute and in these rules. (7-1-00)T

01. Certification Of Licensees Under Group Insurance Plan. Licensees covered under the Group Insurance Plan, as provided for in Section 118 of these rules, shall be deemed to have satisfied the certification requirement of Section 117, upon the Commission receiving payment of the appropriate premium and a ten dollar (\$10) administrative fee from the licensee. The effective date of coverage, however, shall be the day of final license approval. (7-1-00)T

02. Certification Of Licensees Obtaining Independent Coverage. Licensees obtaining independent coverage, as provided for in Section 119 of these rules, shall provide to the Commission a Certificate of Coverage, signed by an authorized agent or employee of the insurance carrier, which certificate shall be in a form approved by the Commission. (7-1-00)T

118. GROUP INSURANCE PLAN.

The Commission shall make available to all active licensees, subject to terms and availability from a qualified insurance carrier, a policy of Errors and Omissions Insurance under a Group Plan obtained by the Commission. (7-1-00)T

01. Qualified Insurance Carrier Defined. For the purposes of this section, a “qualified insurance carrier” shall mean an insurance carrier: (7-1-00)T

a. Which, for the entire term of its contract shall provide the Group Plan of errors and omissions insurance contemplated by these rules, maintains an A.M. Best Company rating of B+ or better, and an A.M. Best Financial Size Category of Class VI or higher; (7-1-00)T

b. Which is and will remain for the policy term duly authorized by the Idaho Department of Insurance to do business in the state of Idaho as an insurance carrier; (7-1-00)T

c. Which is and will remain for the policy term qualified and authorized by the Idaho Department of Insurance to write policies of errors and omissions insurance in Idaho of the type contemplated by these rules; (7-1-00)T

d. Which, after competitive bidding, has been notified by the Commission that it is the successful bidder for the Group Plan to provide the errors and omissions insurance contemplated by these rules; and (7-1-00)T

e. Which has entered into a contract to provide said group errors and omissions plan in conformity with said contract, these rules and the Idaho Real Estate License Law. (7-1-00)T

02. Right To Cancel. The group policy obtained by the Commission under these rules shall be available to all active licensees with no right on the part of the carrier to cancel any licensee. (7-1-00)T

03. Approved Policy. The group policy obtained by the Commission shall cover all activities contemplated under Chapter 20, Title 54, Idaho Code, shall be subject to such terms and conditions as are customary in the insurance industry for policies of errors and omissions insurance, which are otherwise permissible under Idaho law and the rules of the Idaho Insurance Department, and which are contained in a policy of insurance which has been approved by the Department of Insurance; provided, however, that said Group Plan shall provide, at a minimum, the following terms and conditions: (7-1-00)T

a. Not less than one hundred thousand dollars (\$100,000) limit liability coverage for each occurrence, not including costs of investigation and defense. (7-1-00)T

- b. An annual aggregate limit of not less than three hundred thousand dollars (\$300,000), not including costs of investigation and defense; (7-1-00)T
- c. The minimum coverage requirements of this Subsection shall apply to each individual licensee; (7-1-00)T
- d. A deductible amount of not greater than three thousand five hundred dollars (\$3,500), which shall include costs of investigation and defense; (7-1-00)T
- e. A reasonable premium not to exceed the maximum premium set forth in Section 54-2013, Idaho Code; (7-1-00)T
- f. A policy period equal to each licensee's two (2) year license renewal date or the prorated equivalent, or, if an annually renewable policy, a statement of the policy period, and in either case, the policy shall provide for continuous coverage during the policy period. (7-1-00)T
- g. An extended reporting period per insured of at least ninety (90) days following termination of the policy period; (7-1-00)T
- h. Prior acts coverage shall be offered to licensees with continuous past coverage. (7-1-00)T

04. Standard Of Group Policy Determined. For the purposes of these rules and the fulfillment of the Commission's obligations under Idaho Real Estate License Law, approval by the Idaho Department of Insurance of any group policy of errors and omissions insurance to be issued to the state of Idaho pursuant to these rules shall be conclusive proof that the terms and conditions of said policy meet the standards and practices in the insurance industry with respect to such policies, and that said policy meets the requirements of Idaho law and the rules of the Idaho Insurance Department with respect to such policies of insurance. (7-1-00)T

119. INDEPENDENTLY OBTAINED ERRORS AND OMISSIONS INSURANCE.

Licensees may obtain errors and omissions insurance independently of the Group Policy available through the Commission, subject, however, to the terms and conditions set forth in these rules. (7-1-00)T

01. "Independently Obtained" Insurance Defined. The term "independently obtained" insurance shall mean a policy of errors and omissions insurance issued to each individual licensee or issued to the firm with which the licensee is affiliated and which shall provide, at a minimum, all of the following terms and conditions: (7-1-00)T

- a. Covers all activities contemplated under Chapter 20, Title 54, Idaho Code, under such terms and conditions as are customary in the insurance industry for policies of errors and omissions insurance, which are otherwise permissible under Idaho law and the rules of the Idaho Department of Insurance, and which are contained in a policy of errors and omissions insurance which has been approved by the Idaho Department of Insurance; (7-1-00)T
- b. If an "individual" policy specifies not less than one hundred thousand dollars (\$100,000) limit liability coverage for each occurrence, not including costs of investigation and defense; (7-1-00)T
- c. If a "firm" policy specifies not less than five hundred thousand dollars (\$500,000) limit liability coverage for each occurrence, not including costs of investigation and defense; (7-1-00)T
- d. If an "individual" policy, an annual aggregate limit of not less than three hundred thousand dollars (\$300,000), not including costs of investigation and defense; (7-1-00)T
- e. If a "firm" policy, an annual aggregate limit of not less than one million dollars (\$1,000,000), not including costs of investigation and defense; (7-1-00)T
- f. If an "individual" policy, the minimum coverage limits specified in Subsection 119.01 shall be

available to each licensee; (7-1-00)T

g. If a “firm” policy, the minimum coverage limits specified in Subsection 119.01 shall apply to the firm; (7-1-00)T

h. An extended reporting period per insured of at least ninety (90) days following termination of the policy period; (7-1-00)T

i. No policy of errors and omissions insurance shall be deemed “independently obtained” for purposes of this rule unless the insurance company specifically agrees in writing that it will not terminate, cancel, lapse, fail or refuse to renew or modify such policy without the company first providing the Commission and the licensee with thirty (30) days' written notice; (7-1-00)T

j. Contains a policy period equal to each licensee's two (2) year license renewal date or the prorated equivalent and which provided for continuous coverage during said policy period, or, if an annually renewable policy, a statement of the policy period and, in either case, the agreement of the insurance carrier that it will not modify, terminate, cancel, lapse or not renew the policy without first providing the Commission and licensee thirty (30) days written notice; and (7-1-00)T

k. Prior acts coverage shall be offered to licensees with continuous past coverage. (7-1-00)T

02. Approval By Department of Insurance. For the purposes of these rules and the fulfillment of the licensees' obligations under Idaho Real Estate License Law, approval by the Idaho Department of Insurance of a policy of independently obtained errors and omissions insurance covering the licensee shall create a presumption that the terms and conditions of said policy meet the standards and practices in the insurance industry with respect to such policies, and that said policy meets the requirements of the law and rules of the Idaho Department of Insurance with respect to such policies of insurance. Approval by the Department of Insurance, however, does not create any presumption of equivalency in coverage as required by Idaho Real Estate License Law and these rules. (7-1-00)T

03. Carrier Issuing Independent Policy. A carrier issuing an independent policy shall meet all of the requirements of a qualified carrier set forth in Subsections 118.01.a. through 118.01.c. and shall maintain an A.M. Best Company rating of B+ or better and an A.M. Best Financial Size Category of Class VI or higher. (7-1-00)T

120. CERTIFICATION A PREREQUISITE FOR LICENSE ISSUANCE OR RENEWAL.

No applicant for an original active license or for renewal of an active license shall be issued such active license unless proper payment of insurance premiums and any fees have been received by the Commission if the licensee is with the Group Plan, or unless he has first filed with the Commission the Certificate of independently obtained coverage required by Subsection 117.02. (7-1-00)T

121. FAILURE TO MAINTAIN INSURANCE.

Failure of a licensee to obtain and maintain insurance through the Group Plan or failure to file the certificate of independently obtained coverage required by Subsection 117.02 shall result in inactivation or expiration of any active license issued pursuant to Idaho Real Estate License Law or denial of any application for issuance or renewal of an active license. Failure to maintain insurance as required herein shall be deemed insufficient application for licensure under Section 67-5254, Idaho Code. (7-1-00)T

01. Notice Of Noncompliance. Within five (5) working days of the date the Commission is notified that a licensee does not have required coverage, the Commission shall notify the affected licensee of noncompliance. Notice shall be sent by certified mail to the licensee's business or residence address, as reflected in the Commission's records, and a copy of the notice shall be sent to the licensee's broker, if any. The notice shall provide that the licensee has ten (10) days in which to comply with the law and these rules regarding errors and omissions insurance. Failure to comply at the end of ten (10) days shall result in the license being automatically inactivated. (7-1-00)T

02. Reactivation. Any licensee whose license has been inactivated for failure to comply with these rules shall be entitled to activate said license, relating back to and including the date of inactivation, provided that, within thirty (30) days of the date of inactivation, the licensee or Group Plan Administrator files with the Commission a certificate of coverage showing that such coverage has been and is currently in effect on and from the date of

inactivation, with no lapse in coverage. Further, the licensee must submit required documents and fees to activate said license. In the event the certificate of coverage shows an effective date later than the date of inactivation, said license shall be activated as of the effective date of said insurance, as reflected in the certificate of coverage, and upon submission of any required documents and fees. (7-1-00)T

03. Failure To Maintain Insurance. Failure of a licensee to maintain errors and omissions insurance or failure of a licensee to submit or cause to be submitted a certificate of coverage as required by Section 54-2013, Idaho Code, and in accordance with these rules and while engaging in the business of real estate broker or real estate sales person, as defined in Sections 54-2002 and 54-2004, Idaho Code, shall constitute a violation of these rules, and shall be grounds for disciplinary action as provided in Sections 54-2059 and 54-2060, Idaho Code, including but not limited to the assessment of civil fines. (7-1-00)T

122. FALSIFICATION OF CERTIFICATES.

Any licensee who, acting alone or in concert with others, wilfully or knowingly causes or allows a certificate of coverage to be filed with the Commission which is false, fraudulent, or misleading, shall be subject to disciplinary action, including but not limited to suspension or revocation of license, in accordance with Chapter 52, Title 67, Idaho Code; provided, however, that nothing herein shall entitle such licensee to notice and hearing on the automatic inactivation of license provided for in Subsection 121.01. (7-1-00)T

123. -- 199. (RESERVED).

Rules 200 through 299 --
OFFICE OPERATIONS

200. TRANSACTION NUMBER AND LEDGER SHEET.

The responsible broker shall account for the funds or other consideration by assigning a transaction number and maintaining an individual ledger sheet, as required by law, regardless of when the funds are to be deposited. (7-1-00)T

201. OBTAINING COMMISSION APPROVAL OF AN ESCROW DEPOSITORY.

An entity not specified as an approved escrow depository in Section 54-2042(1), Idaho Code, may be accepted and approved by the Commission as an escrow depository upon disclosure of: (7-1-00)T

01. Financial Structure. The details of the entity's financial structure; (7-1-00)T

02. Amount And Terms Of Errors And Omissions Insurance And Any Bonding; (7-1-00)T

03. Copy Of Last Audit And Financial Statement; (7-1-00)T

04. Copy Of License(s) Or Certificate(s) Issued To The Entity; and (7-1-00)T

05. Information Which Will Help The Commission Make Its Determination. Any other information which will help the Commission make its determination. (7-1-00)T

202. LOCATION OF TRUST ACCOUNT RECORDS FOR BRANCH OFFICES.

When a separate real estate trust account is maintained for a branch office, all records for that account, together with all the related files, shall be maintained at one (1) office, which shall be the branch office. (7-1-00)T

203. TRANSFERRING TRUST FUNDS TO THE NAMED CLOSING AGENCY.

Funds received as earnest money deposits or other payments, when it is set forth in the purchase and sale agreement that such funds are to be paid to the person or company named as the escrow closing agent or agency, are to be paid to the person, company, agent, or agency on or before the day of closing and a receipt for such funds shall be retained in the broker's transaction file. The broker will remain accountable and responsible for such funds until a full accounting has been made to the parties involved. (7-1-00)T

204. -- 399. (RESERVED).

Rules 400 through 499 --
BUSINESS CONDUCT

400. DUTY TO KNOW LAW AND RULES.

It shall be the duty of all licensees to have knowledge and be aware of all laws regulating the real estate industry in Idaho including, but not limited to, the Idaho Real Estate License Law and the Broker Representation Act, as set forth in Chapter 20, Title 54, Idaho Code, and the administrative rules of the Idaho Real Estate Commission. (7-1-00)T

401. (RESERVED).

402. DOUBLE CONTRACTS.

For purposes of the prohibition against double contracts, contained in Section 54-2054, Idaho Code, and defined in Section 54-2004, Idaho Code, an agreement or loan application "is not made known to the prospective loan underwriter or loan guarantor" unless its existence is disclosed in writing to the prospective loan underwriter or loan guarantor. (7-1-00)T

403. -- 409. (RESERVED).

410. DUTIES OF CONFIDENTIALITY TO CLIENTS.

A real estate licensee and brokerage who have gained "confidential client information" in the course of acting as an agent or limited dual agent have the following duties: (7-1-00)T

01. Duty To Maintain Confidentiality. Information must be kept confidential under this statute as long as the information held by a licensee or brokerage about a client or former client: (7-1-00)T

a. Is not a matter of public record; (7-1-00)T

b. Is information the client or former client has not disclosed or authorized to be disclosed to third parties; (7-1-00)T

c. If disclosed, would be substantially detrimental to the bargaining position of the client or former client in the same or related real estate transaction; or (7-1-00)T

d. Is otherwise within the statutory definition of "confidential client information" in Section 54-2083, Idaho Code. (7-1-00)T

e. This duty to a client continues beyond termination of representation only if the information continues to meet the definition of "confidential client information" or if the information does not become generally known in the marketing community from a source other than the former brokerage or its affiliated licensees. (7-1-00)T

02. Change Of Office And Duty To Maintain Confidentiality. A licensee who has personally gained "confidential client information" about a buyer or seller while associated with one (1) broker and who later affiliates with a different broker is still obligated to maintain the client confidentiality as defined in this rule. (7-1-00)T

03. Clients And Former Clients With Conflicting Interests. If a brokerage represents a buyer or seller whose interests conflict with those of a former client, the brokerage must inform the second client of the broker's prior representation of the first client and that "confidential client information" obtained during that first representation cannot be given to the second client with a conflicting bargaining position as long as it fits the definitions in Subsection 410.01. Nothing in this rule prevents the brokerage from asking the former client for permission to release any such information. (7-1-00)T

04. Not A Privileged Communication. Nothing in this rule or statute is intended to create a

“privileged communication” between any client and any brokerage or licensee for purposes of civil, criminal or administrative legal actions. The issue of confidentiality in this rule is intended to address information which, if disclosed before or during a real estate transaction, would be seriously detrimental to the bargaining position of a represented buyer or seller who has reasonable expectations that such information would remain commercially confidential. (7-1-00)T

411. DISPUTES CONCERNING COMMISSIONS AND FEES.

The Idaho Real Estate Commission shall not be involved in the resolution of disputes between licensees or between licensees and buyers and sellers concerning matters of commissions or fees. (7-1-00)T

412. PRICE FIXING.

The Idaho Real Estate Commission neither recommends nor recognizes any agreement to fix or impose uniform rates of commission on any real estate transaction by licensed real estate brokers. (7-1-00)T

413. TITLE OPINIONS.

No real estate broker or sales associate shall pass judgment upon or give an opinion with respect to the merchantability of the title to property in any transaction. (7-1-00)T

414. LEGAL OPINIONS.

A broker or sales associate shall not discourage any party to a real estate transaction from seeking the advice of an attorney. (7-1-00)T

415. OFFICE OPERATIONS AND BROKER SUPERVISION.

A designated broker is required to adequately supervise the activities of licensees and unlicensed personnel for whom he is responsible. The following factors will be among those used to determine adequacy of supervision; however, the Commission is not limited to making a determination on these factors alone, but will examine all pertinent evidence. (7-1-00)T

01. Designated Broker Physically Available To Supervise. Was the designated broker physically available to supervise? (7-1-00)T

02. Experience Level Of The Licensed Associate. What was the experience level of the licensed associate? (7-1-00)T

03. Designated Broker Contracted To Avoid Supervisory Responsibility. Has the designated broker contracted to avoid supervisory responsibility? (7-1-00)T

04. Types Of Activity. What types of activity were licensed sales associates or unlicensed personnel engaged in? (7-1-00)T

05. Established Written Or Oral Policies And Procedures. Had the designated broker established written or oral policies and procedures? (7-1-00)T

06. Determine That Policies And Procedures Are Being Properly Implemented. Does the designated broker hold regular staff meetings and follow-up meetings to determine that policies and procedures are being properly implemented? (7-1-00)T

07. Corrective Or Remedial Action. What corrective or remedial action does the designated broker take if a misdeed of a sales associate or unlicensed personnel is discovered? (7-1-00)T

416. INACTIVE LICENSEES.

During the period of time that his license is inactive, the licensee shall not engage in, carry on, or advertise any real estate activity, or hold himself out as engaging in real estate activity. An inactive licensee may not receive a referral fee for referrals made while the licensee was inactive, unless the referral was made while the licensee was on active status. (7-1-00)T

417. -- 599. (RESERVED).

Rules 600 through 699 --
CERTIFICATION OF PROVIDERS, INSTRUCTORS AND COURSES

601. CONTINUING EDUCATION CREDIT FOR LIVE COURSES.

A licensee may receive continuing education course credit, without having to take or pass an exam, if the licensee personally attends the entire "live" presentation of an approved course. (7-1-00)T

602. PRELICENSE CREDIT FOR SIMILAR REAL ESTATE COURSES.

Upon written request from a license applicant, the Commission may waive or modify one (1) or more prelicense course requirements based upon the applicant's satisfactory completion of similar real estate courses, in Idaho or in another state or jurisdiction. The request for waiver shall be accompanied by an official transcript from the institution that provided the course of instruction, along with a description of the subjects covered in the course and number of classroom hours involved in the instruction. "Satisfactory completion" means the applicant regularly attended the course and received a final grade of "C" or better. (7-1-00)T

603. POSTING AND RECORDING FEES.

The Commission may require that course providers pay, to the Commission, a non-refundable posting and recording fee, the purpose of which is to defray normal expenses incurred in maintaining the certificate program. The fee amount shall be established by the Commission by motion. (7-1-00)T

604. DISCLOSURE OF FEES CHARGED BY PROVIDERS.

All fees charged to a student by a course provider shall be specified separately in writing. If additional fees are charged for supplies, materials or books needed in course work, such fees shall be itemized by the provider, and, upon payment of such fees, the supplies, materials or books shall become the property of the student. All fees, and the manner in which they are to be paid, shall be stated in a student contract, in a form approved by the Commission. The student contract shall expressly include the provider's policy regarding the return of fees in the instance where the student is dismissed or voluntarily withdraws from the course. (7-1-00)T

605. CHANGES IN COURSE CURRICULUM.

Each course provider shall submit schedules of its courses and instructors, as requested by the Commission. Whenever there is a change in a course, such as, but not limited to, curriculum, course length or instructor, the provider shall promptly notify the Commission in writing of the change. (7-1-00)T

606. WITHDRAWAL OF CERTIFICATION FOR COURSE CONTENT, COURSE PROVIDER, OR COURSE INSTRUCTOR.

If the Commission at any time determines that an instructor, course, or provider is not meeting the requirements for continued Commission approval or certification, written notification shall be made immediately to the appropriate person, detailing the deficiencies requiring correction. The Commission shall take no action to withdraw the certification for thirty (30) days from the date of such written notice. At the expiration of this period, if the deficiencies have not been corrected to the Commission's satisfaction, the Commission may take action to withdraw certification. Withdrawal of certification shall be governed by the Idaho Administrative Procedure Act, Chapter 52, Title 67, Idaho Code, and IDAPA 33.01.02, "Rules of Practice and Procedure of the Idaho Real Estate Commission". (7-1-00)T

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Bulletin Summary of Proposed Rulemakings

PUBLIC NOTICE OF INTENT TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all related, pertinent information concerning their intent to change or make the following rules in the new issue of the state Administrative Bulletin.

IDAPA 01- IDAHO BOARD OF ACCOUNTANCY P.O. Box 83720, Boise, ID 83720-0002

Docket No. **01-0101-0001**, Idaho Accountancy Rules. Conforms to statutory changes requiring more college education to sit for the Uniform CPA Exam and defines and updates the standards for the Educational Equivalencies allowed in place of the college requirement. Comment By: 6/28/00.

IDAPA 11 – DEPARTMENT OF LAW ENFORCEMENT (IDAHO STATE POLICE*)

P.O. Box 700, Meridian, ID 83680-0700

Docket No. **11-1001-0001**, Rules Governing the ILETS System - Idaho Criminal Justice Information System. Repeal of chapter. Comment By: 6/28/00.

Docket No. **11-1001-0002**, Rules Governing the ILETS System, Idaho Law Enforcement Teletypewriter System. Rewrite of chapter changes the name of chapter and includes provisions relating to network security, user fee collection, and the board meetings that were previously adopted and published outside the APA. Comment By: 6/28/00.

*Note: After July 1, 2000, the Department of Law Enforcement will be called the Idaho State Police.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE (IDAPA 58 – DEPARTMENT OF ENVIRONMENTAL QUALITY*) 1410 N. Hilton, Boise, Idaho 83706-1255

Docket No. **16-0102-0001****, Water Quality Standards and Wastewater Treatment Requirements. Adopts the most recent EPA recommended aquatic life criteria for ammonia for the Spokane River. Comment By: 7/7/00.

*Note: After July 1, 2000, the Division of Environmental Quality will be the Department of Environmental Quality and will have the agency designation IDAPA 58. This rulemaking docket number will change to 58-0102-0001** at that time.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE P.O. Box 83720, Boise, Idaho 83720-0036

Docket No. **16-0309-0001**, Rules Governing Medical Assistance. Clarifies that if services or items do not have a specific price on file, the vendor must submit documentation to the Department and reimbursement will be based on the documentation. Comment By: 6/28/00.

Docket No. **16-0309-0002**, Rules Governing Medical Assistance. Requirements for authorization of out-of-state medical care in non-bordering counties will be the same as for medical care received within the state of Idaho; methodology for computing the penalty assessed against physicians who fail to obtain a timely pre-admission PRO review will be changed to conform to that used for hospital penalties and the Physician Penalty Chart will be revised to assess a penalty for a certain dollar amount per day, depending upon the number of days the pre-admission review

is late; Department retrospective late review will be allowed to determine if psychiatric admissions of Medicaid clients under age 21 meet medical necessity criteria when the pre-admission or continued stay review was not requested in a timely manner and a set monetary penalty will be imposed on providers who fail to request such review; in-patient hospital services will be changed to comply with the change in length of stay criteria for admissions; changes wording "round trip mileage" to "transportation costs" which will no longer be dependent on prior authorization for out-of-state care; and removes the requirement of x-ray to demonstrate subluxation to pay for manipulation of the spine. Comment By: 6/28/00.

Docket No. **16-0309-0003**, Rules Governing Medical Assistance. Lowers minimum age for Targeted Service Coordination to 18 years, to reflect a change made to the Developmental Disabilities and Idaho State School and Hospital waivers. Comment By: 6/28/00.

Docket No. **16-0309-0004**, Rules Governing Medical Assistance. Provides greater specificity to assure that all eligible persons for nursing home, Aged and Disabled Waiver, and the Traumatic Brain Injury Waiver services are properly identified and uses the Uniform Assessment Instrument to standardize the process for all program applicants; clarifies who can order/recommend/refer a Medicaid Reimbursable service other than a physician; other changes reflect the current citation for NF Level of Care. Comment By: 6/28/00.

Docket No. **16-0310-0001**, Rules Governing Medicaid Provider Reimbursement. Identifies the addition of a special rate for consumers who have long term care needs beyond the scope of facility services; determination for a special rate will be made on a case-by-case basis and will be in addition to any authorized payments. Comment By: 6/28/00.

**IDAPA 27 – BOARD OF PHARMACY
PO Box 83720, Boise, ID 83720-0067**

Docket No. **27-0101-0001**, Rules of the Board of Pharmacy. Changes physical address of the Idaho Board of Pharmacy. Comment By: 6/28/00.

**IDAPA 29 – IDAHO POTATO COMMISSION
PO Box 1068, Boise, ID 83701**

Docket No. **29-0102-0001**, Rules Governing Payment of Advertising Tax and Usage of Federally Registered Trademarks. Authorizes the packing of Number 2 Grade Idaho potatoes in cardboard box containers under defined conditions in order to meet changes within the food service industry, but to limit the possibility of putting non-Idaho® potatoes into containers bearing the certification marks owned or administered by the Idaho Potato Commission. Comment By: 6/28/00.

**IDAPA 33 – IDAHO REAL ESTATE COMMISSION
PO Box 83720, Boise, ID 83720**

Docket No. **33-0101-0001**, Rules of the Idaho Real Estate Commission. Repeal of chapter. Comment By: 6/28/00.

Docket No. **33-0101-0002**, Rules of the Idaho Real Estate Commission. Rewrite of chapter reflects changes conforming to new statute SB 1312. Comment By: 6/28/00.

PUBLIC NOTICE OF IMPLEMENTATION OF SENATE BILL 1530

Section 56-227E, Idaho Code, effective April 14, 2000, which was enacted through Senate Bill 1530, prohibits non-commercial Medicaid transportation providers from billing for more than 5 clients per motor vehicle.

PUBLIC HEARINGS ON RULEMAKINGS

Public Hearings have been scheduled for the following dockets:

Department of Health and Welfare

Docket No. **16-0102-0001**, Water Quality Standards and Wastewater Treatment Requirements.

Idaho Potato Commission

Docket No. **29-0102-0001**, Rules Governing Payment of Advertising Tax and Usage of Federally Registered Trademarks.

Please refer to the Idaho Administrative Bulletin, **June 7, 2000, Volume 00-6** for notices and text of all rulemakings, public hearing schedules, Governor's executives orders, and agency contact names.

Citizens of your county can view all issues of the Idaho Administrative Bulletin at the county law libraries.

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The Idaho Administrative Bulletin and Administrative Code are available on the Internet at the following address: **<http://www.state.id.us/>** - from the State of Idaho Home Page select Administration Rules.

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